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PREVENTION & POLITICS:
AN INVESTIGATION OF SEX EDUCATION POLICY IN PENNSYLVANIA

A Dissertation in

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by

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ABSTRACT

Sex education in the United States is a complicated and expansive issue. Its reach extends into many different public, political, and theoretical arenas and it serves multiple (and often competing) purposes, including, but not limited to, the prevention of adolescent pregnancy and HIV and sexually transmitted infection (STI) acquisition, the prevention or delay of adolescent sexual activity, and the promotion of critical thinking and healthy decision-making skills around sexuality. The content, duration, and approach of sex education programs and curricula vary considerably both within and across states as a consequence of the U.S.'s decentralized education system. This study employs survey and case study methods to respond to two research questions: what types of sex education policies and programs are currently in place across the state of Pennsylvania, and what factors influence their adoption or design? The methods of data collection and analysis are rooted in a culture wars theoretical framework, which purports that American attitudes on issues involving morality policies are not a function of individual material stakes, but rather of personal fundamental beliefs about right and wrong and about the source(s) of moral authority. The results of this investigation demonstrate a great deal of variation in program offerings across the state and suggest that time and resource constraints (due in large part to standardized testing demands) as well as the progressive or orthodox impulses of those responsible for sex education decisions are the most influential factors on these offerings. Implications for policy and theory are discussed.
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Chapter 1
Introduction

Unplanned pregnancy and sexually transmitted infection (STI) acquisition among adolescents have been severe societal and public health problems throughout the second half of the 20th century and they continue to be pressing social issues as we move further into the 21st century. In 2006 the teen birth rate in the United States rose for the first time in fifteen years by 3%, from 40.5 to 41.9 live births per 1,000 15-19 year olds (Centers for Disease Control and Prevention, 2007). They rose again by another percentage point in 2007 from 41.9 to 42.5 (Hamilton, Martin, & Ventura, 2009). While it is too early to discern whether these increases are indicative of a new trend, the fact remains that even during their 14 years of decline, the teen pregnancy and birth rates in the United States were still significantly higher than those in Western Europe, Japan, Australia, Canada, and many other developed countries across the world (Singh & Darroch, 2000). The same is true of STI acquisition rates, including HIV/AIDS (Panchaud, Singh, Feivelson, & Darroch, 2000); recent data from the Centers for Disease Control and Prevention (CDC) indicates that one in four teenage girls in the United States is infected with a sexually transmitted infection (Centers for Disease Control and Prevention, 2008). Despite its wealth, power, and international standing, the United States has among the highest rates of teen pregnancy and STI acquisition of all
industrialized nations. Why does the U.S. lag so far behind its peers with regard to the promotion of adolescent sexual health?

The answers to this question cover a wide range of social, political, and economic issues, including distribution of wealth, cultural norms, levels of religiosity, availability, affordability, accessibility, and acceptability of contraceptives, and the roles of family and school in the education of young people about sex. As a result, it would be virtually impossible to isolate one or two unique factors that are singularly responsible for our elevated rates or their reduced rates. Despite the complex array of issues accounting for internationally differentiated rates in teen pregnancy and STI acquisition, it remains true that in other nations and within our own, sexuality education that teaches youth about sexual abstinence as well as safer sex has been demonstrated to influence positive behavior change among youth in the short term and reduce their rates of unplanned pregnancy and STI acquisition in the long term. Numerous peer-reviewed empirical research studies have confirmed the success of this comprehensive approach in delaying the onset of sexual intercourse, reducing frequency of sexual activity, reducing number of sexual partners, and increasing the usage of condoms and contraceptives during sexual activity (Collins, Alagiri, Summers, & Morin, 2002; Kirby, 2001; Silva, 2002). Consequently, these are all behaviors that will ultimately result in a reduction in unplanned pregnancies and STIs.

Ironically however, despite demonstrated effectiveness, comprehensive sex education programs have faced a great deal of political opposition in the United States over the past three decades. Since 1981, U.S. federal policy has supported an
abstinence-only approach to sex education, in which students are taught that sexual abstinence is the only acceptable behavior for unmarried individuals. This approach does not provide youth with knowledge or skills related to the acquisition or usage of contraceptives, as such information would be contradictory with the approach’s core message. Whereas comprehensive sex education programs have a wealth of empirical data to support their effectiveness, abstinence-only programs have been consistently denounced as ineffective in their primary goal of keeping young people abstinent until they are married, and further, have no effect on condom or contraceptive use when they are sexually active (Santelli et al., 2006; Trenholm et al., 2007). Further, abstinence-only sex education is a phenomenon that is wholly unique to the United States; no other government in the industrialized world promotes this method of teaching young people about sex.

Sex education is considered by many to be a hot button issue in the United States, but public opinion data indicates that there is not nearly as much controversy over it as the media, activist groups, and various political players would have us believe (Bleakley, Hennessy, & Fishbein, 2006; National Public Radio, Kaiser Family Foundation, & Kennedy School of Government, 2004a). The rhetoric used by these parties suggests that socially conservative Americans are at war with their liberal counterparts over what schools should be teaching our kids about sex. It implies that there cannot be a satisfactory compromise because those who favor a strict abstinence-only approach to sex education will never be convinced that teaching kids about condoms is a worthwhile endeavor as it encourages and is permissive of sexual activity among young people and
consequently undermines the message that youth should remain abstinent until they marry. Alternatively, those who support a comprehensive approach to sex education will never be able to endorse the abstinence-only approach because it conflicts with all of the public health research and scholarship that suggest that these programs put kids at greater risk for sexually transmitted infections and unplanned pregnancies.

To be clear, the debate over sex education has nothing to do with whether schools should be teaching kids about sex, but rather what they should be teaching them. Sex education in some form is virtually omnipresent across the United States (Guttmacher Institute, 2008), but in a country where the vast majority of curricular decisions are made at the local school district level, it is nearly impossible to know what each individual school district is teaching its students about sex. The Guttmacher Institute (2008) regularly compiles a collection of sex education and STI/HIV education policies in each state, focusing on mandated topics, required emphases, and parental opt-out options, but this summary tells us nothing of what is occurring at the local level in any of the states. Further, because state educational standards are often worded in ways that leave room for interpretation to allow local districts the autonomy to implement them in ways that are meaningful and relevant to their unique circumstances, the range of curricular possibilities is essentially limitless.

This study examines the sex education policies and programs in place within a sample of school districts in the state of Pennsylvania and subsequently investigates the influences and motivations involved in the selection of these policies and programs. An assessment of sex education policies and programs in local school districts is extremely
valuable precisely because there is no source currently that documents this information at the school district level in any state. With teen pregnancy, birth, and STI rates on the rise, the need for medically accurate, empirically supported sex education programs is exceedingly apparent, but recent survey data suggests that at least 30% of American schools are implementing a strict abstinence-only approach (National Public Radio et al., 2004a). Whereas a plethora of empirical research studies endorse comprehensive sex education as an effective means for delaying sexual activity, reducing number of sexual partners, and increasing condom and contraceptive use during sexual activity, evaluations of abstinence-only programs indicate that they have no impact on any of these behaviors (Trenholm et al., 2007). Moreover, a majority of American parents (approximately 82%) want schools to teach students about both abstinence and contraception (Bleakley et al., 2006; National Public Radio et al., 2004a), yet a third of school districts employs an abstinence-only approach. This investigation therefore attends to the lack of information about and likely variation of sex education policies and programs as well as the explanations for the adoption of these policies and programs.

Research Questions

This study is guided by two main research questions. First, what sex education policies, programs, or other activities are in place in Pennsylvania’s school districts? Second, what factors shape the outcomes of decision-making processes by school
districts around sex education programming? To respond to the first question, I examined the school based sex education policies and programs in place within a sample of 29 of Pennsylvania’s 501 school districts by conducting surveys with teachers, administrators, and/or school nurses within each of these districts. To tackle the second query, I constructed case studies of two of these districts, compiling a wide array of socioeconomic and public health data and news media and conducted intensive, probing interviews with several key informants within these districts that were similar in several respects, but varied markedly on the type of sex education program they employed.

**Operational Definitions**

Terminology regarding sex education is often used without much forethought or explanation of what certain words and phrases imply to others, and the fact that many of these terms or concepts lack formal, objective definitions (even within many sex education policies and programs) complicates the situation further. Even the word “sex” means different things to different people. I therefore offer the following definitions for common terms and phrases involved with sex education. Unless otherwise noted, these definitions will apply throughout this dissertation.
Sex

Though it may seem odd that the term “sex” would require formal definition, there is, in actuality, a wide range of behaviors that are considered sexual intercourse or sexual contact depending on the social context and cultural values of the individuals involved. Sanders and Reinisch (1999) discovered a great deal of variation in how individuals define “having sex.” In a survey of 599 undergraduates at a large Midwestern state university, the researchers provided the participants with a list of 11 different behaviors and asked them, “Would you say you ‘had sex’ with someone if the most intimate behavior you engaged in was...” (p. 276). The list included the following set of behaviors: (1) deep kissing; (2) oral contact on your breasts/nipples; (3) person touches your breasts/nipples; (4) you touch other’s breasts/nipples; (5) oral contact on other’s breasts/nipples; (6) you touch other’s genitals; (7) person touches your genitals; (8) oral contact with other’s genitals; (9) oral contact with your genitals; (10) penile-anal intercourse; and (11) penile-vaginal intercourse.

As one would likely expect, almost everyone in the sample responded that penile-vaginal intercourse qualified as having “had sex.” However, nearly 20% of the respondents indicated that they did not believe that engaging in penile-anal intercourse was the same thing as “having sex,” and 60% said that engaging in oral-genital contact was not “having sex” either. Approximately 15% of the respondents considered manual genital stimulation (given or received) as “having sex.” In summarizing the data, the authors stated, “These data make it clear that general agreement regarding what
constitutes having ‘had sex’ and how sexual partners are counted cannot be taken for
granted” (p. 277). Further, there is more to sex than just physical acts. The broader
concept of “sexuality” incorporates issues of gender, sexual orientation, body image,
etc. For the purposes of this study, the term “sex” will refer to any and all acts that
involve penile penetration of either the vagina or the anus, as well as all oral-genital
contact. The justification for this definition is based on the fact that the vast majority of
sexually transmitted infections (STIs) are transmitted by engaging in one or more of
these behaviors. To put it more simply, because sexually transmitted infections are by
definition transmitted sexually, if you can get an STI from it, then it is “sex.” This
definition omits the broader concepts associated with “sexuality” not because they are
irrelevant concepts, but because they are not generally addressed (at least in very much
detail) in the vast majority of sex education programs (National Public Radio, Kaiser
Family Foundation, & Kennedy School of Government, 2004b).

Abstinence

Abstinence is the act of not doing something. In the sex education arena,
“abstinence” means not having sex. However, as we have just seen, there are so many
different conceptions of what “sex” is, which makes it even harder to explain what not
having “sex” is. Further, many sex education programs and curricula also fail to provide
a specific definition for the concept, as do the federal grant programs that were
designed to promote it. “Abstinence” can either be intentional or de facto. In other
words, an individual can deliberately opt not to have sex or may just happen not be sexually active at a particular point in time. For those whom abstinence is a deliberate choice, the rationales for their choices vary. These rationales include (but are certainly not limited to) prevention of pregnancy and STIs, not feeling psychologically or emotionally ready for sex, and/or religious/moral obligations. Similarly, intentionally abstinent individuals differ in the length of time that they plan to remain abstinent. Some individuals intend to abstain from sex until they marry. For others, the goal is to remain abstinent until after high school or college, and some intend only to remain abstinent until they find a partner that they feel comfortable having sex with, regardless of age or context. Further, self proclamations of sexual abstinence are nonspecific about the particular sexual behaviors being abstained from.

Dailard (2003) further questions this muddled concept by placing it in a contraceptive/prophylactic context:

What is abstinence in the first place, and what does it mean to use abstinence as a method of pregnancy or disease prevention? What constitutes abstinence ‘failure,’ and can abstinence failure rates be measured comparably to failure rates for other contraceptive methods? What specific behaviors are to be abstained from? And what is known about the effectiveness and potential ‘side effects’ of programs that promote abstinence? (p. 4)

When abstinence is promoted as a public health strategy to prevent unintended pregnancy or STI acquisition, the term takes on an entirely different connotation than when it is used to describe morally or religiously based decisions to refrain from having sex. She contends that attempts to define the term as a prevention method (in the same way we would describe other pregnancy and STI prevention methods) obfuscate
the issue further because no one has ever attempted to measure or study users of
“abstinence” as a prevention method. In this context, “abstinence” is just as subject to
user failure as other prevention methods, a proposition that is contrary to the
commonly stated assertion that “abstinence” works in preventing pregnancy and STIs
100% of the time.

A recent cognitive linguistic analysis of terminology and rhetoric pertaining to
sex education (Real Reason, 2008) indicated that the term “abstinence” tends to be
used primarily in the context of harmful, compulsive or addictive, violent, or otherwise
negative behaviors or activities, that the concept is understood to be about discipline
and self-restraint, and is connected to the process of character development. These
varied conceptions of the term suggest that the concept of “abstinence” is not as simple
as just “not having sex.” For the purposes of this study, “abstinence” will be defined as
the intentional practice of not having sex (which includes each of the sexual behaviors
outlined in the previously) for the purpose of preventing pregnancy and STI acquisition
as well as psychological and emotional harm. The term also carries with it undertones
about purity and the promotion of heterosexual marriage, but most public school-based
programs do not blatantly address these issues, but rather promote the concept in a
strictly preventative context.
Sex Education

“Sex education” involves the provision of information about human sexuality and the development of skills regarding sexual behavior and decision-making. Sex education occurs in a variety of settings (e.g., school, home, church, community group) and is provided to individuals of all ages. For the purposes of this study, the phrase “sex education” refers specifically to public school-based sex education aimed at youth in grades K-12. Sex education in public school settings may take place in a separate sex education class, may be a lesson or series of lessons in another class, may take place during individual counseling sessions, and/or may involve special assemblies, presentations, or lessons outside of classes. School-based sex education also varies in duration, content, and method(s) of information delivery. The providers of school-based sex education include (but are not limited to) teachers, nurses, counselors, and individuals with external organizations (e.g., Boys and Girls Clubs, rape and victim assistance centers, family planning organizations, hospitals). Sex education also serves several different (and occasionally conflicting) purposes, including the prevention of unplanned pregnancy and STI acquisition, the installment of values about sexuality and its place in our lives, and the promotion of healthy body image and self-esteem, among others. The wide-ranging diversity in sex education program possibilities is, in fact, the impetus for this research; this dissertation examines each of these dimensions as they relate to sex education within a sample of Pennsylvania school districts. In recent years, sex education programs have been lumped into one of two major categories:
abstinence-only and comprehensive. While it is most definitely an oversimplification to suggest that a program must fit neatly into one of these categories or the other, these are the labels most commonly used by policy-makers, school administrators, journalists, academics, advocacy groups, and the general public as well. I will begin by introducing the former category, abstinence-only sex education.

**Abstinence-Only (Until Marriage) Sex Education**

“Abstinence-only” sex education is sometimes referred to as “abstinence-based,” “abstinence-only-until-marriage,” or simply “abstinence education.” I have opted to use the “abstinence-only” label for the purposes of this study. While the approach promoted in federal policy is quite clearly “abstinence-only-until-marriage,” schools that apply an “abstinence-only” focus are not always specific in designating the time at which abstinence is no longer the necessary or expected course of action. To be clear, schools or other organizations that receive funding through one of the federal “abstinence-only-until-marriage” grant programs are required to be specific about the “until marriage” piece, but because this study is not focusing solely on schools that receive this funding, I will use the more general “abstinence-only” label. Abstinence-only sex education teaches that abstinence is the only acceptable behavior for school-aged youth. These programs can vary in the extent to which they disseminate information regarding alternative pregnancy and STI-prevention methods, such as condom and contraceptive use. In general, though, they provide little to no information
on these topics and in the instances that information is provided, it is often to censure or condemn their usage in order to further emphasize abstinence as the only acceptable option for young (unmarried) people.

**Comprehensive Sex Education**

“Comprehensive sex education” is the second major category of sex education approaches and it too is often understood very differently by different people. Comprehensive programs, like abstinence-only programs, vary in the degree to which they emphasize abstinence versus safer sex techniques, but at their core, all of the programs that fall into this category acknowledge that not all students will remain abstinent throughout high school and even fewer will wait until marriage and therefore provide information and skills regarding both topics. Comprehensive programs are sometimes referred to as “abstinence-plus” programs because this title implies that they do, in fact, cover abstinence, among several other sexual health topics, including condoms and contraception. However, this moniker appears to only have sprung up in an attempt to reconcile this approach with the politically favorable abstinence-only approach.

In a recent study of the predictors of comprehensive sex education in public schools, “comprehensiveness” was defined as “coverage of, at a minimum, all of the following topics: abstinence (either until older or marriage), HIV/AIDS, other STDs, and contraception” (Lindau, Tetteh, Kasza, & Gilliam, 2008, p. 259). This definition was a
summation of all of the shared elements of eleven prevailing definitions from organizations such as Planned Parenthood, the American Academy of Pediatrics, the American Medical Association, and others. The researchers acknowledged that organizations and pieces of legislation vary both by which topics they recommend be covered in a comprehensive curriculum and in the level of detail of their guidelines, but that overall, “there is general agreement that adolescents should be provided, at minimum, medically accurate information about abstinence, contraception, HIV/AIDS, and other sexually transmitted diseases (STDs)” (p. 257).

Based on the various definitions and understandings of the concept both in the scientific literature and among politicians, parents, advocacy groups, and so on, I find it useful to envision the “comprehensiveness” of sex education as a spectrum. Imagine at one end of this spectrum the most basic example of a comprehensive sex education program conceivable. It would include, at minimum, information about abstinence as well as contraception and disease prevention in addition to covering the basics of human reproduction, but would not cover more culturally sensitive topics such as sexual orientation, abortion, or masturbation. This very basic program may or may not promote abstinence as the best choice for young people, but still discusses (in a nonjudgmental way) preventative measures for those who choose not to abstain. The program would start somewhere between the fifth and eighth grade (before most teens typically become sexually active), but may or may not continue and be reinforced throughout the high school years.
Now imagine at the other end of the spectrum what a completely comprehensive school-based sex education program would look like. It would encompass all of the possible topics relating to human sexuality without bias or judgment. It would begin in Kindergarten and extend through the twelfth grade, providing youth with developmentally appropriate information throughout the school years, and the dissemination of this information would be fully integrated into other courses and school activities throughout one’s schooling. This program would also cover the entire gamut of possible subjects relating to human sexuality in an objective, academic fashion. The fact of the matter is that there is no one model or typical comprehensive sex education program but rather a range of possibilities. For the purposes of this study, I define a “comprehensive sex education” program as one that at the bare minimum covers both abstinence and safer sex as viable options for youth for preventing unplanned pregnancies and STIs. If a sex education program fits somewhere along the previously envisioned comprehensiveness spectrum, it will be qualified as a comprehensive program here.

**Dissertation Outline**

This dissertation is organized into seven chapters. In this initial chapter I have introduced the topic of school based sex education, proposed two research questions pertaining to school based sex education, and provided operational definitions for key terms and phrases. Chapter 2 reviews literature pertinent to this dissertation. It first
summarizes empirical evaluations of sex education programs and approaches, focusing primarily on meta-analyses that have examined multiple sex education evaluations simultaneously. Next, it discusses the social and economic costs associated with adolescent childbearing and STI acquisition. Third, the chapter gives an overview of federal policy pertaining to sex education, from 1981 to present. Fourth, it situates the United States in a global context, examining adolescent sexual health outcomes and sex education approaches cross-nationally. The chapter concludes by similarly situating the state of Pennsylvania in a national context and discussing sex education in the context of the country’s decentralized educational system.

Chapter 3 presents the dissertation’s conceptual underpinnings. First, I introduce the concept of morality policy, explaining what it is and why it makes up its own distinctive policy typology, and demonstrate how sex education falls within it. Second, I explain how morality policy issues are at the epicenter of the alleged American culture wars, or conflicts that arise over the codification of dissonant values into policy or law. The literature documented in this chapter examines the nature of this cultural conflict and describes how and why schools are a common battleground for morality policy conflict. To conclude, I propose a culture wars theoretical framework upon which the methods of this investigation are based. This framework consists of a set of theoretically based assumptions about the distinctive character of morality policy and the dynamics of American cultural conflict.

Chapter 4 describes the design and methods employed in this dissertation. First, it explains the survey portion of the study, in which I conducted telephone surveys with
professionals in a sample of 29 school districts in Pennsylvania. It discusses the survey instrument and the type of data collected as well as the means of data analysis employed. Second, it describes the second phase of data collection in which I conducted more thorough interviews in two of the 29 originally sampled districts to take a closer look at the dynamics of sex education program and policy adoption at the local district level and generate two small district case studies. I iterate the means of case selection, describe the interview protocol used, and again explain the process of data analysis. This chapter concludes with a section addressing the rigor and soundness of these methods in investigating the phenomena of interest.

Chapters 5 and 6 discuss the results of my investigation and connect these results back to the study’s research questions. Chapter 5 provides the results from the school district surveys. This chapter summarizes the findings into four major categories: (1) approaches to sex education employed; (2) sources of influence and decision-makers; (3) quality of sex education programming and teacher training; and (4) controversiality. Chapter 6 contains the findings from my two school district case studies. In this chapter I describe socioeconomic and demographic characteristics, public health indicators, and relevant news items for the two regions that comprise these districts and provide a thorough discussion and analysis of the aforementioned data as well as the two districts’ survey results and key informant interviews.

In Chapter 7, I discuss the policy and theoretical implications of the results generated from this research. I offer recommendations and discussion based on the findings of the study and summarize the study’s overarching findings and relate them
back to the theories discussed in Chapter 3, proposing amendments to the original framework and making recommendations for future research. The chapter concludes with a discussion of an alternative paradigm to guide the future sexuality education in the United States.
Chapter 2

Literature Review

Sex education is an expansive issue. Its reach extends into many different public, political, and theoretical arenas. Sex education involves young people in school settings and is also a form of health promotion, but it can be highly politicized and controversial because of its moral implications concerning the propriety and/or normality of adolescent sexuality. Consequently, this study is one that is fundamentally interdisciplinary, drawing literature, theory, and methods from a variety of fields, including education, public health and prevention science, public policy research, and political science. In this literature review, I will provide an overview of the research on sex education and discuss the social and economic implications of adolescent childbearing and STI acquisition. I will also contextualize the issue by discussing sex education policy in the United States, compare sex education and adolescent sexual health outcomes in the United States to those in other developed nations, and explain how the U.S.’s decentralized education system affects what sex education looks like at the local school district level.

Sex Education Research and Evaluation

One of the most common purposes (if not the most common purpose) of sex education is the prevention of unplanned pregnancies and STI acquisition. To
accomplish this aim, sex education must focus on how to prevent the behaviors that lead to these outcomes. Effective teen pregnancy and STI prevention programs concentrate on the reduction or mediation of risk factors and the enhancement of protective factors. Prevention scientists define factors that encourage one or more of the behaviors that lead to unplanned pregnancy or STI acquisition as risk factors. Protective factors, on the other hand, discourage one or more of these behaviors and thereby help prevent unplanned pregnancy and STI acquisition (Kirby & Lepore, 2007).

Researchers have been attending to the question of how to best prevent risky sexual behaviors by way of reducing risk factors and/or enhancing protective factors in young people for decades. Scholarship in this area has focused on unveiling the approaches and methods that are the most effective prevention mechanisms. Researchers have examined school-based and community-based programs, programs for at-risk youth and those aimed at a general audience, skills-based versus knowledge-based programs, programs that emphasize abstinence, programs that emphasize contraception, and programs that emphasize both, and programs geared toward specific racial groups. In their assessments, they pose a variety of questions in evaluating programs and approaches: Do these programs delay the onset of sexual intercourse, and if so, for how long? Do they hasten the onset of sexual intercourse and/or increase the frequency of sexual activity? If and/or when teens do become sexually active, do they take preventative measures, such as using condoms? How frequent is their condom or other contraceptive usage? How many sexual partners do these teens have? Do these programs have an impact on multiple sexual behaviors (including vaginal, oral,
and anal sex)? Is there any impact on student knowledge, attitudes, skills, and/or behavior? What are the rates of teen pregnancy and STI acquisition among graduates of these programs? The following summary offers answers to each of these questions from the literature on sex education approaches. Because there have been so many evalulative studies conducted that have addressed these issues, it would be implausible to include all of them in this one place. Therefore, this section will focus on the findings of summative reviews that capture the results from a multitude of studies in this area.

Silva’s (2002) meta-analysis attends to the question of whether school-based sex education programs have any effect in delaying the onset of sexual activity. Her review incorporated the findings from 12 controlled studies on sex education programs. The programs were coded as abstinence-oriented if “the explicit aim was to encourage abstinence as the primary method of protection against sexually transmitted diseases and pregnancy, either totally excluding units on contraceptive methods, or if including contraception, portraying it as a less effective method than abstinence” (p. 474). Programs were coded as comprehensive or safer-sex focused if they “included a strong component on the benefits of use of contraceptives as a legitimate alternative method to abstinence for avoiding pregnancy and sexually transmitted diseases” (p. 474). The results of the analysis concluded that neither program type had a significant effect on increasing or prolonging abstinent behavior, suggesting that the complete prevention of all sexual activity in young people is an improbable achievement.

Kirby (2002a) offered a similar review of sex education approaches that covered 73 studies and their respective programs. This review described the degree to which
these programs delayed sex, increased condom or contraceptive use, and reduced teen pregnancy or childbearing. Pertaining to the programs that would fall into the category of comprehensive sex education, Kirby’s results indicated the following:

These data strongly indicate that sex and HIV education programs do not significantly increase any measure of sexual activity, as some people have feared, and that to the contrary, may delay or reduce sexual intercourse among teens. These results are also consistent with reviews of programs evaluated in other countries that have also found that sex and HIV education programs do not increase any measure or sexual activity...These studies also demonstrate that some programs increased condom use or contraceptive use more generally...None of the programs reduced either condom or contraceptive use (p. 52).

Moreover, a more recent analysis by Kirby, Laris, and Rolleri (2006) identified 17 distinguishing characteristics of curricula that are effective in reducing unprotected sex. Of these 17 characteristics, five pertain to the development of curricula, eight have to do with the curricula themselves, and four involve the implementation of the curricula. These seventeen characteristics are depicted in Figure 2-1.

Collins et al. (2002) published a report summarizing the evidence on the abstinence-only and comprehensive approaches as well. Their review covered many frequently cited studies of both types of programs, including Bearman and Bruckner’s (2001) study of virginity pledges, which noted that while individuals who took a virginity pledge were more likely to remain abstinent than their non-pledging peers, the pledging was generally only effective when the pledgers felt like they were part of a small, select group and was not effective at all ages. Collins et al.’s (2002) findings echoed those of Silva and Kirby, suggesting that “if the goal of school-based sex education is to increase positive health outcomes for youth, comprehensive (or ‘abstinence-plus’) sex education
is the proven effective choice. Abstinence-only programming runs the serious risk of leaving young people, especially those at elevated risk, uninformed and alienated” (p. 8). This report also emphasized the disconnect between the federal funding stream for abstinence-only sex education and the scientific evidence that supports comprehensive sex education.

Curriculum Development

- Involvement of multiple people with varied backgrounds
- Assessment of relevant needs and assets of target groups
- Use of a logic model approach that specifies health goals and other objectives and activities
- Design of activities consistent with community values and available resources
- Pilot-testing of the program

Curriculum Content

- Focus on clear goals of preventing HIV/STI and/or pregnancy
- Focus on specific behaviors that lead to these health goals (e.g., abstaining from sex or using condoms or contraception)
- Address psychosocial risk and protective factors affecting these behaviors
- Create safe environments for youth
- Include multiple activities to change the targeted risk and protective factors
- Employ instructionally sound teaching methods that actively involve the participants and help them to personalize the information
- Cover topics in a logical sequence

Curriculum Implementation

- Secure at least minimal support from authorities
- Select educators with desired characteristics
- Recruit youth if necessary and retain them
- Implement virtually all of the activities as they are designed

Fig. 2-1: Seventeen Characteristics of Effective Sexuality and HIV Education Programs

Source: Kirby, Laris, & Rolleri (2006)
To date, very few evaluations have examined the impact of abstinence-only sex education programs on adolescent sexual behavior. Evaluations of this approach have primarily focused on program impacts on knowledge, attitudes, and intentions to abstain. Of the few studies that have looked at behavioral outcomes, very few employ rigorous experimental designs and are therefore subject to design weaknesses.

According to Trenholm et al. (2008), a recent meta-analysis, which included three random assignment abstinence evaluations, found no statistically significant program impacts on sexual intercourse or pregnancy risk (unprotected sex). Trenholm et al.’s (2008) evaluation of federally funded abstinence-only programs similarly found no significant impacts on teen sexual activity or rates of unprotected sex. This evaluation will be discussed in greater detail in the section on federal sex education policy.

Organizations such as Advocates for Youth and The National Campaign to Prevent Teen and Unplanned Pregnancy have compiled lists of evidence-based, empirically supported sex education curricula based on the data compiled in the evaluations of these programs. These organizations specify standards that prospective programs have to meet in order to qualify for their respective lists. For instance, to be included in Advocates for Youth’s (2003) list of “Programs that Work,” the following criteria must be met: (1) the program must have an evaluation that was published in a peer-reviewed journal, (2) the evaluation must utilize an experimental or quasi-experimental design with treatment and control conditions, (3) it must include at least a total of 100 young people in the treatment and control groups, and (4) it must collect baseline and post-intervention data from both treatment and control groups.
Additionally, the evaluations have to continue collecting data from both treatment and control groups at three months or later following the intervention and demonstrate that the programs lead to at least two beneficial changes in sexual behavior among the participants in the treatment group, as compared to controls or demonstrated a reduction in pregnancy, STI, or HIV rates among the intervention youth, as compared to controls. Of the 19 programs that met these stringent criteria, 16 of them are comprehensive sex education programs. The remaining three programs are not sex education programs; two are early-childhood interventions and one is a service learning program.

Recent research by Santelli, Lindberg, Finer, and Singh (2007) suggests that the declines in adolescent pregnancy rates between 1991 and 2000 were primarily the result of increased contraceptive use among 15- to 19-year-olds. While decreased sexual activity among 15- to 17-year-olds was responsible for approximately a quarter of the decline during this period, their analysis revealed that the remaining three quarters was specifically attributable to increased contraceptive use in this age group. This finding is consistent with trends in other developed nations where increased contraceptive availability and usage have also corresponded with declines in teen pregnancy rates. This research further emphasizes the theme that promotion of abstinence as the sole means of teen pregnancy and STI prevention ignores the invaluable role that contraceptive use plays in this arena; to ignore it leaves a critical and fundamental component out of the equation.
Overwhelmingly, the evidence on sex education approaches supports the implementation of age-appropriate, medically-accurate, comprehensive curricula. The data demonstrate that these programs can delay the onset of sexual intercourse, reduce adolescents’ frequency of sex and sexual partners, increase condom and contraceptive usage, and reduce the incidence teen pregnancies and STIs. While some programs demonstrated more positive outcomes than others, the general consensus among researchers is that comprehensive programs are always more effective than abstinence-only programs in accomplishing the aforementioned goals and in promoting healthy sexual attitudes and behaviors among their participants.

**Dollars and Sense: Sex Education in Economic and Social Perspective**

It is important to keep in mind that the battles over sex education affect more than just the people who fight them. The stakes are high in this arena. Paramount among the many aims of sex education is the prevention of adolescent pregnancy and STI acquisition. Consequently, regardless of individual attitudes, ideas, or beliefs about the purpose(s) of sex education, the issue has an expansive reach with regard to the number of other issues it impacts. This section will illustrate the social and economic impacts of teen childbearing and STI acquisition both for the individuals directly affected as well as to society at large in order to put the issue of school based sex education in more accurate perspective.
The Social and Economic Consequences of Teen Childbearing

Many scholars have attempted to quantify the net costs of teen childbearing for the public sector, teen mothers and their partners, and the children born to teen mothers. Two publications in particular stand out as being the most thorough and well researched authorities on the subject. The first is Maynard’s (1997) seminal work, *Kids Having Kids: Economic Costs and Social Consequences of Teen Pregnancy*. The second is Hoffman’s (2006) report entitled *By the Numbers: The Public Costs of Teen Childbearing*. Each publication uses the same method to calculate net effects and net costs of teen births.\(^1\)

The major distinction between the two studies, aside from the fact that one was published nearly a decade prior to the other, is that the Maynard (1997) publication focused primarily on mothers 17-years-old and younger and how they compared to mothers aged 20-21, and the Hoffman (2006) study provided cost estimates of childbearing for “younger teen mothers” (ages 17 and younger) as well as “older teen mothers” (ages 18-19) compared with mothers aged 20-21. The Hoffman (2006) report also provided teen childbearing estimates by state as well. Both studies controlled for confounding characteristics that may affect the dependent variables of interest in order

\(^1\) The net effect of a teen birth refers to the impact of only the mother’s age at time of first birth, above and beyond the impact of other risk factors, on the subsequent life outcomes of the mother, the father, and the child. Net effects of teen childbearing are calculated by comparing young women who are as similar as possible in all other respects except for the age at which they had their first birth. Net costs, then, refer to the increased costs associated with the net effects of teen births on a wide range of outcomes. Hence, the net costs of teen childbearing are those that could potentially be averted if the mother’s age at first birth were delayed (Hoffman, 2006).
to provide the most accurate estimates of economic costs and social outcomes possible and eliminate any potential selection bias. The vast majority of the cost data that follows was drawn from these two sources, but is supplemented with relevant research from other reports as well. The costs (both social and economic) of teen childbearing are divided into three categories: costs to society, costs to teen mothers, and costs to the children of teen mothers.

**Costs to Society**

The public sector (federal, state, and local governments and the taxpayers who support them) bears tremendous costs as a result of teen childbearing. To truly understand the impact that teen childbearing has on our economy, assume for a moment that the teen birth rate in the United States remained stable between the years of 1991 and 2004. In actuality, the teen birth rate decreased by one-third during this time frame\(^2\), but the financial outcome would have been quite different had the rate remained stable. Between 1991 and 2004, there were nearly 6.8 million teen births in the United States. The estimated cumulative costs during this time associated with these births totaled approximately $161 billion. Had the teen birth rate not decreased during this time period, but remained at the 1991 rate over the next 13 years, the total cost of teen childbearing in the year 2004 would have equaled $15.8 billion, rather than

\(^2\) Recall that Santelli et al.’s (2007) research suggests that this decline in adolescent pregnancy rates was primarily the result of increased contraceptive use among 15- to 19-year-olds.
$9.1 billion. In other words, the one-third decrease in teen pregnancy in the United States saved taxpayers a total of $6.7 billion just in 2004 alone (Hoffman, 2006).

In 2004, teen childbearing cost U.S. taxpayers approximately $9.1 billion, or roughly $1,430 per teen mother. Of this $9.1 billion, $8.6 billion was directly attributable to young teen mothers (17-years-old and younger), which averages out to $4,080 per young teen mother. Most of the costs associated with teen childbearing are associated with the negative consequences for the children of teen mothers. The breakdown of these costs is illustrated in Figure 2-2.

![Figure 2-2: Costs of Teen Childbearing (2004)](source: Hoffman (2006))

Research suggests that the children of teen mothers visit medical providers less frequently than the children of older mothers, and therefore have lower total medical expenses, but more of the expenses that they do incur are paid for by public services such as Medicaid, Medicare, the Civilian Health and Medical Program for the Uniformed Services (CHAMPUS), and State Children’s Health Insurance Program (SCHIP), all of which are taxpayer supported, rather than through self-payment or private insurance (Wolfe & Perozek, 1997). The children of teen parents are also more likely to be placed in foster care and to have reported cases of abuse or neglect. Research on the impact of
teen childbearing on incarceration suggests that delaying childbearing until just beyond the mother’s 18th birthday would result in a decrease of $522 million to annual corrections budgets and longer delays in childbearing are linked to even larger financial returns. A delay in childbearing until the age of 23 would result in an annual savings of $1.3 billion by local, state, and federal governments. In other terms, under this latter scenario, prison populations would fall by roughly 52,000 to 65,000 inmates (Grogger, 1997). Finally, a hefty portion of the societal costs associated with teen childbearing in 2004 came from the estimated lost tax revenue generated by the children of teen mothers over the course of their adult lives. The children of both younger and older teen mothers are more likely to drop out of high school than children born to older mothers. They also complete fewer total years of education and because educational attainment affects earning capacity, as adults, these children will earn, on average, less than the children of older mothers will earn, and hence generate less tax revenue.

The issue of teen pregnancy and childbearing is also intrinsically connected to the more fundamental, overarching issue of human capital development. In an economy where the attainment of academic credentials has become increasingly necessary for job attainment and promotion and salary increase, high school drop outs have fewer employment opportunities and lower salaries than ever before and according to Hotz, McElroy, and Sanders (1997), fewer than four out of 10 teen girls who give birth before the age of 18 ever complete high school. Workforce development is critical to the maintenance of a healthy economy, but when teen childbearing encumbers even the attainment of a high school diploma, it is not just the teen parents
and their children who suffer economic hardship; the national economy as a whole is affected as well.

**Costs to Teen Mothers**

The figures discussed above represent the costs assumed by society at large, but say nothing of the financial or personal hardships endured by teen mothers and the fathers of their children. The research indicates that teen mothers are more likely than their peers to drop out of school, live in poverty, and rely on public assistance (Logan, Holcombe, Manlove, & Ryan, 2007; Maynard, 1997; National Campaign to Prevent Teen and Unplanned Pregnancy, 2002). According to The National Campaign to Prevent Teen and Unplanned Pregnancy (2002), almost half of all teen mothers and over three-quarters of unmarried teen mothers begin receiving welfare assistance within five years of the birth of their first child, and approximately 52% of all mothers on welfare had their first child as a teenager. A report issued by The Brookings Institution indicated that virtually all of the increase in child poverty between the years of 1980 and 1996 was related to the increase in nonmarital childbearing, half of which was to teenagers (Sawhill, 1998).

The data demonstrate a clear relationship between teen childbearing and poverty and welfare dependency. However, the nature of this relationship is ambiguous because some contend that many of the women who have children as unmarried teenagers would have been poor and ended up on welfare even if they had married.
and/or delayed childbearing (Sawhill, 1998). In other words, it is possible that their poverty and/or welfare dependence has more to do with the fact that many of these women come from disadvantaged neighborhoods, attended poor schools, and faced other adverse societal influences than with their teen motherhood. This dilemma begs the question: does teen pregnancy contribute to poverty or does poverty contribute to teen pregnancy? The answer to this chicken-and-egg question is likely that both are true to a certain extent, and that their relationship is circular and cyclical. Regardless of whether teen childbearing is a cause or a symptom of poverty, the existence of their interrelationship is irrefutable and efforts to combat each of these issues ultimately involve the other. Consider the Personal Responsibility and Work Opportunity Act of 1996’s provision for abstinence education; this provision is based entirely upon the premise that a reduction in adolescent and nonmarital pregnancies is intrinsically linked to reducing the number of welfare cases (Sawhill, 1998).

Teen pregnancy has a negative impact on educational attainment, but on the other hand, increased school achievement, attendance, and involvement are all connected to reductions in teen pregnancy. Teenagers who stay in school and earn their high school diplomas are far less likely to become pregnant than those who drop out. Also, school engagement (as measured by grades, test scores, class participation, homework completion, and perception of support and connectedness with teachers and administrators) and plans for college attendance following high school are also associated with decreases in teen pregnancies (Kirby, 2002b). The direction and nature of influence between education and teen pregnancy is unclear, but according to Kirby’s
(2002b) research, just as the prevention of teen pregnancy can help to reduce school dropout, the reverse may also true as well.

On a macro-level, teen pregnancy prevention makes sound economic sense because it would result in billions of dollars in savings for taxpayers and governments, as argued above. It would also help to ameliorate poverty and would result in greater human capital development, which would ultimately boost the economy as well. On a micro-level, teen pregnancy prevention has immense implications for improving the overall well-being of young women by increasing their odds of completing high school, achieving higher levels of educational attainment, and obtaining and maintaining gainful employment. If a cycle of poverty does indeed exist and teen pregnancy and childbearing are inextricably linked to it, efforts to reduce and ultimately eliminate the latter will most certainly have a palpable impact on the former.

**Costs to the Children of Teen Parents**

The children of teen parents endure more than simply the economic burdens of their parents’ adolescent childbearing. These children are at increased risk for a number of social and health problems as well. To start with, teen mothers are much less likely than older women to receive timely prenatal care. In fact, they are far more likely to begin care during the third trimester or not receive any care at all. They are also more likely than older women to smoke during pregnancy and to not gain an appropriate amount of weight. As a result of these and other factors, babies born to teen mothers
are more likely to be born prematurely and at low birth weight, thereby increasing the probability of infant death, blindness, deafness, chronic respiratory problems, mental retardation, mental illness, cerebral palsy, dyslexia, and hyperactivity (National Campaign to Prevent Teen and Unplanned Pregnancy, 2002; Ventura, Mathews, & Hamilton, 2001; Wolfe & Perozek, 1997). Also, as previously mentioned, the children of teen mothers are more likely to depend on publicly-provided healthcare than the children of older mothers. Rates of child abuse and neglect are also twice as high for the children of teen parents than for children of older parents, and the sons of teen mothers are twice as likely to end up in prison than the sons of mothers aged 20-21, their daughters are three times more likely to become teen mothers themselves than the daughters of mothers aged 20-21 (Hoffman, 2006).

The children of teen mothers also fare worse academically than those born to older mothers. These children are 50% more likely to repeat a grade, are less likely to complete high school than the children of older mothers, and score lower on standardized tests (Haveman, Wolfe, & Peterson, 1997; Hoffman, 2006). Several studies have reported that the children of teen mothers also score lower on cognitive measures (e.g., vocabulary and math skills) and behavioral measures (e.g., problem behaviors) than the children of older mothers. Terry-Humen, Manlove, and Moore’s (2005) research on outcomes for the children of teen mothers indicated that these children differ from the children of older mothers on measures of cognition and knowledge, language and communication skills, approaches to learning, emotional well-being and social skills, and physical health and well-being. There are a couple of key themes to be
taken from this research. The first is that children born to older teen mothers (18- to
19-years-old) fare similarly to children born to younger teen mothers (aged 17 and
younger), suggesting that programmatic attempts to delay childbearing must look
beyond merely preventing pregnancy and birth for high school aged youth. A second
major issue raised by this study is the circular relationship between background
characteristics and teen childbearing discussed previously. In several of the areas
studied, after controlling for child, maternal, and household characteristics, many
differences between the children of teen parents and those of older parents leveled off
or in some cases disappeared entirely, suggesting that these differences may likely be
the result of issues that extend beyond solely the age of the child’s mother at the time
of birth.

Adolescent STI Acquisition in Fiscal and Human Perspective

A discussion of the stakes involved in school based sex education would be
grossly incomplete without acknowledging its connection to the control of the spread of
disease. After all, the rampant spread of venereal disease at the turn of the century was
the primary impetus for the origin of school based sex education in the United States. A
hundred years since the inception of school based sex education, the incidence and
prevalence of venereal disease (or sexually transmitted infections as they are referred
to now) continue to be troublesome concerns.
Compared to older adults, adolescents (as defined by the CDC as 10- to 19-year-olds) and young adults (20- to 24-year-olds) are at higher risk for STI acquisition and sexually active individuals in each of these age groups have among the highest rates of gonorrhea and chlamydia infection (Centers for Disease Control and Prevention, 2003). While teens and young adults aged 15-24 comprise only a quarter of the sexually active population, they account for approximately half of all new STI cases (Weinstock, Berman, & Cates, 2004). Chesson, Blandford, Gift, Tao, and Irwin (2004) reported that in 2000, an estimated nine million new STI cases occurred among 15- to 24-year-olds. Furthermore, the estimated economic burden of treating these nine million new STI cases (including HIV cases) in this age group was approximately $6.5 billion in year 2000 (inflation not applied). This estimate includes direct medical costs (e.g., expenses of treating STIs), but not direct nonmedical costs (e.g., cost of transportation to and from medical services). This estimate also does not include indirect costs, such as wage losses or intangible costs, including psychological and physiological pain and suffering associated with STIs. This figure also does not take into account costs associated with the ongoing treatment of pre-existing STI patients. Chesson et al. (2004) dissected the direct medical cost estimate into the total economic burden of the most prevalent viral STIs (HIV, human papillomavirus or HPV, genital herpes simplex virus type 2, and hepatitis B) and non-viral STIs (chlamydia, gonorrhea, trichomoniasis, and syphilis) and revealed that viral STIs accounted for 94% of the total cost (or $6.2 billion).

Consider the fact that while non-viral (or bacterial) STIs are curable, viral STIs are not, and now contemplate the implication that the vast majority of direct medical cost
associated with STI acquisition comes from viral STIs. The one year cost of treatment of all new STI cases alone in 2000 was $6.5 billion, and $6.2 billion of that was attributed specifically to viral STIs. If one extrapolates what viral STIs cost out over the course of each patient’s lifetime (since viral STIs are incurable and will require continual treatment), continues to account for the cost of new viral and non-viral cases each year, and adds in the STI costs in other age groups, we can start to understand the immensity of the economic burden that STI acquisition places on society.

STI acquisition rates had been steadily decreasing during the same period in which teen pregnancy rates were on the decline, but now is not the time for complacency. Recent evidence suggests that advances in STI treatment options (particularly HIV antiretroviral therapies) may be having a negative impact on safer sex behaviors and could potentially result in an increase in infection rates. Demmer’s (2003) review of studies assessing the impact of new HIV treatments on perceptions of risk and behaviors revealed that the AIDS “cocktail,” as it is commonly referred to, may indeed be connected to STI-related attitudes and preventative behaviors. Demmer’s (2003) summary included studies of homosexual men, HIV-positive individuals, young people, and women. HIV-positive individuals, all of whom believed that HIV transmission risk was reduced as a result of the new therapies and consequently practiced safer sex less often following their availability. It is important to recognize, however, that some of the studies cited in Demmer’s (2003) report were subject to methodological weaknesses regarding establishment of causality, but they nevertheless
provide some rich preliminary data that is food for thought regarding how advanced
treatment options will impact rates of STI acquisition in the future.

Teen pregnancy and STI acquisition are costly on many levels and therefore
present an intriguing dilemma for policy-makers. Government has a vested interest in
reducing poverty, improving educational attainment, decreasing crime, and maintaining
a healthy citizenry, but the federal policies that have promoted abstinence-only sex
education over the past three decades as the means for attaining these aims are
shamelessly out of touch with the recommendations of the scientific literature.

Context

Sex education sits at a crossroads where the promotion of public health
intersects with the process of character development. To better understand how sex
education came to be situated at this intersection, it is helpful to examine some of the
many purposes it serves. Sex education is a form of primary prevention; arming young
people with knowledge and skills helps them to make informed decisions and protect
themselves from harmful outcomes. Sex education helps shape individual values; the
provision of information about sex and sexuality allows young people to come to
determine how and when sex will fit into their lives. Sex education also provides
positive messages about respect for one’s self and others, which promotes healthy body
image, self-empowerment, and gender equity, and also works to reduce the incidence
of sexual abuse and violence. Sex education is about far more than the maintenance of
student physiological health. As Kristen Luker (2006) puts it, fights over sex education are really “fights about gender, about power and trust and hierarchy, about human nature, and not surprisingly, about what sex really is and what it means in human life” (p. 7).

The idea that schools can have an impact on a young person’s sexual knowledge, attitudes, and behaviors is not a new one. Schools have taught kids about sex in some form or another since the beginning of the twentieth century. The controversies over sex education are certainly not new either. While the nature of debates over sex education has changed over time, the issue has always been highly contentious. In the remaining sections of this chapter, I contextualize the issue of school based sex education by discussing the history of federal sex education policy in the United States, describing how adolescent sexual health indicators and sex education policies in the United States compare with those in other nations, and finally explaining how the U.S.’s distinctive decentralized educational system impacts the American sex education landscape.

**History of Federal Sex Education Policy**

The Tenth Amendment of the U.S. Constitution states that, “the powers not delegated to the United States, nor prohibited by it to the states, are reserved to the state respectively; or the people” (U.S. Const., amend X). Consequently, because the Constitution makes no specific mention of education, it falls within state jurisdiction.
However, while the federal government does not have the authority to make educational mandates, it can put forth an educational agenda by means of offering financial incentives for schools, districts, or states that adhere to that agenda. The No Child Left Behind Act of 2001 (NCLB) is one notable example. Schools and districts need only comply with its statutes if they choose to accept the federal funds attached to them; they can alternatively opt to refuse the funds altogether if they do not wish to adhere to the criteria.

The first instance in which the federal government established a grant program pertaining to educating adolescents about sexual issues occurred in 1981 with the passing of the Adolescent Family Life Act (AFLA). AFLA provided funds for public and nonprofit organizations that made it their mission to prevent adolescent premarital sexual activity in order to reduce the incidence of adolescent pregnancy. The act also established provisions for pregnant and parenting teens. In 1983, the American Civil Liberties Union (ACLU) sued the federal government on the grounds that AFLA violated the Constitution’s provision for separation of church and state “by endorsing a particular religious point of view and largely benefiting religious groups” (Oster, 2008, p. 128). The Department of Civil Justice and the Center for Reproductive Law and Policy reached an out-of-court settlement in 1993 stating that the AFLA program could only fund sex education programs that were “medically accurate, did not include religious references, respected adolescents’ right of self determination regarding contraceptive referrals, and did not utilize churches for their programs” (Oster, 2008, p. 128). Funding
for AFLA has substantially increased since 1982, reaching $52 million by 1996, the year in which the second major federal sex education initiative occurred (Collins et al., 2002).

The second instance in which the federal government established sex education relevant policy was in 1996 when President Clinton signed welfare reform legislation that contained a provision for funding abstinence-only sex education programs. The provision is located in Section 510 of Title V of the Social Security Act (1998), a federal grant program for which state Maternal and Child Health Bureaus may apply. The abstinence-only provision provides funds for schools or other organizations that implement abstinence-only sex education programs that satisfy eight specific criteria (Separate Program for Abstinence Education, 2003). Appendix A contains the full text of this provision, which includes this eight-point definition. The Title V abstinence education grant provides 50 million federal dollars annually for five years and participating states must provide a 75% match in funds, which would equal $37.5 million in combined state funds for the full $50 million provided by the federal government. Consequently, a maximum of $87.5 million can go into abstinence-only-until-marriage education programs each year in the states that apply for and receive this grant.

In 2007, a new evaluation report emerged that examined the effectiveness of Title V funded programs (Trenholm et al., 2007). This evaluation was commissioned in 1998, the year that the Title V grant provision took effect. At that time, Congress authorized a “rigorous, experimentally based impact evaluation of Title V, Section 510 abstinence education programs” (Trenholm et al., 2008, p. 255). Four Title V funded programs were included in their analysis. These programs were purposefully selected
because they were early grant recipients, were cited by numerous state officials and
experts across the country as being promising programs, and had the capacity to
support a rigorous, experimental-design impact evaluation. The team responsible for
undertaking this evaluation ensured maximal similarly between control group and
experimental group participants, included measures of risk behavior and behavioral
consequences as well as measures of knowledge and perceptions of risks associated
with teen sexual activity, and constructed weighted regression models that pooled data
from all four sites for their analyses. Their findings revealed no statistically significant
impacts on rates of sexual abstinence, number of sexual partners, age at first sexual
intercourse, rates of unprotected sex, rates of pregnancy and childbirth, or STI
acquisition. Because this evaluation took place over a period of nine years and focused
on model “first generation” Title V program participants, its results had quite an impact.

Because the Title V abstinence education grant is a federal inducement and not a
mandate, states can decide whether or not they wish to apply for it. The law took effect
in 1998 and initially, nearly every state and U.S. territory had applied for and received
abstinence funding through this initiative. Since that time, however, the number of
states rejecting the funds has been steadily increasing, and as of October 2008, 24
states declined to participate in the program (Freking, 2008). Between the years of
2006 and 2008, participation dropped by 40%. The vast majority of the states that have
rejected the funds cite the grant program’s strict requirements and limitations as well as
the previously cited evidence that the educational programs they support are largely
ineffective in keeping young people abstinent or in increasing condom and
contraceptive usage as their reasons for opting not to participate (Freking, 2008).

Congress approved a third abstinence-only sex education grant program in 2000.
The Special Projects of Regional and National Significance—Community Based
Abstinence Education (SPRANS-CBAE) (Maternal and Child Health Federal Set-Aside
Program, 2000), like its predecessor (Title V), funds abstinence-only-until-marriage sex
education programs. However, whereas Title V requires a 75% match from the state,
SPRANS-CBAE does not require any state money matching. SPRANS-CBAE grants can
also go directly to public or private organizations, while Title V funds are distributed as
categorical block grants to states. The vast majority of federal funding for abstinence-
only sex education is provided through the SPRANS-CBAE program.

As of this writing, there has not been a federal policy in support of
comprehensive sex education. This presents a complicated dilemma since all of the
peer-reviewed empirical research studies in this area strongly recommend a
comprehensive approach and caution the implementation of programs with a strict
abstinence-only focus. This situation is further complicated by the fact that the vast
majority of American parents support comprehensive sex education in schools over
abstinence-only sex education (Bleakley et al., 2006; National Public Radio et al., 2004a).
Bills have been crafted that would provide funding for empirically supported
comprehensive sex education programs, but none have become law. In 2001,
Representative Barbara Lee of California introduced the Family Life Education Act, which
would have provided $100 million in grants for states that implemented comprehensive
sex education programs for the prevention of teen pregnancy and STIs (including HIV/AIDS) (Collins et al., 2002). The Family Life Education Act died in committee, but was resurrected as the Responsible Education about Life (REAL) Act in 2007 by Senator Frank Lautenberg of New Jersey and again Representative Barbara Lee of California and Representative Christopher Shays of Connecticut ("Senator Lautenberg, Representatives Lee and Shays say it's time to provide 'real' comprehensive sex education," 2007). As of this writing, the fate of the REAL Act remains undecided. Additional information about comprehensive sex education policy proposals is located in Chapter 7’s section on policy implications.

One of the latest developments in the arena of sex education policy, which has occurred at the state level, is the advent of medical accuracy laws. These laws have come about in response to the plethora of research suggesting that abstinence-only sex education curricula were not only ineffective in preventing adolescent sexual activity and affecting condom or contraceptive use, but were also promoting scientifically inaccurate and potentially harmful information to young people. A recent survey of these laws indicates that 21 out of 50 states\(^3\) have implemented some form of medical or scientific accuracy statute with regard to sexuality and/or HIV/AIDS education. However, according to Santelli (2008), many of these statutes fail to even provide a definition for what “medical accuracy” actually means. Seven of these states do offer a

\(^3\)These states include Arizona, California, Colorado, Iowa, Illinois, Indiana, Louisiana, Maine, Maryland, Michigan, Minnesota, Missouri, Nevada, New York, North Carolina, Oklahoma, Oregon, Rhode Island, Texas, Utah, and Washington.
definition in some area of health law. In each of these statues and regulations, medical accuracy is defined by three features: “(1) verification or support of research conducted under accepted scientific methods, (2) publication in peer reviewed journals, and (3) recognition as accurate and objective by mainstream professional organizations such as the AAP [American Academy of Pediatrics], ACOG [American College of Obstetrics and Gynecology], and APHA [American Public Health Association] and government agencies such as CDC” (Santelli, 2008, p. 3). Several states add additional qualifiers to this basic definition. For example, New Mexico, New Jersey, and Iowa add “weight of research” as an important qualifier and Colorado includes “(1) linkage to social, behavioral, and biomedical theories and (2) adaptation of programs that are evidence based” (Santelli, 2008, p. 3). Medical accuracy laws are fairly new and are not without flaws and limits, but their intent is quite clear. These statutes and regulations originated to address the two major issues of concern with federal abstinence-only policies, the scientific inaccuracy of material presented as fact and purposeful omission of potentially life-altering or life-saving information. In states that have enacted medical accuracy laws, federally funded abstinence education programs are often by default in violation of the laws and therefore prohibited from being implemented in public schools.

Federal abstinence-only sex education policy has existed in one form or another in the United States for over 30 years. Over the course of this time frame, we have seen considerable changes in both the scientific and political realms. We clearly have far

4 These states include California, Iowa, New Jersey, Washington, Utah, New Mexico, and Colorado.
more evaluation research now regarding the efficacy of various teen pregnancy and STI prevention approaches, but there have also been philosophical and ideological shifts at the political level that are evident in the various pieces of abstinence-only legislation that were generated by the different administrations. Even though each policy promotes abstinence as its sole means of teen pregnancy and STI prevention, the language used to frame certain issues and the prescribed means for policy evaluation are significantly distinctive.

Consider as an example that when the Title V program first took effect in 1996 under the Clinton administration, federally funded abstinence-only sex education programs were expected to show “demonstrable behavioral outcomes, such as a reduction in STDs and pregnancies among adolescents” (McClelland & Fine, 2008, p. 66) to be considered successful. These behavioral measures of success were modified under the Bush administration in 2001; under the new stipulations, successful programs had to demonstrate that they “create[d] an environment within communities that support[ed] teen decisions to postpone sexual activity until marriage” (McClelland & Fine, 2008, p. 66). By 2006, any program that had increased the proportion of participants “who indicate[d] understanding of the social, psychological, and health gains to be realized by abstaining from premarital sexual activity” (McClelland & Fine, 2008, p. 66) was deemed a success. According to the first of these three specifications, the problem the policy is addressing is adolescent pregnancy and STI acquisition and the programs funded by the policy would be considered successful if they could demonstrate a reduction in these rates. The second and third statements consider pre-
marital sexual activity as the problem and in both cases success is measured by increased acceptance and promotion of sexual abstinence among unmarried individuals and the communities in which they live. The same policy and the problem it was designed to address were interpreted very differently by different administrations. The language used in each policy revision conceivably displays underlying assumptions about behavior and morality, and also the government’s role in regulating them. This premise will be expounded upon further in Chapter 3.

The United States in Global Context

Many people are surprised to learn that the United States has the highest teen pregnancy and childbearing rates in the developed world and among the highest rates of abortion among teenagers. It also has among the highest rates of adolescent STI acquisition (including HIV/AIDS) as well. Further, the difference between teen pregnancy, childbearing, and STI acquisition rates in the U.S. and other developed nations is far from marginal; rates of teen childbearing in the United States are more than double those in Canada and are five times as high as those in Western European countries, including Sweden, Italy, and Denmark (Child Trends, 2002). Research by Singh and Darroch (2000) noted that of the 33 developed nations that provided data on adolescent abortion rates from 1970 to 1995, the United States had the highest teenage pregnancy rate. Among the other nations with particularly high teen pregnancy rates (more than 70 per 1,000 15-19-year-olds) were Belarus, Bulgaria, Romania, and the
Russian Federation. The lowest teen pregnancy rates (fewer than 40 per 1,000 15-19-year-olds) were found in Japan, the Netherlands, Italy, Spain, and several other western European nations. Rates of syphilis, chlamydia, and gonorrhea among adolescents are also significantly higher in the United States than in Western Europe (Panchaud et al., 2000).

It seems counterintuitive that the United States, the wealthiest and arguably most powerful nation in the world, should experience considerably higher rates of teen pregnancy and STI acquisition. However, upon closer inspection, there are many socio-cultural, political, and economic conditions in the United States versus other nations that shed some light on this perplexing situation. Americans do not differ from Canadians, Swedes, the British, or the French in terms of age at first intercourse or proportion of individuals who have engaged in sexual intercourse before the age of 20 (Darroch, Singh, & Frost, 2001). While the data suggests that adolescent sexual activity is a universal phenomenon, the U.S.’s rates of adolescent pregnancy and STI acquisition are far from universal. The data indicate that teens in the U.S. have a greater number of sexual partners and use far less contraception than their Canadian and European counterparts, which helps explain the U.S.’s vastly different teen pregnancy and STI rates. According to research by Lottes (2002) on sexual health policies in industrialized countries, factors characteristic of the U.S. that have been identified as significant predictors of high adolescent pregnancy rates include, “restrictive ideas about teenage sexuality, lack of openness and discussion about contraception and sexual responsibility, high levels of poverty and an unequal distribution of wealth and income, high levels of
religiosity, low availability of contraceptive education and family planning services, and high cost of such services” (p. 79). The remainder of this section will examine each of these factors in greater detail.

**Ideas about Teenage Sexuality**


No country forms a more stark contrast for comparison with the United States than does the Netherlands: Dutch teenagers are far less likely to either become pregnant or contract an STD than are their American peers. American teenage girls are 3 times more likely to have an abortion, and 8 times as likely to give birth, as are their Dutch counterparts, even though both are typically 17 years old when they first have intercourse...How is it possible that an essentially biological phenomenon—the onset of puberty and the capacity for reproduction—produces such disparate results in 2 countries that are similar in terms of wealth, education, and reproductive technologies (para. 3-5)?

The answer, as Schalet (2004) came to find, has much to do with how the two nations view adolescents and adolescent sexuality.

Americans view teenagers as having “raging hormones” over which they have no control. They believe that teens cannot regulate these hormonal drives and forces, and that it is the job of parents to set rules, limits, and boundaries to control their children’s sexuality. Americans also firmly believe that girls and boys are driven by opposing wants and needs. In other words, boys want sex and girls want love. The American
parents surveyed in Schalet’s (2004) study expressed great cynicism over the notion that teenagers could truly be in love because of their belief in this “battle of the sexes.”

Schalet (2004) writes:

With sex at adolescence conceptualized as a battle where there are costs and benefits, winners and losers, it is not only the power of biology that makes adolescent sex such a risk-ridden territory. The battle between the sexes and the different types of pressures boys and girls exert on one another are also cause for parental concern. Given these concerns, the American parents view it as their job to rein in romantic relationships during the high school years (The Battle Between the Sexes section, para. 7).

Finally, Americans seem to prefer avoiding and denying the notion that their teenage children are sexually active and therefore prohibit sleepovers with boyfriends and girlfriends in their homes. Prohibition of sexual activity within their own homes gives them some peace of mind and permits them to perpetuate their avoidance and denial. The American parents that Schalet (2004) interviewed, however, did not seem to be operating under the assumption that if they prohibited their kids from having sex in their homes that it would keep it from occurring elsewhere, which is a particularly interesting finding. Their discomfort with adolescent sexuality is so great that they refuse the girlfriend/boyfriend sleepover solely on the principle that what is out of sight is out of mind and helps them to maintain some kind of psychological appeasement.

The Dutch have an entirely different take on adolescent sexuality. First, while Americans consider teens to be governed by their “raging hormones,” the Dutch view teens as self-regulating sexual agents. In other words, they, rather than their hormones, are in control of their actions. Whereas Americans do not believe that teens can make
responsible decisions about sexuality because of these raging hormones, the Dutch strongly feel that teens can make up their own minds about engaging in sexual activity in a mature fashion. “They need to determine [when they are ready] themselves,” (Self Regulating Adolescent Sexuality section, para. 2) said one Dutch parent. Second, the “battle of the sexes” that is waging between American youth seems to be absent among Dutch teens. Dutch parents rarely mention differences between boys and girls with regard to how they approach sex. The coinciding American skepticism over young love is also missing in Dutch discussions of adolescent sexuality. The Dutch believe firmly that teens can most definitely experience love and have mature relationships and that sex is a natural and normal component of both. Finally, while Americans strongly assert the “not under my roof” approach to adolescent sexuality, the Dutch actually prefer that their teens bring their girlfriends and boyfriends home to spend the night. Because the Dutch view sex as a natural and normal progression in a relationship and because they want to foster trust and open and honest communication with their children, they view it as a positive thing when their sons and daughters talk to them about their sexuality and therefore do not prohibit “the sleepover,” as Schalet (2004) refers to it.

**Openness and Discussion about Contraception and Sexual Responsibility**

The second factor that Lottes (2002) cites as being a significant predictor of the U.S.’s high teen pregnancy and STI rates (which is tied in with the first) is lack of openness and discussion about contraception and sexual responsibility. Discussions
about contraception and sexual responsibility would require acknowledgement and acceptance of teen sexuality, and as we have seen, Americans, on the whole, are quite uncomfortable with this issue. It is a common misconception among Americans that teaching adolescents about condoms and contraceptives and/or making them more available and accessible encourages and increases the frequency of sexual activity. Americans, in general, want to curb adolescent sexual activity and believe that discussing contraception will do just the opposite and as a result, American teens receive little information about safer sex and therefore have less of it (less safer sex that is, they still engage in unprotected sexual activities). Research has demonstrated that contraceptive education and availability do not increase sexual activity among teens; they just increase the frequency of protected sexual activity (American Academy of Pediatrics, 2001; Blake et al., 2003; Dodge, Reece, & Herbenick, 2009; Furstenberg, Geitz, Teitler, & Weiss, 1997; Kirby, 2002a; Schuster, Bell, Berry, & Kanouse, 1998), yet this misconception still somehow persists in the discourse on this issue. Further, Darroch, Landry, and Singh (2000) have pointed out that between the years of 1988 and 1999 emphasis on contraception in sexuality education across the nation has actually decreased, while emphasis of abstinence has substantially increased, a finding that is in stark contrast to trends in sexuality education in Western Europe and that is generally representative of the lack of openness and discussion about contraception and sexual responsibility described by Lottes (2002).
Poverty and Distribution of Wealth and Income

The third factor cited by Lottes (2002) is the U.S.’s high levels of poverty and its uneven distribution of wealth and income. This issue of poverty’s connection to teen pregnancy and childbearing was explored previously. The situation remains unclear as to whether poverty is a cause or a symptom of teen pregnancy, but the two are no doubt connected in a cyclical fashion. Regardless, comparative data do suggest that nations with smaller income gaps and more equal distribution of wealth exhibit lower rates of teen pregnancy and STI acquisition, which suggests that improvements to the welfare system, the minimum wage, the health care crisis, etc. may have a positive impact on teen pregnancy and STI prevention.

An analysis by Singh, Darroch, and Frost (2001) examined the relationship of socioeconomic disadvantage and adolescent sexual and reproductive behavior in five developed countries. The researchers provided two measures for “economic disadvantage,” proportion of the population with an income below 50% of the median and ratio of the proportion of income received by the richest 20% of the population to the proportion received by the poorest 20%. With regard to the first indicator, 17% of the U.S. population has an income below 50% of the median compared to 8-9% in France and Sweden, and 11% in Canada and Great Britain. On the second measure, higher ratios indicated greater inequality in income distribution; the ratio in the United States was 8.9 compared to 3.6 in Sweden and 5.2-6.5 in Canada, France, and Great Britain. Differences in the initiation of sexual activity across members of different
socioeconomic groups within each of these five countries were relatively small and therefore “unlikely to contribute significantly to subgroup differences in adolescent pregnancy rates and birthrates” (p. 257). Contraceptive use at first intercourse, however, does vary substantially according to income or social class in both the United States and Great Britain. At all socioeconomic levels, though, U.S. teens were more likely than teens in Great Britain to report not using contraceptives, a finding that is undoubtedly connected to their increased teen pregnancy rates. According to the authors, the proportion of the U.S. population that is poor (those with an income less than half the median) is at least two-thirds larger than that of the other four study countries, and the U.S. also has a significantly higher proportion of racial and ethnic minorities. The authors are cautious not to unequivocally equate socioeconomic disadvantage with teen pregnancy and childbearing risk, but emphasize that it is indeed a critical part of the equation:

A large concentration of socioeconomic disadvantage in the U.S. population is not the only factor in the country’s higher adolescent pregnancy rate. When we compared adolescents of similar status across countries, we found large differences in almost all measures of sexual behaviors and disadvantage...Nevertheless, socioeconomic disadvantage correlates strongly with adolescent reproductive behaviors and outcomes, and is worthy of policymakers’ attention. Improving adolescents’ socioeconomic status is a way to prevent their having poor reproductive health outcomes—not only unplanned or early pregnancies or births, but also STDs (pp. 257-258).
Levels of Religiosity

High levels of religiosity are also cited by Lottes (2002) as being predictive of high teen pregnancy and STI rates. Americans attend worship services more frequently than the Dutch, the Germans, and the French and are more likely to identify themselves as Christians and/or to profess a high degree of religiosity (Berne & Huberman, 1999). Frequent church attendance among adolescents, however, has actually been linked to delaying the onset of sexual intercourse (Hardy & Raffaelli, 2003). In this respect, religiosity is actually a protective factor on an individual level. It is on a societal level that high levels of religiosity become a predictor of high teen pregnancy and STI rates.

For example:

In the United States, the religious right—a political movement whose motive is to create public policy with a particular religious agenda—has a strong role in the creation of many abstinence-only or abstinence-until-marriage programs and in the formation of the conservative organizations that embrace them. The religious right, openly expressing its determination to influence political processes in the United States, has successfully placed supporters on school boards, county governing boards, and in state legislators (Berne & Huberman, 1999, p. 60).

On the other side of the Atlantic, religion plays a much smaller role in public policy and everyday life. Religious institutions in Germany, France and the Netherlands acknowledge that for their teachings to be accepted as relevant, they must be consonant with changing social values and norms. In Europe, religious organizations appear to change with the times, whereas in the U.S., they seem to object to certain social changes and expect individuals to appeal to their authority instead. Because religious affiliation and service attendance are far lower in Europe than in the United
States, it is possible that religious organizations in these nations feel compelled to reflect current societal norms or else become irrelevant, but regardless, they never attempt to control or affect public health policy or suppress research based efforts at teen pregnancy and STI prevention. The same cannot be said for many American religious institutions and it is primarily in this fashion that religiosity can have a negative impact on adolescent sexual health indicators.

**Availability and Cost of Contraceptive Education and Family Planning Services**

Lottes (2002) also includes low availability of contraceptive education and family planning services and the high costs of these services to her list of characteristics predictive of high teen pregnancy and STI rates. When compared to nations such as the Netherlands, Germany and France, reproductive health care is lacking in many respects in the United States for teens especially, but for adults as well. For adults, while 97% of employer health plans in the U.S. cover prescription drugs, only 33% of them pay for oral contraceptives, the most widely used form of female birth control other than sterilization (Berne & Huberman, 1999). With regard to adolescents, Berne and Huberman (1999) state that, “In the United States, policies and practices discourage teens from using reproductive and sexual health services. Sexually active teens in the United States must overcome barriers ranging from lack of transportation and shortage of funds to pelvic exams and adult censure or disapproval when they seek to obtain the services they need” (p. 28).
Recent interview-based research by Cromer and McCarthy (1999) on family planning services for adolescents in four developed countries (the Netherlands, Sweden, Great Britain, and the United States) revealed while the Netherlands and Sweden foster close liaisons between family planning services and schools, interview respondents in the United States reported parental resistance to such coordination. Respondents in the Netherlands, Sweden, and Great Britain all felt that to make services more “user friendly” for teens, contraceptive provision should not require a pelvic exam; this view was not shared by U.S. respondents. Further, while family planning services received ample governmental support in the Netherlands and Sweden, respondents in the U.S. reported little in the way of governmental, medical, or family support for preventative health care, including family planning services.

In assessing condom and contraceptive use among adolescents, four dimensions are of particular importance. I refer to them as The Four As of Contraception: availability, affordability, accessibility, and acceptability. Each dimension is equally important. For instance, even if condoms were free and obtaining them was effortless and confidential, if social norms discourage usage, they will go unused. The United States falls short on each of these four dimensions. According to Berne and Huberman (1999):

Condoms are less available and more costly in the United States than in many other countries. While pharmacies stock them, condoms are often kept behind counters or where pharmacists can watch them. When teens in one survey were asked to rate the difficulty of carrying out various tasks related to sexual health, over 90 percent rated buying a condom in the public as nearly impossible” (p. 27).
With regard to social norms surrounding condom and contraceptive usage, interviews with teens during Advocates for Youth’s (2000) European Study Tour revealed some disturbing attitudes on the parts of the teens themselves. In the United States, teens seem to equate carrying a condom with promiscuity while in Germany, France, and the Netherlands, carrying a condom is equated with responsibility. As one American teen put it, “I don’t think you should like prepare to have sex cuz if you carry a condom it’s like you’re expecting to have sex, so yeah, I don’t think you should carry them” (Advocates for Youth, 2000). Another noted, “A girl who carries a condom can be perceived as a slut” (Advocates for Youth, 2000). Their Dutch counterparts, however, felt quite strongly that not carrying a condom and not being prepared was irresponsible and disdainful. One Dutch teen stated, “You have sex with a condom or you don’t have sex until you’re married. I mean, that’s it basically. I mean it’s not difficult to understand, is it” (Advocates for Youth, 2000).

The Decentralized American Educational System

The Constitution of the United States of America provides Americans with a bill of rights that guarantees all citizens the rights to free speech, to own a gun, to not have their person, possessions, or place of residence searched without permit, and to a speedy and public trial among others. Since its original writing, additional amendments have been added to the initial ten, but nowhere in the Constitution are American citizens guaranteed the right to an education. In fact, it makes absolutely no mention of
public education whatsoever. As per Amendment X in the Bill of Rights, if an issue arises that is not specifically mentioned within the Constitution as being under the purview of the federal government, it falls under the jurisdiction of the individual states.

Consequently, the United States has a decentralized system of public education in which each state has the authority to establish its own unique educational standards and practices.

Each state is further divided up into regional units in the form of school districts and each school district is governed and managed by a group of elected or appointed officials comprising a school board and a chief administrator as superintendent. Hawaii is the only state that operates as a single school district, while states such as California and Texas are composed of over 1,000 districts each. School districts are in charge of establishing curricula and coordinating programs and services to the individual schools that comprise them. While each state retains the authority to set academic guidelines and standards, the districts may decide for themselves how they will go about meeting them. This system is highly representative of America’s longstanding deference for local control. Educational governance in the U.S. is most definitely a ground-up operation and this system has its fair share of advantages and disadvantages, but I will limit my discussion of these advantages and disadvantages to how they apply to the issue of sex education.

Each state has standards (or educational guidelines) for Health and Physical Education, the discipline within which sex education typically falls. Because each of a state’s school districts are autonomous entities that make curriculum decisions
independently of one another, and because state educational standards leave room for interpretation of the specific sexual health content that need be covered and mode of delivery of that content, there is no single source documenting the sex education policies and programs in place across a given state. The primary advantage to this system is its flexibility. Different school districts serve youth who vary on all demographic dimensions and in education, one size rarely fits all. The advantage of allowing local school districts to decide how to best serve their particular students permits them to select programs and approaches that make the most sense for the young people who attend their schools. However, the main advantage to this decentralized education system is simultaneously its disadvantage. Allowing individual school districts to set their own curricular agenda may and often does result in decisions that are in best interests of the students, but it also means that these decisions can be swayed by the individual opinions and values of the decision-makers and their fellow community members.

To better understand exactly why flexibility in this way can be problematic, consider that school board members are not educational professionals; the sole requirements for school board membership are that applicants be over the age of 18 and reside within the school district. State departments of education, however, are staffed with educational professionals, and state standards of education are based on educational research. In many cases, the curricular choices made by local school boards are not consistent with or may even contradict prevailing educational theory and scholarship. The prevailing scientific theory on the origin of life is Charles Darwin’s
theory of evolution, but if a state’s standards do not specify that this theory be taught
and school board members oppose the theory on religious grounds, it can be omitted
from a science curriculum solely on that basis. J.D. Salinger’s novel *The Catcher in the
Rye* is considered by most literary experts to be a classic piece of American literature,
but again, the book can be taken off of a reading list if a school board objects to its
content on moral grounds. Similarly, instruction of young people on contraceptive
methods is recommended by most medical and public health professionals, but this
information can be kept from a health curriculum if a school board considers it to be
objectionable.

A 1998 survey of school superintendents regarding sex education policies
revealed the following:

Only 69% of districts had a policy of teaching sexuality education, while
the remainder left the decision up to the school principal or to the
teachers. Among school districts with a sexuality education policy, 35%
(23% of all school districts) required that abstinence be taught as the only
option for unmarried people, either by prohibiting the discussion of
contraception or requiring instructors to emphasize its shortcomings;
51% required that abstinence be taught as the preferred option for
adolescents but also permitted discussion of contraception as an
effective means of protecting against unintended pregnancy and STDs;
and 14% had a policy of teaching about both abstinence and
contraception as part of a broad sexuality education program (Darroch et
al., 2000, pp.204-205).

The flexibility that is afforded to local school districts in curricular decisions by the
decentralized education system is the basis for this study. Pennsylvania does not have a
single state-mandated sex education curriculum and does not require individual school
districts to report on the specific programs they implement, which means that there is
no way of knowing exactly what Pennsylvania’s young people are being taught about sex.

Focusing on Pennsylvania

We have seen how the United States compares with other industrialized nations with regard to adolescent sexual health, but the U.S. is a large and diverse nation and each state has its own rich history and data with regard to sex education and sexual health indicators. Therefore, it is important that we examine the state of Pennsylvania in a national context to see how its rates of teen pregnancy and childbearing and STI acquisition compare to national averages and how its policy choices compare to those promoted at the federal level.

The most recent teen childbearing data in Pennsylvania indicates that while overall, childbirth rates are lower than the national average they are following the same national trends. The national teen childbirth rate increased 3% from 40.5 births per 1,000 15- to 19-year-olds in 2005 to 41.9 in 2006 (Centers for Disease Control and Prevention, 2007). Pennsylvania’s teen childbirth rate increased from 28.2 births per 1000 15- to 19-year-olds in 2005 to 29.5 in 2006, an increase of 4% (Pennsylvania Department of Health, 2008). The By the Numbers (Hoffman, 2006) report cited earlier that provided national cost estimates associated with teen childbearing also estimated state level costs as well. According to this report, in 2004, teen childbearing cost
Pennsylvania taxpayers a total of $389 million. Figure 2-3 depicts the teen pregnancy and birth rate trends in the state from 1999 to 2007.

Fig. 2-3: Pregnancy and Birth Rates for 15-19 Year Olds in Pennsylvania (1999-2007)
Source: Pennsylvania Department of Health

Figure 2-4 illustrates the disproportionate rates of STI acquisition among adolescents. For instance, in 2007, Pennsylvania teens aged 15-19 accounted for nearly 40% of all new chlamydia infections, but 15-19 year olds comprise only about 20% of the state’s total population (U.S. Census Bureau, 2009).
Schools in Pennsylvania are not required to teach sex education, but are required to teach STI/HIV education at the elementary, middle, and high school levels. Parental opt-out is permitted, though removal of a student must be based on religious or moral beliefs (Guttmacher Institute, 2008). Pennsylvania consists of 67 counties and 500 separate school districts. Within these 501 districts are over 1,200 public middle and high schools, the settings in which students generally receive school-based sex education programming. Twenty-nine intermediate units exist to help coordinate services among the 500 districts.

The state of Pennsylvania has at various times received federal abstinence-only sex education funding in the form of AFLA grants, Title V grants, SPRANS-CBAE grants, and federal earmarks. In 1997, the Pennsylvania Department of Health commissioned

Fig. 2-4: Incidence of Chlamydia and Gonorrhea in Pennsylvania by Age (2007)
Source: Pennsylvania Department of Health
an evaluation of its Title V funded programs. The results of the evaluation, which took place between the years of 1997 and 2003, indicated that of the 13 programs quantitatively assessed, seven had no effect on reducing early sexual onset, two had a negative effect, and four had a positive effect, but these effects diminished by the time the youth reached ninth grade (Smith, Dariotis, & Potter, 2003). Subsequently, Pennsylvania did not submit an application for Title V funds in 2005, but abstinence education funding was still procured for various organizations within the state via earmarks made by Senator Arlen Specter, as well as through AFLA and SPRANS-CBAE. Pennsylvania reapplied for the Title V funds in 2006, but was a year late with their application. States have two consecutive years to expend any funds provided in a given fiscal year, meaning that the FY2006 Title V funds had to be expended by the June 30, 2007, the end of the state’s fiscal year. Because of their late application, the state was unable to distribute the funds prior to this deadline and therefore had to return it to the federal government.

The Sexuality Information and Education Council of the United States (SIECUS) collects information about sex education in each state annually and generates state profiles that synthesize this information. As of the writing of the latest SIECUS State Profiles, there are nine SPRANS-CBAE and three AFLA grant recipients in Pennsylvania (Sexuality Information and Education Council of the United States, 2008). In addition to these three federal grant programs, Pennsylvania has also received millions of dollars in federal earmarks for abstinence-only sex education. According to the SIECUS report, in FY2003, Senator Specter “set a new precedent for the federal funding of abstinence-
only-until-marriage programs by securing earmarks of approximately $3.15 million within the federal Omnibus Appropriations” (Community-Based Abstinence Education (CBAE) and Adolescent Family Life Act (AFLA) Grantees section, para. 2). Specter earmarked an additional $3 million in both fiscal years 2004 and 2005. In FY2007, the state received $3.36 million for abstinence-only sex education via earmarks made by Senator Specter. These earmarks were designated for 29 different state organizations.

In this chapter I have attempted to better define and clarify the complex issue of sex education and illustrate its uniqueness and importance within our society. In the next chapter on the study’s theoretical framework, I will provide an even broader context for the issue that attends to more conceptual, philosophical questions of what sex education really is and what it is meant to accomplish.
Chapter 3

Theoretical Framework

Sex education has come a long way since Progressive reformers first started fighting for its inclusion in classrooms in the early twentieth century. Since that time, there have been many changes in content and mode of delivery, but it still remains an integral part of American schooling. On the whole, Americans want the schools to teach their kids about sex (Bleichley et al., 2006; National Public Radio et al., 2004a) and the schools (some more willingly than others) oblige. In comparison to other nations, however, the U.S. government supported abstinence-only approach to sex education is a distinct anomaly and stands out given the nation’s substantially higher rates of teen pregnancy and STI acquisition. School based sex education (or lack thereof) regardless of its content or message is in no way the sole cause of or reason for these rates, but it is nonetheless regarded as one of several indicators that do play a role in the prevention of teen pregnancies and STIs.

Americans are not unified, however, in their opinions on this issue. The approach promoted by the federal government for over 30 years has been strictly abstinence-only, but public opinion data demonstrate a wide array of thoughts and beliefs about sex education among the general public. Those who look to scientific evidence and public health data to inform their decisions tend to prefer a more comprehensive approach when it comes to school based sex education because of its
demonstrated effectiveness in changing risk behavior among young people. On the other hand, those who refer to more traditional moral standards to guide their decisions advocate for the abstinence-only message in classroom curricula because it is unequivocally clear about the impropriety of sexual behavior in adolescence. The main distinction between these two generalized sets of people is in where they believe moral authority stems from. Therein lies the theoretical basis of this study; cultural conflict is fueled by a fundamental disagreement over whether moral authority is external, definable, and transcendent or whether it is flexible, indefinite, and open to interpretation. When this disagreement reaches the policy arena (federal, state, or local), small battles over contentious issues like abortion, gay rights, and, of course, sex education escalate into full out culture wars in which the victors are afforded the opportunity to define America and what it means to be an American. In this chapter I will introduce the concept of morality policy and explain its distinctive characteristics and the role they play in the values clashes known as culture wars. I will focus on the schools as one of the battlegrounds for these skirmishes and discuss how the culture wars theory can offer some clarity on the sex education debate.

Morality Policy

There is a strand of public policy and political science research that suggests that issues like sex education create social and political conflict because they are rooted in differing systems of moral understanding (Hunter, 1991). Policy issues in which the
primary stakes are matters of fundamental religious values or deep-seated beliefs about the propriety of a behavior or activity rather than material or economic interests are unique entities known as “symbolic” or “morality” policy issues (Sharp, 2002). According to scholars in this arena, morality policy is a distinctive entity within the realm of public policy and it differs from other types of policy in several important ways: it is not amenable to compromise, its language and concepts are both technically simple, it has high public salience, and it generates high levels of citizen participation (Mooney, 2000; Mooney & Schuldt, 2006). Conventional political economic theories contend that individuals and groups are motivated by material stakes and that “the development of governing coalitions is based upon divisible benefits and the marshaling of power resources” (Sharp, 1997, p. 262), but as Sharp (1997) explains, “the symbolic politics and morality issues that are at the heart of local culture wars are not readily treated as divisible benefits, and the compromise and coalition-building that are central to regime theory are less relevant for understanding the uncompromising social conflicts of interest here” (p. 262).

Morality policy is a type of regulatory policy. Regulatory policies govern norms for behavior or interaction. The level at which this regulation occurs depends, of course, on the nature of the policy in question and the individuals being regulated. In many cases, policies are explicit and have a direct effect on the regulation of behavior. For example, specific laws exist that prohibit solicitation of prostitution, alcohol consumption by individuals under the age of 21, and drug use. However, policies can also have an indirect regulatory affect on behavior (and may, in fact, be designed with
this indirect impact in mind). For instance, age-based curfews mandate that anyone under a certain age be off the streets by a specified time. The stated purpose of curfews is to maintain public order and safety, but curfews indirectly regulate the behavior of young people by ordering their return home and therefore keeping them from engaging in any of a host of pursuits ranging from general public loitering to gang involvement.

Regulatory policies differ from *distributive* policies, which are collective public provisions like research grants or general tax reductions, and *re redistributive* policies, which are policies that reallocate costs and benefits within systems or across groups, such as progressive taxation and social assistance (Heinelt, 2007). Researchers have pointed out, however, that the process of morality policy generation and adoption resembles that of redistributive politics because groups are ultimately attempting to redistribute values (as opposed to income) by having the government approve or disapprove of some specified set of values (Haider-Markel & Meier, 1996). As Mooney and Lee put it, morality policies are essentially “policies that regulate behavior to validate basic principles that are not universally held in a polity” (1999, p. 81). Further, redistributive policies are characterized by conflict, polarization between winners and losers, and ideological issue framing (Heinelt, 2007).

Until recently, the notion that policy issues involving core moral values comprised their own unique policy category was nothing more than an assumption among some political scientists and public policy analysts, but Mooney and Schuldt (2006) tested the veracity of this assumption. In their review of the literature, they found that overwhelmingly, the characteristic that distinguished morality policy from
other types of policy was its basis in fundamental first principles, or basic moral values and opinions about absolute right and wrong. The authors used the results of a public opinion survey to test some general assumptions about morality policy and their analyses validated morality policy as a distinct policy typology. Their results indicated that policies designated as “morality policies” do generate more values-based conflict, are indeed less amenable to compromise, and are also less technically complex than non-morality policies. (The data did not support the hypothesis that these policies were more publicly salient than non-morality policy.) The results of this study offer verification and clarification of morality policy. The existence and nature of morality policy as a distinctive category of public policy sets the stage for understanding the social and political contexts of the sex education debate.

As a morality policy, the factors influencing decisions about sex education policy adoption and the contexts within which they exist are noticeably distinct from non-morality policy and therefore worthy of further scrutiny. I have adopted this framework because of its ability to make sense of what on the surface appears to be a completely nonsensical situation. Despite the facts that 82% of Americans favor a comprehensive approach to sex education and that empirical research has provided compelling evidence of its relative effectiveness in delaying adolescent sexual activity, reducing number of sexual partners, reducing frequency of sexual activity, and increasing condom and contraceptive use, abstinence-only sex education is taught in one-third of American schools and federal policy continues to provide fiscal support for it (Doan & Williams, 2008; Kaiser Family Foundation, 2002). Doan and Williams (2008) similarly adopted a
morality policy framework in their assessment of the formation of federal abstinence-only legislation. Their central thesis was that “abstinence-only education is more than a symbolic representation of a modern cultural disagreement. Abstinence-only education represents a policy innovation in the battle for footing in the cultural and moral conflicts taking place in American politics” (p. xv). They refer to this policy innovation as *stealth morality policy*, wherein policymakers discretely insert an unpopular policy initiative into a prominent bill that has widespread public and political support.

Initially, when abstinence-only proponents put forth legislative proposals, these proposals were either heavily modified or defeated following Congressional and public debate. In effect, abstinence-only proponents recognized that to get their policies passed, they would need to link the issue of sex education to other social problems on Congress’s agenda at the time and simply tack on provisions for abstinence-only education in legislation addressing these greater social problems. In so doing, they would be able to bypass Congressional and public debate. This tactic has become common in Washington and is referred to as *omnibus legislating*, defined by Congressional scholar Barbara Sinclair as “legislation that addresses numerous and not necessarily related subjects, issues, and programs, and therefore is usually highly complex and long” (as cited in Doan & Williams, 2008, p. 15). Omnibus legislating has become useful tactic for passing bills in a politically fragmented government that would otherwise be stuck in Congressional gridlock, but is not without its critics. Doan and Williams (2008) contend that stealth morality politics is the application of omnibus legislative techniques to morality policy issues.
Doan and Williams (2008) used a morality policy framework to understand the formation of abstinence-only policy-making at the federal level. I adopt this framework here to frame sex education policy-making at the local level. At the national level, politicians and interest groups are locked in an endless debate about whether abstinence-only sex education provides a positive, values-based message that will keep America's youth physically, psychologically, and spiritually healthy and serve to strengthen the American family, or whether it imposes a set of values on youth that are not universally held by all Americans, and ultimately leaves youth unprepared to responsibly handle the realities of life in modern society. These debates filter down to the local level where the onus of sex education policy adoption falls on local school districts. Unlike other school district policy decisions in which the major factors of influence are issues of cost and capacity, sex education decisions require moral judgments about the acceptability and/or normality of adolescent sexuality and the appropriateness and/or necessity of teaching young people about options other than abstinence.

It is for this reason that sex education and other morality policy issues are at the heart of the cultural conflict driving the countless battles fought by politicians, interest groups, and ordinary citizens over fundamental issues of right and wrong known as culture wars. The “warriors” who fight these battles are fighting to define America and what it means to be an American. With such immensely high stakes, the clashes are intense, and with no room for compromise on these issues, the culture wars have no foreseeable end. The section that follows elaborates on these metaphorical wars—
where they come from, who is fighting them, what are they fighting over, and why are they fighting—and illustrates how sex education fits in as one of the many battles involved the larger war.

**Culture Wars**

Value-based cultural conflict is certainly not new within the United States, but the nature of this conflict has changed over time. The initial European settlers arrived on these shores seeking refuge from religious persecution and during the colonial period, various Protestant sects emerged in the different colonies. Above and beyond their sectarian differences, however, the members of these various Protestant traditions were united in their opposition to Catholicism. Herein lie the roots of America’s culture war; various denominations of Protestants set aside their differences to advance their common vision for a Protestant America. Morone (1996) explains that Protestantism and the United States “both sprang from revolts against centralized authority” (p. 428) and as Hunter (1991) describes,

The symbols and language of Protestant culture permeated republican political rhetoric and informed the conduct of electoral politics (in which anti-Catholic propaganda and parties provided rallying points). It influenced the formation and execution of law (seen clearly in the enforcement of blasphemy law and the like). It provided the vision for popular education: both the establishment of the common school (where the moralistic school book McGuffey’s Reader became a staple of instruction and the reading of the King James version of the Scriptures a source of devotion) as well as the expansion of denominationally founded and governed colleges and universities. It offered the institutional mechanisms for the allocation and administration of public welfare. And finally, Protestant culture provided an agenda for social
reform (as seen, for example, in the powerful initiatives of the temperance movement) (p. 69).

The influx of Catholic immigrants beginning in the 1830s and later Jewish immigrants in the 1880s heightened religious hostilities. Protestants viewed these immigrants as threats to “their” America. These Catholic and Jewish immigrants, however, proved to be formidable opponents and over time the Protestant American vision evolved into a more general Judeo-Christian vision. Religious pluralism expanded following World War II as the United States became home to a variety of new religious groups, including Mormons, Muslims, Hindus, Buddhists, and secularists. Just as the influx of Catholics and Jews upset the original Protestant balance, this postwar religious expansion challenged the subsequent Judeo-Christian consensus. Morone (1996) points out that cultural conflicts tend to follow a pattern in which immigrants arrive with differences that challenge the predominating American culture and as marginalized groups fight for rights, the balance of power between different races, genders, creeds, and classes is challenged. The result is a culture war between those who wish to maintain the status quo and those who seek to amend (or rectify) it. On the postwar religious expansion, Hunter (1991) notes:

The most recent expansion of pluralism signifies the collapse of the longstanding Judeo-Christian consensus in American public life... in the wake of the fading Judeo-Christian consensus has come a rudimentary realignment of pluralistic diversity. The “organizing principle” of American pluralism has altered fundamentally such that the major rift is no longer born out of theological or doctrinal disagreements—as between Protestants and Catholics or Christians and Jews. Rather the rift emerges out of a more fundamental disagreement over the sources of moral truth (pp. 76-77).
American culture has been evolving since the first Puritans set foot on these shores. Social norms and values have shifted with the arrival (or emergence) of new groups. The older Protestant-Catholic divide has evolved into a conflict between impulses toward progressivism versus orthodoxy (Hunter, 1991; Layman, 1997).

According to Hunter (1991), orthodoxy and progressivism are formal properties of one’s belief system or worldview. He defines orthodoxy as “the commitment on the part of adherents to an external, definable, and transcendent authority” (p. 44) and progressivism as “the tendency to resymbolize historic faiths according to the prevailing assumptions of contemporary life” (pp. 44-45). While interdenominational religious tensions were the basis of American cultural conflict in the nineteenth century, today the tensions exist within and across denominations. In other words, the battles are no longer between Catholics and Protestants, but rather between progressive Catholics and orthodox Catholics, and progressive Protestants versus orthodox Protestants.

Progressive Catholics and progressive Protestants are allies in today’s culture wars, as are orthodox Catholics and Protestants.

While the conventional dichotomy between political conservatives and liberals may come to mind, Hunter (1991) cautions against equating political dispositions and foundational moral commitments. “On political matters,” he states, “one can compromise; on matters of ultimate moral truth, one cannot” (p. 46). This distinction, which was supported by the Mooney & Schuldt (2006) study, is key to understanding cultural conflict over any contentious moral issue, including sex education. Further, individuals are not either progressive or orthodox; a simple dichotomization such as this
one ignores the rich diversity and variation in belief and action among the American public. As Doan and Wilson (2008) note, “on many morality issues, the public does not consistently hold a conservative or liberal ideology. Individual opinion is more contextual and tends to fluctuate depending on the saliency of the specific issue in question” (p. 10). Progressivism and orthodoxy should be conceptualized as the ends of a continuum upon which individuals gravitate toward one side or the other, as opposed to being fixed points upon it. Further, Luker (2006) cautions against making automatic judgments about individual views on sex education based on stereotypes that classify supporters of sex education as secular, politically liberal, and middle- and upper-middle class, and opponents of sex education (and/or supporters of abstinence-only sex education) as less educated conservative Christians from more modest social backgrounds. “[The] reality,” she says, “is much more interesting...although such people are probably in the minority, some sexual liberals are praying in the pews of the most conservative Christian churches, and some sexual conservatives are attending ACLU meetings. And here’s where things get tricky” (pp.125-126).

Research by Layman and Carmines (1997) indicates that the U.S. political landscape has become increasingly values-based and that cultural cleavages (i.e., orthodoxy and progressivism) have become just as relevant (if not more relevant in some ways) than other social cleavages, such as race or class in influencing political attitudes and behavior. Layman (1997) notes that the role of religious orthodoxy on variables such as partisanship and presidential vote choice, for instance, increased considerably between the years of 1980 and 1994, even after controlling for a wide
range of religious, sociodemographic, and political variables. The role of religious affiliation (as opposed to level of religious commitment or orthodoxy) in predicting presidential vote choice, however, declined between the 1960 and 1992 presidential elections (Brooks & Manza, 1997). As Hunter (1991) has noted, this distinction between religion and religious orthodoxy is key to understanding modern cultural conflict.

Progressive or orthodox impulses or tendencies transcend conventional lines of political division, such as religion (i.e., religious affiliation), income level, race, sex, etc. These cleavages are still important in the study of American politics, however, as Layman and Carmines (1997) point out:

Social and cultural concerns such as abortion, homosexual rights, women’s rights, and prayer in the public schools have moved to the forefront of American politics [and] the struggles between those with progressive orientations on these matters and those striving to defend traditional values have received a great deal of attention in the popular press, and attitudes on social and cultural issues have come to play a substantial role in voting decisions in both national and state elections (p. 752).

This distinction between those with progressive orientations and those striving to defend traditional values is at the heart of the polarizing issue of school-based sex education, and at the heart of that issue are our personal beliefs about sex itself.

**Red Sex, Blue Sex**

Sex education is one of many issues at stake in the American culture wars, but at the core of the battles over what we should be teaching kids about sex are our personal beliefs about sex. These beliefs are intensely personal and passionate and are often
Beliefs about sex influence not just the sex education battles, but also battles over marriage, family, homosexuality, pornography, prostitution, and abortion. Beliefs about sex impact individual sexual decisions, gender norms, pregnancy and childbearing choices, marriage, and divorce. By extension, they also affect education, employment, industry, family, health, and economy. Our beliefs about sex shape our social dynamics, and are concurrently influenced by those dynamics. While there is a wide array of opinions about the proper place(s) for sex (e.g., in a heterosexual marriage, in a loving relationship, in a consensual partnership) and purpose(s) of sex (e.g., procreation, love, pleasure), the jargon we see around this issue models Hunter’s (1991) orthodox/progressive dichotomy. Luker (2006) speaks of “sexual liberals” and “sexual conservatives.” Cahn and Carbone (2007) describe “red families” and “blue families.” Regnerus (as cited in Talbot, 2008) refers to “red sex” and “blue sex.” The urge to neatly categorize and polarize people and their worldviews is consistent with the culture war analogy, even if it is dismissive of variation.

In Luker’s (2006) more than one hundred interviews of individuals on the issues of sex and sex education, she observed that the chasm between those on the “sexual right and left” (p. 91) has grown considerably since the sexual revolution of the 1960s. The terms “liberal” and “conservative,” however were not her own. “Almost all the people I spoke with used some formulation of the conservative-liberal or right-left dichotomy to talk about where they and others stood when it came to sexuality and
education about it” (p. 92)\(^5\). Luker’s (2006) investigation concluded that the values at
the core of our sexual beliefs involve how you do it and where you do it. For sexual
conservatives, a (heterosexual) marriage is the only appropriate context for sex. Sexual
liberals, on the other hand, view marriage as one of several possible contexts for sexual
activity and believe that sex is appropriate between consenting individuals who take
measures to protect themselves from harm (e.g., unplanned pregnancy, STI acquisition).

Behind these values are ideas about the nature and meaning of sex. Luker
(2006) observed that conservatives view sex as being sacred, while for liberals, it is
natural. Sacred acts require powerful institutions, like marriage, to protect and
legitimate them; natural acts do not. The meaning of sex is also of central importance
here. For example, when sexual liberals affirm that pleasure is a legitimate premise for
sexual activity, it dismisses the idea that it must be thought of solely in the context of
marriage. Hence, issues such as masturbation and homosexuality are problematic for
sexual conservatives because they are thought to undermine heterosexual marriage by
suggesting that sexual pleasure can be experienced in other contexts. Luker (2006)
suggests that the key to understanding what makes individuals sexually liberal or
sexually conservative is the role that information plays in their life. More specifically,
sexual liberals believe that information is a good thing and there cannot be such a thing
as too much or the wrong kind of it; sexual conservatives believe that too much or the
wrong kind of information can cause problems and get people into trouble.

\(^{5}\) Interestingly, many of the survey respondents in my study used this same kind of language. I will discuss
this issue in greater depth in Chapter 5.
When you look at the world through the strict and clear-cut moral lens of the sexual conservatives, you accept that there is a clear set of rules that holds true across time and space. Hence, according to this worldview, youth only require as much information as is necessary to uphold these clear-cut moral standards. Moral absolutes unquestionably exist. Consequently, sexual conservatives support the existence of boundaries and the maintenance of hierarchies because they believe “that society and individuals are best served by an orderly world, and orderly worlds have both boundaries and hierarchies within those boundaries” (Luker, 2006, p. 158). Sexual liberals, on the other hand, view the world through a situationist moral lens that accepts that “morality is based on a set of principles that must be adapted to the changing contours of modern life” (Luker, 2006, p. 136). Moral absolutes do not exist for sexual liberals. They favor facts over faith because facts can be tested and scrutinized and also because they can be amended when flawed, unlike, for instance, sacred texts.

According to Luker (2006), sexual liberals believe that boundaries and hierarchies only serve to separate people from each other and are “just one more example of how ‘society’ alienates people from genuine and meaningful connection” (p. 166).

Luker (2006) astutely refers to sexual liberals as the heirs to Descartes and sexual conservatives as the heirs to Calvin. Sexual liberals firmly believe that humans make good decisions when they are sufficiently informed. Sexual conservatives (the modern-day Calvinists), however, see humans as victims of unruly desires and view strict structures as the means to keep these destructive impulses under control. In summary, it appears that both sexual liberals and sexual conservatives (and all of those
who fall somewhere in between) all have the best interests of our youth at heart, but they fundamentally disagree on what those best interests are, and hence strongly believe that their opposition is doing young people harm.

While Luker (2006) examined the distinctions between sexual liberals and conservatives on an individual level, Cahn and Carbone (2007) contrast how their two differing worldviews play out on a societal level. In other words, they examine how over generations, beliefs about sex develop into family patterns and social trends. Cahn and Carbone (2007) contrast red families in red states with blue families in the blue states to illustrate how sexual values are a function of our regional politics, and also how these values in turn shape regional, social, and political dynamics. Their analysis depicts how blue families have adopted what the authors refer to as “the new middle class morality,” a moral standard that promotes delayed childbearing and an investment in education and occupation for both men and women. This new middle class morality has resulted in families that are characterized by greater wealth, higher average levels of education, greater urbanization, lower fertility levels, and lower levels of church attendance. In effect, it also involves a reduction in the prescribed controls of sexuality; individuals are in control of their own sexual decision-making and are encouraged to make use of contraception in order to plan their childbearing around their educational and career goals. Abortion is considered an acceptable option in the event of an unintended pregnancy, single parenthood is a respected personal choice, and same-sex relationships are recognized as legitimate as a matter of basic equality.
Red families, on the other hand, are opposed to the new middle class morality, and instead promote a more traditional family system that establishes marriage as the sole designated institution for sex, childbearing, and childrearing. As such, sex outside of the context of a marriage is condemned; abstinence is the “moral imperative” (p. 3). Unmarried individuals who become pregnant (or get someone pregnant) are encouraged to marry and bear the children. To red families, the two parent household structure is considered to be the foundation of good and moral family life, not economic self-sufficiency or emotional maturity that are considered to be the foundations of good and moral family life for blue families.

These two distinct family styles are a compilation of regional and demographic factors. First, the authors note that red families typically reside in red states, which they defined as states that voted Republican in the 2004 presidential election; blue states voted Democratic. All of the Northeastern, mid-Atlantic, and West Coast states along with four upper mid-western states (Illinois, Michigan, Minnesota, and Wisconsin) are blue. The remaining 31 states are situated in the Mountain West, the Midwest, central Midwest, Southwest, and the Southeastern region known as the Bible Belt. Figure 3-1 depicts the 2004 presidential election map and the regional dispersal of red and blue states.
The authors acknowledge that presidential vote choice is a somewhat crude measure for the cultural differences they were attempting to capture, but that this distinction does in effect represent other key demographic differences that distinguish red families from blue, the first of which is age at first marriage. The average age of first marriage in the United States is 25 for women and 27 for men. In Massachusetts (a blue state), the average age of first marriage is 27 for women and 29 for men. In Utah (a red state), the average woman marries before age 22 and the average man before age 24. This trend holds reasonably steady across the other states in each category. The second major distinguishing factor that aligns with the regional designations is church attendance. Frequent church attendance is correlated with more conservative sexual attitudes and values and is much higher on average in the red states than the blue. Appendix B summarizes data compiled by Cahn and Carbone (2007) on each state’s teen pregnancy rate rank, teen abortion rate rank, and divorce rate alongside the percentage of people
in those states who attend church or synagogue either once a week or almost once per week\(^6\). The rows containing blue state data are shaded to distinguish from them from the red states. In the 2004 presidential election, pollsters included “moral values” for the first time among the issues (i.e., health care, education, terrorism) they asked voters to rank in order of importance to their vote choice. Of those who selected “moral values” as their most important issue, 78% voted for the Republican candidate, George W. Bush.

Religion, education, and class all certainly influence our beliefs about sex, but do our beliefs about sex influence our actual sexual behavior? Talbot’s (2008) recent article in *The New Yorker* raises this question in reflecting on the very high profile pregnancy of former Republican vice-presidential nominee, Sarah Palin’s, seventeen-year-old daughter Bristol. Sarah Palin is a devoutly religious, outspoken pro-life, pro-family conservative, and an advocate of abstinence-only sex education. It would be safe to assume that her value-set would place her in Luker’s (2006) “sexual conservative” category or within one of Cahn and Carbone’s (2007) “red families,” yet her unmarried teenage daughter became pregnant despite being raised with these values. Talbot’s piece, which draws on work by both Regnerus (2007) and Cahn and Carbone (2007), expresses her confusion over the paradoxically high rates of teen pregnancy among evangelical teens who, in theory, based on their religious beliefs should experience far fewer non-marital pregnancies. According to Regnerus’s (2007) research, however, religion may affect an adolescent’s attitudes and motivations about sex, but they are

\(^6\) All rates are per 1,000 teens (15-19 year olds).
not necessarily predictive of their actions. He notes that while evangelical Protestant youth hold less sexually permissive attitudes, they are not, on average, the last to lose their virginity. They are, however, significantly less likely to use contraception for any of a variety of reasons. For instance, the data suggest that evangelicals believe that being prepared with contraception sends the message that one is looking for sex. Further, the abstinence-only sex education movement warns these youth that condoms are actually ineffective in preventing pregnancy and STIs. As it turns out, our beliefs about sex are not necessarily the best predictors of our actual sexual behavior, but they undoubtedly influence sociocultural and political disputes about issues that involve sex, like abortion, same-sex marriage, and of course, sex education in schools. Finally, as Luker (2006) describes, the battles over sex education are not just about sex, but also about education more generally as it pertains to the role of information and the setting of boundaries versus the encouragement of independent decision-making.

It is not difficult to understand why educational issues generate a fair amount of cultural conflict; the culture wars are ultimately over the struggle to define America, and schools play a visible role in defining what it means to be an American. Schools serve to socialize children into American society by promoting meritocratic and democratic ideals and are offered as the solution to many of the nation’s social and economic problems. For instance, President Johnson’s famous “Great Society” initiative was centered around the idea that “the answer to all our national problems comes down to a single word: education” (as cited in Tyack & Cuban, 1995, p. 2). According to historians Tyack and Cuban (1995), the notion that improving public education will
ultimately improve the overall quality of the nation as a whole is one that is almost uniformly held among Americans. This “school as social panacea” mindset posits that modern schools need to go far beyond educating youth in the conventional areas of reading, writing, and arithmetic and be responsible for attending to the needs of the whole child (e.g., social, developmental, academic, athletic, artistic). According to this philosophy, schools are meant to do more than merely provide facts and figures; they strive to teach students how to think critically and reason. They encourage mindful citizenship and provide the skills and knowledge necessary for entering the modern workforce or for advancing into the arena of higher education (e.g., colleges, universities, vocational/technical schools). Given the importance, or rather, imperativeness of schooling in the modern world, it is evident why education would be at the top of the cultural agenda.

Because sex education is a morality policy issue, individual attitudes on the subject are not the result of individual or group material stakes, but are instead determined by that individual or group’s impulse toward either orthodoxy or progressivism. According to this framework then, the ultimate discrepancy over the issue has little or nothing to do with scientific evidence or public health research, but is ultimately over fundamental values about right and wrong. For advocates of comprehensive sex education, the purpose of sex education is to provide adolescents with complete and thorough information with the belief that this will enable

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7 To be clear, these statements do not make up a single, universally held philosophy about the roles of American schools, but reflect different dimensions that schools have been believed to have been able to affect and improve.
adolescents to make informed, healthy sexual decisions. Inherent within this assumption regarding the purpose of sex education is the progressive values of appreciation of and respect for individual freedom and autonomy. Alternately, advocates of abstinence-only sex education believe the purpose of sex education is to promote sexual abstinence until marriage because pre-marital (or extra-marital) sexual activity is inappropriate and/or immoral. This position represents an orthodox stance, which accepts that moral authority is “independent of, prior to, and more powerful than the human experience” (Hunter, 1991, p. 120) or the popular trends of the day. The two sides view the problem differently, and consequently promote distinctively dissimilar solutions.

Culture Wars as a Theoretical Framework

The culture wars framework provides a context for understanding why sex education programming varies across local school districts and why the issue of sex education is so hotly contested within them. According to this framework, beliefs and attitudes about sex education policy are a function of personal moral beliefs as opposed to individual material stakes or empirical research findings. Ergo, sex education policy adoption decisions are likely to be influenced by the decision-makers’ perceptions of sex education beliefs and attitudes within their communities as well as their own personal beliefs and attitudes. This framework, or lens, was selected because of its ability to help us understand sex education policy adoption at the school district level. This theoretical
framework shaped the methods of inquiry and analysis for this study by informing the selection of survey items and interview protocols and the establishing the means for evaluating the resulting data.

If cultural conflict is ultimately about the struggle for the domination of one worldview over another, one must question the likelihood of a democratic solution to the sex education quandary that will be satisfactory to individuals with orthodox impulses as well as those with progressive impulses. As stated previously, there is no compromise when fundamental, or absolute truth is at stake and as Hunter (1991) puts it, “the reality of politics and public policy in a democracy is, for better or worse, compromise born out of public discussion and debate. But such discussion would seem to be unattainable when the moral language employed by opposing sides is so completely antithetical” (p. 129). In most instances, it appears that comprehensive sex education advocates and abstinence-only advocates are speaking entirely different languages and end up talking at one another rather than with each other.

Consequently, it is evident that language, rhetoric, symbols, framing, and social constructions all affect the way morality policy is made and the manner in which it is perceived and it is therefore necessary to study each of these elements in the process of deconstructing sex education policy debates. Irvine (2002) and Luker’s (2006) analyses of these elements in their respective investigations of school-based sex education and Davies’ (1999) study of the reemergence of the promotion of religion in public schools via political framing served as the models for this investigation’s method of analysis. Irvine’s (2002) primary research question (which is very similar to this study’s second
question) asked, “How can we explain the bitter battles over sex education given that, since the sixties, most people have reported to pollsters that they support it” (p. 201).

To respond to this inquiry, she focused on analyzing the discursive political nature of the sex education debates and how these debates illustrate how we (collectively and individually) think, talk, and feel about sexuality by emphasizing the role of language, emotions, and the power of national organizational rhetoric in battles at the local level.

Luker’s (2006) intensive ethnographic study of sex education in four distinctive communities in the United States responded to the three following research questions:

How did sex education, which has been surprisingly common for the better part of a century and which has enjoyed very high levels of public support for most of that time, come to be so controversial? What is it about sex education that makes people so passionate about it? And what is it that translates that passion into politics at the national level (p. 18)?

In analyzing the narratives of parents and community members, Luker (2006) discovered that behind every conversation about sex and sex education were larger concerns about gender, power, trust, hierarchy, and human nature, as well as a supposition that what we teach kids about sex in schools implies beliefs and values about each of these issues.

Finally, the Davies (1999) study qualitatively analyzed how special interest groups use modern causes or initiatives to reintroduce or reinvent issues that would not otherwise be politically viable in their original or more basic forms. He refers to this process as political framing, “the tactical tailoring of shared understanding to promote certain perceptions of injustice and certain solutions” (p. 4). In much the same way as the religious coalitions Davies (1999) described promoted their issue via the frames of multiculturalism and school choice, the abstinence-only movement has adopted more
modern frames (e.g., public health, poverty reduction) and taken advantage of policy windows (e.g., welfare reform) to promote its cause as well.

Rogers’ (2003) diffusion of innovations theory was also initially considered as a possible conceptual lens. This theory explains how innovations (i.e., ideas, practices, objects) are diffused or spread through specific channels over time. The theory takes into account characteristics of the receiver (or decision-maker), characteristics of the social system, perceived characteristics of the innovation, and sources of communication. Figure 3-2 is a graphical depiction of the diffusion of innovations theory. Walker (1969) and Gray (1973) brought this theory, which originally sought to explain the adoption of technological innovations, into the policy arena. Since that time, several studies have used this theory in their examinations of policy adoption in the educational arena (e.g., Brink et al., 1995; McCormick, Steckler, & McLeroy, 1995; Pankratz, Hallfors, & Cho, 2002; Parcel et al., 1995; Wilson, Pruitt, & Goodson, 2008). Other studies have even considered political devices such as federal monetary incentives in policy diffusion (Welch & Thompson, 1980).
Diffusion of innovations theory is certainly a good place to start in attempting to understand the hows and whys of sex education policy adoption, but only when it is understood within the greater context of the culture wars. The adoption of a sex education policy occurs at the local school district level. Hence, the “social system variables” in this study would apply to the local school districts, but the local school districts are embedded within a diverse state and an even more diverse nation. There are social, economic, and political dynamics at each of these levels that diffusion of innovations theory would have difficulty capturing. The culture wars framework that I
have introduced here takes into account national, state, and regional politics that impact the adoption of morality policy at the school district level.

According to the culture wars framework, it is unknown whether a mutually agreeable solution to the sex education quandary actually exists. Abstinence-only and comprehensive sex education advocates frame the issues in distinctly different fashions. Their attitudes and beliefs about sex education are also the result of differing beliefs about the source(s) of moral authority. The literature suggests that a compromise on this issue will be complex at best and at worst, impossible. The ultimate goal of this research is to better understand how and why various sex education policies are adopted in order to develop strategies to market and promote solutions that more accurately reflect the needs and desires of the American public.
Chapter 4
Design and Methods

This investigation was designed to serve two purposes. First, it provides a
glimpse of the sex education policies and programs in place within a sample of
Pennsylvania school districts. Second, it offers explanations as to why these particular
sex education policies and programs were adopted or designed. The unit of analysis in
this investigation, therefore, is the school district as a whole. This unit of analysis is
embedded within several macro-environments that each exert some influence over
school district operations. These macro-environments are depicted in Figure 4-1.

Fig. 4-1: The School District as an Embedded Unit of Analysis
Examining the various roles and influences that these larger macro-environments exert on the districts adds more detail and dimensionality to the analyses and results, yielding more thorough and descriptive responses to the study’s research questions.

This chapter describes the design and methods employed to respond to the research questions posed in this study. Each design choice was informed by the study’s theoretical framework as well as previous research in the field. The sections that follow describe the study’s two phases of data collection and the methods of collection and analysis used in each. This study is a two part qualitative investigation. In the first part, I conducted a telephone survey in 29 school districts in Pennsylvania to obtain information about the types of sex education policies and programs in place across the state. The data collected in this part helped inform the second part, in which I compiled two school district case studies to analyze the factors that influence sex education policy and program decisions. The sections that follow describe these two phases of data collection and the methods of analysis used in each. The chapter concludes with a discussion of rigor and soundness and addresses its credibility, confirmability, dependability, and transferability, and limitations.
Part I: Survey

Sample and Population

The population for this study includes all 500 school districts in the state of Pennsylvania. I employed a stratified random sampling technique to obtain a sample of 29 school districts, one district per intermediate unit; within each stratum (i.e., intermediate unit), each school district had an equal chance of selection. Figure 4-2 depicts the location of the state’s 29 intermediate units. All districts and district personnel discussed in this study have been given pseudonyms to protect their anonymity. The names of the counties and intermediate units that comprise the districts are not divulged either; each district is described by the region of the state to which it belongs (e.g., northwest, southwest, north central, south central, northeast, or southeast). These regional designations are the same used by the Pennsylvania Department of Health’s School Health division. The counties discussed in the case study results chapter have been given pseudonyms.

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8 Intermediate units are regional agencies that coordinate programs and services for groups of school districts. Pennsylvania consists of 29 intermediate units.

9 Bandiera, Jeffries, Dodge, Reece, & Herbenick’s (2008) utilized a stratified random sampling technique as well in their investigation of regional differences in sex education programs in Florida. In their study, each of the state’s 67 counties was a stratum, but in Florida each county is also a school district. Most Pennsylvania counties consist of multiple school districts, thereby making stratification by intermediate unit a more attractive and realistic option for this study.

10 A list of the counties included in each region can be found at http://www.dsf.health.state.pa.us/health/lib/health/2008SchoolHealthConsultant.pdf
I also collected geographic (e.g., type of community\textsuperscript{11}), demographic (e.g., student racial composition), and socioeconomic data (e.g., student/teacher ratio, per pupil expenditure, percentage of students that qualify for the federal free and reduced lunch program, percentage of students with individualized education plans (IEPs), and percentage of English language learner (ELL) students\textsuperscript{12}) for each sampled district from

\begin{figure}
\centering
\includegraphics[width=\textwidth]{Fig_4-2.png}
\caption{Map of Pennsylvania’s Intermediate Units}
\source{Pennsylvania Department of Education}
\end{figure}

\textsuperscript{11} The United States Census Bureau classifies core census block groups or blocks that have a population density of at least 1,000 persons per square mile and surrounding census blocks that have an overall population density of at least 500 persons per square mile as urban. All areas that do not fall within this definition are classified as rural (For more information, visit http://nces.ed.gov/ccd/rural_locales.asp). The Center for Rural Pennsylvania defines a rural school district as one with a population density of 274 or fewer persons per square mile. Districts with greater than 274 persons per square mile are considered urban (For more information, visit http://www.rural.palegislature.us/). According to these definitions, 243 of Pennsylvania’s 501 school districts are rural districts. For the purposes of this study, the relative rurality or urbanicity of districts is designated by the U.S. Census Bureau’s new urban-centric locale codes, which are listed in Appendix D.

\textsuperscript{12} Student/teacher ratio, per pupil expenditure, and percentage of students on the federal free and reduced lunch program are all indicators of a district’s relative wealth. Typically, the lower the student/teacher ratio and percentage of students on the federal free and reduced lunch program, and the
the National Center for Educational Statistics (NCES)'s 2006-2007 Common Core of Data and the Pennsylvania Department of Education (PDE)'s Education Names and Addresses (EDNA) database. All of this information is compiled in Table 4-1\textsuperscript{13}. Approximately half of the sampled districts were located either in the Southeastern or Southwestern part of the state, which happen to be the most populous regions and consequently comprise a greater number of school districts than less populous areas. Additionally, half of the sampled districts were classified as rural districts; half of the state of Pennsylvania is considered rural as well. Figures 4-3 and 4-4 depict the breakdown of the sampled school districts by region and locale, respectively. Figures 4-5 and 4-6 illustrate the distributions of student-teacher ratios and per-pupil expenditures, respectively.

\textsuperscript{13} To protect the anonymity of the school districts, per pupil expenditure is rounded to the nearest hundredth and student/teacher ratios and percentages of students on the Free and Reduced Lunch Plan are rounded to the nearest tenth.
Table 4-1: Sample Characteristics

<table>
<thead>
<tr>
<th>District</th>
<th>Region</th>
<th>Locale</th>
<th>% Non-White</th>
<th>S/T Ratio</th>
<th>PPE</th>
<th>% FRLP</th>
<th>%IEP</th>
<th>%ELL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bellemont</td>
<td>SW</td>
<td>suburb</td>
<td>6%</td>
<td>17</td>
<td>$10,300</td>
<td>20%</td>
<td>12%</td>
<td>---</td>
</tr>
<tr>
<td>Blue Hills</td>
<td>SW</td>
<td>rural</td>
<td>4%</td>
<td>15</td>
<td>$11,200</td>
<td>40%</td>
<td>17%</td>
<td>---</td>
</tr>
<tr>
<td>Cleaver</td>
<td>SE</td>
<td>suburb</td>
<td>9%</td>
<td>16</td>
<td>$16,400</td>
<td>10%</td>
<td>20%</td>
<td>1%</td>
</tr>
<tr>
<td>Eastern</td>
<td>NE</td>
<td>suburb</td>
<td>13%</td>
<td>17</td>
<td>$10,700</td>
<td>10%</td>
<td>13%</td>
<td>2%</td>
</tr>
<tr>
<td>Elmville</td>
<td>SC</td>
<td>suburb</td>
<td>13%</td>
<td>14</td>
<td>$10,000</td>
<td>20%</td>
<td>15%</td>
<td>2%</td>
</tr>
<tr>
<td>Elvin</td>
<td>SE</td>
<td>suburb</td>
<td>11%</td>
<td>15</td>
<td>$12,200</td>
<td>20%</td>
<td>22%</td>
<td>---</td>
</tr>
<tr>
<td>Fairway</td>
<td>SC</td>
<td>town</td>
<td>2%</td>
<td>14</td>
<td>$10,800</td>
<td>50%</td>
<td>18%</td>
<td>---</td>
</tr>
<tr>
<td>Foxburgh</td>
<td>NC</td>
<td>rural</td>
<td>---</td>
<td>13</td>
<td>$12,000</td>
<td>50%</td>
<td>22%</td>
<td>---</td>
</tr>
<tr>
<td>Franklin City</td>
<td>SE</td>
<td>city</td>
<td>87%</td>
<td>18</td>
<td>$14,100</td>
<td>70%</td>
<td>15%</td>
<td>15%</td>
</tr>
<tr>
<td>Fulton Area</td>
<td>SW</td>
<td>rural</td>
<td>2%</td>
<td>15</td>
<td>$11,200</td>
<td>30%</td>
<td>13%</td>
<td>---</td>
</tr>
<tr>
<td>Greater Sackerton</td>
<td>SE</td>
<td>rural</td>
<td>10%</td>
<td>17</td>
<td>$8,800</td>
<td>20%</td>
<td>18%</td>
<td>2%</td>
</tr>
<tr>
<td>Hirsch</td>
<td>SC</td>
<td>rural</td>
<td>21%</td>
<td>16</td>
<td>$11,100</td>
<td>30%</td>
<td>17%</td>
<td>5%</td>
</tr>
<tr>
<td>Jamestown Area</td>
<td>SE</td>
<td>town</td>
<td>3%</td>
<td>15</td>
<td>$10,600</td>
<td>30%</td>
<td>21%</td>
<td>1%</td>
</tr>
<tr>
<td>Jenkinstown</td>
<td>NC</td>
<td>rural</td>
<td>3%</td>
<td>11</td>
<td>$13,700</td>
<td>40%</td>
<td>23%</td>
<td>---</td>
</tr>
<tr>
<td>Kentwood</td>
<td>NE</td>
<td>rural</td>
<td>2%</td>
<td>12</td>
<td>$10,500</td>
<td>50%</td>
<td>14%</td>
<td>---</td>
</tr>
<tr>
<td>Kilwin</td>
<td>NW</td>
<td>rural</td>
<td>1%</td>
<td>16</td>
<td>$13,100</td>
<td>30%</td>
<td>18%</td>
<td>---</td>
</tr>
<tr>
<td>Marimont</td>
<td>SE</td>
<td>city</td>
<td>87%</td>
<td>20</td>
<td>$10,300</td>
<td>70%</td>
<td>13%</td>
<td>13%</td>
</tr>
<tr>
<td>Montgomery Vale</td>
<td>SC</td>
<td>town</td>
<td>4%</td>
<td>13</td>
<td>$8,900</td>
<td>40%</td>
<td>19%</td>
<td>---</td>
</tr>
<tr>
<td>Parkland</td>
<td>SE</td>
<td>suburb</td>
<td>17%</td>
<td>16</td>
<td>$17,300</td>
<td>10%</td>
<td>14%</td>
<td>3%</td>
</tr>
<tr>
<td>Penns Lake</td>
<td>NC</td>
<td>rural</td>
<td>2%</td>
<td>16</td>
<td>$8,700</td>
<td>40%</td>
<td>13%</td>
<td>---</td>
</tr>
<tr>
<td>Potteryville</td>
<td>NE</td>
<td>rural</td>
<td>11%</td>
<td>16</td>
<td>$9,600</td>
<td>20%</td>
<td>18%</td>
<td>---</td>
</tr>
<tr>
<td>Pratt</td>
<td>SW</td>
<td>rural</td>
<td>2%</td>
<td>15</td>
<td>$11,500</td>
<td>50%</td>
<td>21%</td>
<td>---</td>
</tr>
<tr>
<td>Prothero</td>
<td>SW</td>
<td>rural</td>
<td>1%</td>
<td>13</td>
<td>$16,300</td>
<td>30%</td>
<td>14%</td>
<td>2%</td>
</tr>
<tr>
<td>Queensboro Area</td>
<td>NW</td>
<td>suburb</td>
<td>77%</td>
<td>15</td>
<td>$14,000</td>
<td>50%</td>
<td>18%</td>
<td>---</td>
</tr>
<tr>
<td>Redmont</td>
<td>NE</td>
<td>suburb</td>
<td>6%</td>
<td>16</td>
<td>$9,700</td>
<td>20%</td>
<td>15%</td>
<td>1%</td>
</tr>
<tr>
<td>Southern Valley</td>
<td>SE</td>
<td>suburb</td>
<td>14%</td>
<td>14</td>
<td>$12,500</td>
<td>10%</td>
<td>14%</td>
<td>1%</td>
</tr>
<tr>
<td>Trenton</td>
<td>SW</td>
<td>city</td>
<td>64%</td>
<td>13</td>
<td>$18,800</td>
<td>40%</td>
<td>23%</td>
<td>1%</td>
</tr>
<tr>
<td>Village Acres</td>
<td>NE</td>
<td>rural</td>
<td>5%</td>
<td>20</td>
<td>$8,600</td>
<td>20%</td>
<td>13%</td>
<td>1%</td>
</tr>
<tr>
<td>West Millerstown</td>
<td>NW</td>
<td>rural</td>
<td>3%</td>
<td>13</td>
<td>$10,000</td>
<td>30%</td>
<td>17%</td>
<td>---</td>
</tr>
</tbody>
</table>

S/T = Student/Teacher ● PPE = Per Pupil Expenditure ● FRLP = Free and Reduced Lunch Program ● IEP = Individualized Education Plan ● ELL = English Language Learner

Sources: National Center for Educational Statistics & Pennsylvania Department of Education
Fig. 4-3: Sample Characteristics: School Districts by Region

Fig. 4-4: Sample Characteristics: School Districts by Locale

Source: Pennsylvania Department of Education
Fig. 4-5: Sample Characteristics: School Districts by Student/Teacher Ratio
Sources: National Center for Educational Statistics & Pennsylvania Department of Education

Fig. 4-6: Sample Characteristics: School Districts by Per-Pupil Expenditure
Sources: National Center for Educational Statistics & Pennsylvania Department of Education
There were two primary advantages to conducting a stratified versus unstratified random sample. First, each region of the state was guaranteed representation in the sample. Second, the two major urban centers in the state were automatically included in the sample because they comprise their own intermediate units. This second feature is important because in a random sample of 500 school districts, it is unlikely that these two locations would be included in the sample, but they are worthy of study because of their uniqueness as the sole metropolises in a largely rural state. While the sample size for this study is small (29 of 500 districts), it is important to keep in mind that these results are not intended to generalize to other school districts (in Pennsylvania or other states), but rather to inform the previously discussed theories on morality policy adoption and the dynamics of the conflicts surrounding it.

The process of identifying a survey respondent within each district began with a telephone call to the main district administrative office. I asked the individual who answered to direct me to the person in the district who is the most knowledgeable about the sex education policies and programs in place within that district. In the vast majority of cases, I was informed that I should speak with the high school Health and Physical Education teachers, but Family and Consumer Science teachers, school nurses, building principals, and district administrators were also among those who were identified to participate in the study.

14 The CDC’s School Health Policies and Programs Study (SHPPS) used a similar approach in identifying its survey respondents; SHPSS respondents either had primary responsibility for or were the most knowledgeable about the policies and programs addressing the particular school health program component being studied (Brener, Wheeler, Wolfe, Vernon-Smiley, & Carldart-Olson, 2007). This approach was also employed in the aforementioned sex education study in Florida school districts (Bandiera et al., 2008).
Instrument and Data

I used a telephone survey instrument to determine the existence and nature of sex education policies and programs within the sampled districts. I asked the respondents about formal sex education policies, the individual(s) responsible for sex education decisions, the individual(s) responsible for teaching sex education, the type of sex education classes, programs, assemblies, guest speakers, or other activities, sex education trainings or professional development opportunities for teachers or other school personnel, and perceived levels of awareness and/or controversiality of sex education within the community. The survey items were modeled after questions on the *Sex Education in America* study conducted by National Public Radio (NPR), the Kaiser Family Foundation (KFF) and Harvard’s Kennedy School of Government (2004b). I modified this instrument to include open-ended, free response questions to elicit more detailed accounts and anecdotes that would be of greater benefit to a qualitative investigation\(^{15}\). I also removed or rephrased questions that were not pertinent to the research questions posed in this investigation. The surveys generally took between 20 and 40 minutes to complete, depending on the level of detail provided by the respondent. I conducted the surveys by telephone and with the consent of the participant, audio recorded and transcribed them\(^{16}\). I opted to conduct my surveys by telephone versus by postal mail or e-mail to increase the rate of response, obtain more

\(^{15}\) The NPR/KFF/Harvard survey was a print survey that consisted entirely of discreet and/or categorical items.

\(^{16}\) Bandiera et al.’s (2008) investigation in Florida made use of mail-based surveys, but this method resulted in a low response rate (26%) and discreet data.
descriptive responses, assist respondents when they did not understand a question, and prompt them for additional information wherever possible. Therefore, the intention was not only to maximize survey response, but also to maximize the validity and reliability of the data. The survey instrument utilized in this study is located in Appendix E.

Data Analysis

To analyze the data collected from the sex education policies and programs survey, I employed open coding, an interpretive method for breaking down, examining, comparing, contextualizing, and categorizing data. I first compiled and summarized the responses into narrative district profiles that summarized each district’s survey responses and highlighted the major features of that district’s program, including the sex education program’s approach, the main features of the program (e.g., grade levels served, duration of program, parental opt-out options), individuals identified as responsible for making decisions about sex education, levels and sources of perceived controversy about the program, and perceived sources of influence on sex education decisions. I then constructed tables merging the different variables (e.g., sex education approach by average per pupil expenditure) to identify trends and common themes across school districts.

In examining the narrative district profiles, I realized that they yielded data that went beyond the scope of the questions posed in the surveys. While the data obtained
from these surveys provided a wealth of information on each of the aforementioned topics, they also revealed several unanticipated issues and concerns raised by the respondents pertaining to shared experiences about or perceptions of sex education. I categorized all of the resulting information by topic or theme, reporting first on the issues covered explicitly in the survey (including approaches to sex education, sources of influence and decision-makers, quality of existing sex education programs and of teacher training for sex education, and perceived controversiality) and then on the unforeseen themes that arose from the responses, each of which pertained to the controversiality of sex education. These themes included reactions to the idea of providing condoms in schools, the roles that standardized testing and limited resources play in sex education program and policy decisions and/or controversiality over sex education, the unique contribution of Family and Consumer Science teachers to school based sex education, and perceptions about community norms and/or ideologies and how they influenced (or did not influence) decisions about sex education.

Part II: Case Studies

Case Selection

To obtain a more detailed and thorough understanding of sex education in Pennsylvania, I selected two of the sampled districts for further study. The basis for this selection arose from the study's second research question about the factors that
influence the adoption and/or design of sex education policies or programs, as well as
the theoretical framework, which postulates that opinions and decisions about morality
policy issues, like sex education, are based on a different set of factors than opinions
and decisions about non-morality policy issues (Mooney & Schuldt, 2006). Paramount
among these factors are individual impulses toward orthodoxy or progressivism, which
involve fundamental beliefs about right and wrong and the source(s) of moral authority
(Hunter, 1991). While the surveys provided a great deal of information regarding the
individual(s) responsible for sex education decisions and potential motivating factors
behind these decisions, I opted to conduct case studies of two school districts to more
closely examine the factors that are the most influential in the adoption or design of a
sex education policy or program. In other words, I conducted the surveys to answer a
“what” question. The case studies attended to the question of “why.”

I conducted two district case studies deliberately to highlight their contrasting
situations. I looked for two districts that were relatively similar on several common
elements (e.g., size, locale, per pupil expenditure), but that differed markedly on the
type of sex education policy or program they employed. Within the sample, two such
districts stood out in precisely this manner; the respondents from each referred to their
districts as being “small,” “rural,” and “conservative,” and they each described attempts
made by school personnel to amend their respective abstinence-only curricula to be
more comprehensive. The reformers in one of these districts were successful, while
those from the other were not. Consequently, these two districts were prime cases for
studying the mechanisms and motivations behind sex education policy decisions.
Yin (2003) identifies six major sources of evidence most commonly used in case study investigations: documentation, archival records, interviews, direct observations, participant observations, and physical artifacts. For the case studies conducted here, I made use of the first three. To begin these case studies, I collected data on the educational attainment, income levels, occupations held, and political affiliations as well as adolescent sexual health indicators within the regions that comprise the two districts of interest from the United States Census Bureau and the Pennsylvania Departments of Health and State. I also searched for news items pertaining to sex education and/or adolescent sexual health in the two communities in the *America’s Newspapers* database. Next, I underwent a thorough review of the survey results from these two districts and finally, I employed a snowball sampling strategy to identify key informants in different roles within each district to participate in semi-structured, focused interviews. Recruiting participants in a variety of roles offered distinct perspectives on the same issue in the same place. Using these multiple data sources helped to establish converging lines of inquiry; triangulating evidence from these various sources provided corroboration of the overall results of the investigation.

**Interview Protocol**

The interview protocols used with the key informants in the two case study districts were constructed based on the themes that emerged from the surveys. They cover the history of sex education in the district, key events or situations of note...
pertaining sex education in that district, perceived levels of community or parent support for or controversy over different types of sex education programs or activities, and the factors that are seen as being the most influential in making sex education decisions in that district. The protocol was set up in a semi-structured, focused format to guide the content and direction of the conversations but allow for enough freedom to diverge into different topics when needed (Merton & Kendall, 1946). The decision to select this format was made based on the administration of the telephone surveys. During the surveys, the respondents would occasionally ask to share anecdotes or express opinions not directly related to the questions being posed. I opted to give them the opportunity to share whatever information they saw fit and as a result, the survey results yielded data above and beyond the basic characteristics of the sex education policies and programs, which had been the original intent of the survey. They generated a great deal of information that ultimately translated into new and distinctive themes that have added to the propositions set forth in the culture wars/morality policy theoretical framework. The protocol utilized to guide each interview can be found in Appendix E.

Data Analysis

The interview data underwent more thorough interpretive analyses than did the survey data. The purpose of conducting these case studies was to provide an explanation for why school districts adopt the sex education policies and programs they
do. Hence, I utilized an analytical technique known as explanation building (Yin, 2003). Data analysis was guided by the same theoretical propositions that shaped the research questions and study design. In these analyses, I searched for the usage of shared symbolic language and political rhetoric about sex education programs. Based on Hunter’s (1991) theory about modern cultural conflict, I anticipated that justifications of abstinence-only sex education would share similar thematic language, likely about “morality” and “appropriate” behavior for young people. Similarly, explanations of comprehensive sex education would likely make use of terminology like “medically accurate” and “empirically supported.” These sample terms exemplify different priorities about the same issue, and according to this framework, further investigation of these differing depictions should help broaden and enhance our understanding of adoption decisions involving culturally contentious morality policy. As Stein (2004) describes, “only through consideration of the symbols, language, and routines of the policy process can we unearth the importance and influence of the culture of the policy” (p. 3). An interpretive approach to policy analysis involved a consideration of how the participants talked about the sex education policies and practices in place and the way they framed various target groups (e.g., parents, students, interest groups, school boards, governments). It meant deconstructing the stories they told about controversy over sex education in their communities in a manner that reflected the sentiments and intentions of all parties involved. In sum, what we say (and do not say), how we say it, and to whom it is said are all of immense interest to an understanding of controversial morality policy issues. The resulting data from each districts’ set of interviews was
analyzed in conjunction with that district’s completed survey, and the aforementioned socioeconomic and public health indicators and news sources to assemble a thorough assessment of what sex education looks like in these two districts and why it looks that way. Data triangulation was accomplished by conducting multiple interviews in each district and by analyzing all interview data, survey data, socioeconomic and public health indicators, and news items in conjunction with one another.

**Rigor and Soundness**

The methods employed by a research study should be those that can best respond to the research question(s) of that study. This study sought to examine sex education policies and programs across Pennsylvania and deconstruct the complex social reality surrounding sex education policy formation at the local school district level by analyzing the stories, anecdotes, and reflections of those who are most closely connected to the process. The methods and findings must be credible, confirmable, consistent, and transferable to ensure the soundness and rigor of this research. In this study, I surveyed 29 of the state’s 501 school districts and studied two of those 29 in greater detail. Additional districts were not investigated due to time and resource constraints. When viewed together, the 29 districts surveyed in this study provide a cross-sectional “snapshot” of sex education in the state at the time they were surveyed.

I adapted the survey instrument used in this study from a pre-existing instrument that had previously been used to measure various aspects of sex education
policies and programs to capture the information desired as precisely as possible. The modifications that I made to the instrument were to add more open-ended, qualitative items to elicit more detailed and extensive responses. Hence, the results from the school district surveys should be considered credible because the original incarnation of the instrument employed to elicit the data in this study had been validated previously by the instrument’s original authors, and the additions to it in this investigation were made to elaborate on the respondents’ answers and offer richer, more descriptive data. To address the confirmability of the results, I triangulated multiple sources of data (surveys, interviews, news sources, and socioeconomic and health indicators) to provide as honest, accurate, and complete a portrayal as possible.

The data obtained in this study were accurate and consistent at the time of data collection and to the best of the respondents’ knowledge. However, schools and school districts (including some of those within this sample) are consistently revamping their curricula, changing textbooks, and making a range of other modifications. We must accept that the school district sex education profiles generated here reflect the state of sex education in those districts at a specific point in time and are based on the reflections of the specific person responding to the survey. Conducting the survey with a different individual at a different time could potentially yield considerably different results. The provision of both the survey instrument and interview protocol in the appendices and the description of the procedures employed in this chapter allow other researchers to embark upon similar inquiries in other areas and at different times.
Finally, with regard to transferability, because each of Pennsylvania’s 501 school districts is a uniquely distinctive entity, it would be impossible to claim that the responses of a single district or even a type of district could be generalized to other districts in the state. Curriculum content decisions are independent actions by individual districts and cannot be predicted by mathematical model or even by knowing what surrounding districts or demographically similar districts have done; the content of Kilwin School District’s sex education curriculum, for instance, does not give us any idea about the content of any other district. Although the sample was geographically representative, these findings are not intended to generalize to other school districts in Pennsylvania or elsewhere, but rather to inform the previously described theories on morality policy and cultural conflict. As such, the findings contribute immensely to our understanding of how and why certain sex education policies are adopted and why they are often a source of debate or controversy.

There has not to date been an investigation of sex education policies and programs in the state of Pennsylvania prior to this one. This study offers the first systematic look at the types of sex education offerings in place in school districts across the state and the factors that influence their design and adoption. While the results of this research are indeed novel and insightful, the study was not without limitations. The first and most apparent limitation was the scope of the study. Due to time and resource constraints, the sample size was limited to 29 districts, one per intermediate unit. Second, no school board members were surveyed or interviewed in this study. School boards have a great deal of decision-making authority over sex education policies and
programs, but their perspectives were not captured here. Third, while a fair amount of research has been done to assess the attitudes of parents and community members on school-based sex education, very little has been done to assess student attitudes on the subject. This study did not take into account the role of students in the sex education policy adoption process. Endeavoring to survey minors on any topic involving sex and sexuality is a complicated and tenuous undertaking that was not embarked upon in this investigation.
Chapter 5

Survey Results

Twenty-nine Pennsylvania school districts participated in a telephone survey about their sex education policies and programs between May of 2008 and February of 2009. The survey instrument utilized is located in Appendix D. This chapter will summarize the results from these surveys highlighting key issues of interest, including the type of sex education approach employed, individuals responsible for sex education policy and program decisions, sources of influence on those decisions, the relative quality of programs and teacher training, and perceived controversiality of sex education. These results will be paired with data on the geographic, demographic, and socioeconomic variables described in Chapter 4. Finally, I will discuss the emergent themes from these survey data, those that pertain specifically to the theoretical precepts that guided this study, as well as unanticipated themes that arose, which add to the existing framework.

Approaches to Sex Education

Sex education was defined in this survey as follows:

By sex education I’m referring to any classes or talks in school that discuss the basics of human reproduction, dating and relationships, abstinence, AIDS, pregnancy prevention, and the like. These topics may have been taught in a separate sex education course, as part of another course,
health or science, or as independent lessons in the school auditorium or gym.

The survey identified three categories of sex education approaches: abstinence-only, abstinence-plus, and safer sex focused. Abstinence-only sex education was defined as an approach that maintains that “abstinence from sexual intercourse is best for teens and the district’s sex ed classes do not provide information about condoms and other contraceptives.” The abstinence-plus approach asserts that “abstinence from sexual intercourse is best for teens but some teens do not abstain, so information about condoms and other contraception is provided.” Finally, safer sex focused sex education purports that “abstinence from sexual intercourse is not the most important thing, [and therefore the district’s sex education classes] teach teens to make responsible decisions about sex.” The National Public Radio, Kaiser Family Foundation, and Harvard Kennedy School of Government (2004b) sex education survey revealed that nationally, about 30% of principals identified their school’s approach as abstinence-only, 47% as abstinence-plus, and 20% as safer sex focused. (Three percent of the respondents responded “Don’t Know.”) Table 5-1 breaks down the different approaches to teaching sex education employed in this study’s sampled school districts by region and locale. Table 5-2 breaks the approaches down by the aforementioned socioeconomic variables. Districts that selected the “other” designation indicated that the sex education approach they employed differed by grade level.

The counts presented in Table 5-1 do not fall into a discernable pattern, suggesting that abstinence-only, abstinence-plus, and safer sex focused programs are
present in a variety of regions and locales across the state. There is one point about sex education approaches by region worth noting, however. Each of the eight districts located in the southeastern part of the state employed an abstinence plus approach. With regard to locale, the abstinence-only approach was only employed in rural and small town districts; each of the three city districts and eight of the nine suburban districts employed an abstinence-plus approach. However, not all rural or small town school districts employed an abstinence-only approach, indicating that rural or small town locales and abstinence-only sex education are certainly not mutually exclusive.

Table 5-1: Sex Education Approaches by Region and Locale

<table>
<thead>
<tr>
<th>Region</th>
<th>Abstinence-Only</th>
<th>Abstinence-Plus</th>
<th>Safer Sex</th>
<th>Other</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Northwest</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Southwest</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>0</td>
<td>6</td>
</tr>
<tr>
<td>North-central</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>South-central</td>
<td>1</td>
<td>2</td>
<td>0</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Northeast</td>
<td>1</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>Southeast</td>
<td>0</td>
<td>8</td>
<td>0</td>
<td>0</td>
<td>8</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>4</strong></td>
<td><strong>17</strong></td>
<td><strong>4</strong></td>
<td><strong>3</strong></td>
<td><strong>28</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Locale</th>
<th>Abstinence-Only</th>
<th>Abstinence-Plus</th>
<th>Safer Sex</th>
<th>Other</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rural</td>
<td>3</td>
<td>4</td>
<td>3</td>
<td>3</td>
<td>13</td>
</tr>
<tr>
<td>Town</td>
<td>1</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Suburb</td>
<td>0</td>
<td>8</td>
<td>1</td>
<td>0</td>
<td>9</td>
</tr>
<tr>
<td>City</td>
<td>0</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>4</strong></td>
<td><strong>17</strong></td>
<td><strong>4</strong></td>
<td><strong>3</strong></td>
<td><strong>28</strong></td>
</tr>
</tbody>
</table>
Table 5-2: Sex Education Approaches by Socioeconomic Variables

<table>
<thead>
<tr>
<th></th>
<th>Abstinence-Only (N = 4)</th>
<th>Abstinence-Plus (N = 17)</th>
<th>Safer Sex (N = 4)</th>
<th>Other (N = 3)</th>
<th>Total (N = 28)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Student-Teacher Ratio</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean</td>
<td>15.0</td>
<td>15.6</td>
<td>13.4</td>
<td>15.3</td>
<td>15.2</td>
</tr>
<tr>
<td>SD</td>
<td>3.3</td>
<td>1.7</td>
<td>2.0</td>
<td>1.6</td>
<td>2.0</td>
</tr>
<tr>
<td>Med</td>
<td>14.3</td>
<td>15.5</td>
<td>13.8</td>
<td>16.1</td>
<td>16.1</td>
</tr>
<tr>
<td>Min</td>
<td>12.0</td>
<td>13.1</td>
<td>10.8</td>
<td>13.4</td>
<td>10.8</td>
</tr>
<tr>
<td>Max</td>
<td>19.6</td>
<td>19.6</td>
<td>15.4</td>
<td>16.4</td>
<td>19.6</td>
</tr>
<tr>
<td><strong>Per Pupil Expenditure</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean</td>
<td>$9,798</td>
<td>$11,986</td>
<td>$13,792</td>
<td>$12,063</td>
<td>$11,940</td>
</tr>
<tr>
<td>SD</td>
<td>$1,247</td>
<td>$2,948</td>
<td>$2,049</td>
<td>$976</td>
<td>$2,655</td>
</tr>
<tr>
<td>Med</td>
<td>$9,721</td>
<td>$10,722</td>
<td>$13,834</td>
<td>$12,017</td>
<td>$11,148</td>
</tr>
<tr>
<td>Min</td>
<td>$8,567</td>
<td>$8,824</td>
<td>$11,246</td>
<td>$11,111</td>
<td>$8,567</td>
</tr>
<tr>
<td>Max</td>
<td>$11,184</td>
<td>$18,841</td>
<td>$16,255</td>
<td>$13,061</td>
<td>$18,841</td>
</tr>
<tr>
<td><strong>% Free &amp; Reduced Lunch Program</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean</td>
<td>33%</td>
<td>27%</td>
<td>40%</td>
<td>38%</td>
<td>31%</td>
</tr>
<tr>
<td>SD</td>
<td>14%</td>
<td>20%</td>
<td>9%</td>
<td>10%</td>
<td>17%</td>
</tr>
<tr>
<td>Med</td>
<td>35%</td>
<td>21%</td>
<td>40%</td>
<td>34%</td>
<td>30%</td>
</tr>
<tr>
<td>Min</td>
<td>15%</td>
<td>6%</td>
<td>29%</td>
<td>30%</td>
<td>6%</td>
</tr>
<tr>
<td>Max</td>
<td>48%</td>
<td>70%</td>
<td>50%</td>
<td>49%</td>
<td>70%</td>
</tr>
<tr>
<td><strong>% English Language Learners</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean</td>
<td>&lt; 1%</td>
<td>3%</td>
<td>1%</td>
<td>2%</td>
<td>2%</td>
</tr>
<tr>
<td>SD</td>
<td>&lt; 1%</td>
<td>5%</td>
<td>1%</td>
<td>3%</td>
<td>4%</td>
</tr>
<tr>
<td>Med</td>
<td>&lt; 1%</td>
<td>1%</td>
<td>&lt; 1%</td>
<td>&lt; 1%</td>
<td>1%</td>
</tr>
<tr>
<td>Min</td>
<td>&lt; 1%</td>
<td>0%</td>
<td>&lt; 1%</td>
<td>&lt; 1%</td>
<td>0%</td>
</tr>
<tr>
<td>Max</td>
<td>1%</td>
<td>15%</td>
<td>2%</td>
<td>5%</td>
<td>15%</td>
</tr>
<tr>
<td><strong>% Individualized Education Plans</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean</td>
<td>15%</td>
<td>17%</td>
<td>18%</td>
<td>19%</td>
<td>17%</td>
</tr>
<tr>
<td>SD</td>
<td>3%</td>
<td>3%</td>
<td>4%</td>
<td>2%</td>
<td>3%</td>
</tr>
<tr>
<td>Med</td>
<td>14%</td>
<td>17%</td>
<td>17%</td>
<td>18%</td>
<td>17%</td>
</tr>
<tr>
<td>Min</td>
<td>13%</td>
<td>12%</td>
<td>14%</td>
<td>17%</td>
<td>12%</td>
</tr>
<tr>
<td>Max</td>
<td>19%</td>
<td>23%</td>
<td>23%</td>
<td>22%</td>
<td>23%</td>
</tr>
<tr>
<td><strong>% Non-White</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean</td>
<td>3%</td>
<td>21%</td>
<td>21%</td>
<td>7%</td>
<td>17%</td>
</tr>
<tr>
<td>SD</td>
<td>1%</td>
<td>28%</td>
<td>37%</td>
<td>12%</td>
<td>3%</td>
</tr>
<tr>
<td>Med</td>
<td>3%</td>
<td>11%</td>
<td>3%</td>
<td>1%</td>
<td>17%</td>
</tr>
<tr>
<td>Min</td>
<td>2%</td>
<td>2%</td>
<td>1%</td>
<td>0%</td>
<td>12%</td>
</tr>
<tr>
<td>Max</td>
<td>5%</td>
<td>87%</td>
<td>77%</td>
<td>21%</td>
<td>23%</td>
</tr>
</tbody>
</table>
The mean student-teacher ratio in the districts employing safer sex focused programs was about two students per teacher less than the student-teacher ratios in the districts employing any of the other approaches (13:1 compared to 15:1). Per pupil expenditures in the sampled districts ranged from $8,567 to $18,841, a range of more than $10,000 per student. The safer sex districts had higher average per pupil expenditures than each of the others (mean = $13,792, SD = $2,049); the abstinence-only districts spent substantially less per pupil than the other districts (mean = $9,798, SD = $1,247). The abstinence-plus districts had the lowest average percentage of students on the free and reduced lunch program (though the standard deviation was relatively high due to one school district with 70% of its students qualifying for the program), followed by the abstinence-only districts. The safer sex districts had the largest average percentage of students on the free and reduced lunch program (mean = 40%, SD = 9%). The first two of these economic indicators suggest that the safer sex approach is adopted in more affluent school districts than the other two approaches. However, their higher average percentage of students on the free and reduced lunch program contradicts this assertion. Economics (as we will see in later sections of this chapter) are indeed relevant in the sex education policy and program adoption process, though these data indicate that within this sample, safer sex programs were more prevalent among the middle-class and wealthy districts, but were not exclusive to them, just as abstinence-only programs, which were more commonly seen in the poorer districts, could be found in other places as well.
The average percentages of ELL and LEP students were fairly consistent across districts. (In one abstinence-plus district, ELL students made up 15% of the total student population, but this district a distinct exception.) There were, however, striking differences between each type of district with regard to racial composition. Demographic data was collected for each of the participating school districts, including the number of white (non-Latino), black (non-Latino), Latino, Asian/Pacific Islander, and American Indian/Alaska Native students. From these numbers, I calculated the percentage of non-white students in each district. More than half of the districts in this survey had a non-white student population of less than 10%. About a quarter of the districts were between 10 and 25% non-white. Non-white students comprised more than half of the total student population in just over 10% of the districts. None of the abstinence-only districts in this sample had a non-white population of greater than 5%; each of the districts in which greater than half of their total student population was non-white fell into either the abstinence-plus or safer-sex category.

Given the small sample size, these results are suggestive of trends and connections, but not conclusive about them. For instance, in this study, none of the districts with high concentrations of minority (non-white) students adopted an abstinence-only approach, but this finding implies neither causality nor correlation. Rather, based on the survey results in this sample of districts, we can conjecture that student racial demographics may have some connection with or impact on the sex education approaches employed in the districts. The same is true of the socioeconomic variables. The districts in this sample employing an abstinence-only approach had lower
per-pupil expenditures and higher student/teacher ratios than those employing an abstinence-plus or safer sex approach, suggesting a possible connection between the wealth of a district and its sex education approach. Empirical testing is necessary, though, to certify a causal or correlative connection.

**Perceptions of “Abstinence-Only” Sex Education**

Even though there was not a specific survey item addressing the issue, seven of the respondents acknowledged at some point during the survey that abstinence-only sex education was ineffective in affecting the students’ sexual behavior. As the Health and Physical Education Specialist in Trenton School District mentioned, the federal abstinence-only-until-marriage funding has never shown “any indication that the program would be beneficial to an urban district.” Marimont School District’s Health and Physical Education department chair said, “I think that most of us recognize that in this situation, abstinence-only is not working and it’s not an option, so we need to do what we need to do in order to take care of our kids.” Cleaver School District’s Health and Physical Education department chair laughed as she pointed out how abstinence-based programs “[aren’t] working.” A Health and Physical Education department head in Parkland School District attributed the federal abstinence-only-until-marriage funding’s lack of influence over his district’s sex education program to the fact that the programs had been deemed ineffective by recent research. A Health and Physical Education teacher in Elmville School District also indirectly referred to these research
findings in discussing recent newspaper articles on the issue. The Health teachers in Foxburgh School District, pointed to their district’s teen pregnancy rate as evidence that their previous abstinence-only sex education curriculum was not working. Finally, the Director of Health Safety, and Physical Education in Franklin City School District indicated that accepting that funding or receiving programs or services financed by it would be “almost counterproductive to what we teach.” Statements such as these suggest progressive inclinations because of the credence they give to research and scientific evidence. Hunter’s (1991) description of individuals with impulses toward orthodoxy as well as Luker’s (2006) discussion of sexual conservatives both indicate that people who fall on this end of the morality spectrum believe in singular, absolute truths that supersede the authority or claims of modern science. According to the culture wars theory, the results of scientific evaluations of sex education programs would play a far less significant role in decisions about sex education program or policy adoption.

One noteworthy exception among these statements, however, came from a survey respondent who indicated that (to the best of her knowledge) her school district did not receive any federal abstinence education funding (or services provided by other organizations that do receive it), but she still believed that this federal funding nevertheless influenced her district’s sex education curriculum. Cleaver School District’s Heath and Physical Education department head indicated that her district’s school board, which she described as being “very protective” with regard to sex education, always attempts to align its practices with federal directives. Each of the districts in
Sources of Influence and Decision-Makers

Table 5-3 summarizes the districts’ responses about the sources of influence over sex education. The first three rows refer to items 21-23 on the survey, which ask whether federal abstinence-only funding, state government, or the local school board had any influence over the district’s sex education policies or programs. The latter five rows indicate whether the respondent or someone else in the district had been contacted by parents (or other community members), elected officials, religious leaders, family planning groups, or abstinence-only-until-marriage advocacy groups. The responses are divided up by type of sex education approach.

State government and school boards were each cited by approximately a third of the respondents as groups with influence over their districts’ sex education policies and programs. In the case of the former, most respondents indicated that the state government’s influence over sex education comes through the state prescribed standards for Health and Physical Education, which they all try to adhere to as much as possible\textsuperscript{17}. The federal abstinence education funding was not cited very often as a

\textsuperscript{17} Pennsylvania’s Academic Standards for Health, Safety, and Physical Education, which were last amended in 2002, currently have only one guideline relating to sexual health. Standard 10.1.9 (Concepts of Health for Grade 9), part A states that students should “analyze factors that impact growth and development between adolescence and adulthood [including] relationships (e.g., dating, friendships, peer pressure), interpersonal communication, risk factors (e.g., physical inactivity, substance abuse,
source of influence, though interestingly, it was cited by some respondents as having influence even if they were unsure as to whether their district received any of this funding (either directly or indirectly through organizations that are recipients of it).

Half of all respondents indicated that either they or one of their colleagues had been contacted by parents at some point regarding sex education. The nature of these communications varied from general curiosity and inquiry about curriculum content to requests for their children to be opted out of sex education altogether to complaints about the information presented. With regard to this latter concern, while some parents found the information presented offensive, others complained that it did not go far enough and should be more detailed and forthcoming. Parent requests and complaints were always addressed in some fashion, but most respondents did not feel that parent opinion had any actual impact on sex education decisions. For example, students whose parents asked that they be opted out of sex education were always removed from these classes without argument, but the existing curriculum content would not be changed as a consequence of a parent complaint.

________________________________________________________

Table 5-3: Perceived Sources of Influence on Sex Education Policy Decisions

<table>
<thead>
<tr>
<th>Source of Influence</th>
<th>Abstinence-Only (N = 4)</th>
<th>Abstinence-Plus (N = 17)</th>
<th>Safer Sex (N = 4)</th>
<th>Other (N = 3)</th>
<th>Total (N = 28)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Federal AOUM $^a$</td>
<td>1 (25%)</td>
<td>2 (12%)</td>
<td>0 (0%)</td>
<td>0 (0%)</td>
<td>3 (11%)</td>
</tr>
<tr>
<td>State Government $^b$</td>
<td>1 (25%)</td>
<td>9 (53%)</td>
<td>0 (0%)</td>
<td>0 (0%)</td>
<td>10 (36%)</td>
</tr>
<tr>
<td>School Board $^c$</td>
<td>2 (50%)</td>
<td>4 (14%)</td>
<td>2 (50%)</td>
<td>2 (50%)</td>
<td>10 (36%)</td>
</tr>
<tr>
<td>Parent $^d$</td>
<td>2 (50%)</td>
<td>11 (39%)</td>
<td>1 (25%)</td>
<td>0 (0%)</td>
<td>14 (50%)</td>
</tr>
<tr>
<td>Elected Official $^e$</td>
<td>0 (0%)</td>
<td>4 (24%)</td>
<td>1 (25%)</td>
<td>0 (0%)</td>
<td>5 (18%)</td>
</tr>
<tr>
<td>Religious Leader $^f$</td>
<td>1 (25%)</td>
<td>4 (24%)</td>
<td>0 (0%)</td>
<td>0 (0%)</td>
<td>5 (18%)</td>
</tr>
<tr>
<td>Family Planning Group $^g$</td>
<td>2 (50%)</td>
<td>8 (46%)</td>
<td>2 (50%)</td>
<td>1 (33%)</td>
<td>13 (46%)</td>
</tr>
<tr>
<td>AOUM Group $^h$</td>
<td>1 (25%)</td>
<td>7 (41%)</td>
<td>0 (0%)</td>
<td>1 (33%)</td>
<td>9 (32%)</td>
</tr>
</tbody>
</table>

$^a$ Do you think the federal government’s abstinence-only funding has had any influence in deciding what topics your district’s sex ed curriculum covers?

$^b$ Do you think your state government had any influence in deciding what topics the sex ed curriculum covers?

$^c$ Do you think your school board had any influence in deciding what topics the sex ed curriculum covers?

$^d$ Has someone in the community ever contacted you, one of the teachers, or someone else regarding sex education?

$^e$ Were you or someone else in your school district ever contacted by an elected official regarding sex ed?

$^f$ Were you or someone in your school district ever contacted by a community or religious leader about sex ed?

$^g$ Were you or someone in your school district contacted by a family planning group such as Planned Parenthood about sex ed?

$^h$ Were you or someone in your school district contacted by an abstinence-only-until-marriage advocacy group about sex ed?

Fewer than a quarter of the individuals surveyed indicated that they had been contacted by elected officials or religious leaders regarding their districts’ sex education.
policies or programs. In the instances in which religious leaders made contact to discuss the issue, it was often to encourage that the focus of sex education be more abstinence-based. Some school districts assembled diverse committees, which often included at least one local religious leader, to offer recommendations and/or design a sex education program, so in these instances, clergy undoubtedly had influence over curriculum content.

Nearly half of the total respondents noted that they had been contacted at some point by a family planning group, such as Planned Parenthood. In each of these cases, the groups were offering to come into the schools to provide sex education services. The survey responses suggest that these groups did not influence the design of sex education program content or any actual decisions about sex education. If the respondent him or herself or another decision-maker in the district was already interested in receiving these kinds of services and/or and was receptive to the views and mission of that organization, the partnerships would take place. Family planning organizations that reached out to districts that were uninterested in receiving their services and/or disagreed with the organizations’ philosophies would not be successful in forming partnerships. In other words, these organizations did not open any doors, change any minds, or influence any changes; they were simply accepted in the places that already agreed with their missions and rejected by those that did not.
The same is true of the abstinence-only-until-marriage advocacy groups\textsuperscript{18} that made contact with the districts. A third of the respondents indicated that a group of this type had contacted them at some point. Like the family planning groups, the abstinence-only-until-marriage advocacy groups were attempting to form partnerships with the districts in order to provide sex education services, and just as with the family planning groups, if the individuals with decision-making power were already in agreement with the organization's mission, their offer to provide services would be accepted. If the decision-makers' positions on sex education differed from those of the organization, a partnership would not take place. “The abstinence folks,” said Parkland School District’s Health and Physical Education teacher, “hit a dead end with us.” In a couple of cases, the survey respondent indicated his/her district partnered with an abstinence-only-until-marriage group, even though the respondent him/herself was wary of such a partnership. In these cases the respondents talked about how they attempted to work with the group to temper the strict abstinence-only message (i.e., offer some discussion of condoms and contraception in a non-disparaging way).

\textsuperscript{18} There are very few organizations for which advocacy for abstinence-only-until-marriage sex education is their sole function. In Pennsylvania, pregnancy resource centers tend to be the organizations that most commonly promote and/or provide this type of sex education. Pregnancy resource centers, which are also referred to as crisis pregnancy centers, are organizations typically established by pro-life advocates that attempt to persuade women with unplanned pregnancies to give birth and pursue motherhood or adoption rather than seek abortions. A report by the United States House of Representatives’ Committee on Government Reform from 2006 on pregnancy resources centers indicated that between 2001 and 2006, these centers received over $30 in federal funding as well as an additional funding through earmarks. The report investigated 25 federally funded centers and found that overwhelmingly, they provided medically inaccurate and misleading information about a link between abortion and breast cancer, the effect of abortion on future fertility, and the mental health effects of abortion (http://oversight.house.gov/images/stories/documents/20060717101140-30092.pdf ). Several of the school districts surveyed in this project mentioned working with pregnancy resource centers/crisis pregnancy centers, many of which do receive federal abstinence education funding. The names of specific centers have been omitted to protect the anonymity of the school districts.
These responses indicate that while some agencies or entities may have more impact on sex education policy and program decisions than others, on the whole, these decisions are mostly impervious to outside influence. Complaints, concerns, and suggestions voiced by parents were always attended to, but rarely (if ever) resulted in any significant program or policy alterations. School boards are influential insomuch as they are often one of the final authorities over sex education decisions, but they generally do not influence the design of curricula; they merely approve or reject the finished products presented to them. Family planning groups and abstinence-only-until-marriage advocacy groups often contacted the school districts in an attempt to influence their sex education policies and programs, but were generally unsuccessful in doing so if the district (or the person within the district with whom they made contact) was not already on board with the approach the group was advocating for. Sex education policies and programs, therefore, are primarily influenced by the individual(s) most responsible for the design of them and are rarely created or altered in response to pressure or petitioning from outside sources.

Having influence over a sex education policy or program, however, is not the same thing as actually having authority over its establishment or approval. Table 5-4 compiles the responses about the individuals and groups (both within the school district and outside it) with decision-making authority over the districts’ sex education policies and programs broken down by program type. Teachers were cited by more than three-quarters of the respondents as having decision-making authority over sex education. Many of the teachers who responded to the survey spoke of this fact with both pride
and gratitude. A Health and Physical Education teacher in Bellemont School District was very clear that the administrators in her district gave her a good amount of freedom in her curriculum design and that no one looked over her shoulder or nitpicked her choices. “I guess,” she said, “if [the school board] would disagree they would certainly tell us, but thus far, no, they really have given us full reign.” Two Health teachers in Hirsch School District, echoed these sentiments indicating that while the district superintendent, school board, and school principals had decision-making authority over sex education, they were all generally satisfied with whatever the teachers came up with, so long as it satisfied the state standards. Potterville School District’s Family and Consumer Science teacher feels the same way, stating that she also has had “pretty much free reign of what I want to cover.” School boards, building principals, and other district administrators were each only cited by about half of the respondents as having any authority over sex education decisions. Among the types of individuals mentioned in the “other” category were department heads, directors of curriculum and instruction, and assistant superintendents. District superintendents were cited even less frequently, by only 43% of the respondents. The general undertone of these responses, however, was that each of these entities may have had sex education decision-making power “on paper,” but that this power was rarely (if ever) executed and that most of the actual work and decisions occurred behind the scenes by the teachers, themselves.

Three of four of the respondents from abstinence-only districts and three of four of the safer sex district respondents indicated that students were involved in some capacity in the decisions that were made about sex education. However, the responses
provided about how they were involved in these decisions did not suggest that students had any actual decision-making authority per se, but rather were a source of influence on sex education decisions. Typically, the districts that involved students in the process attempted to elicit student interests and needs and use these interests and needs to inform curriculum development. For instance, Trenton School District conducted a survey of its students asking them about the types of topics they would like to be taught in their sex education classes. An Elmville School District Health and Physical Education teacher has his students fill out course evaluations and he uses the feedback they elicit to tailor the course content for future classes. Overall, however, fewer than half of all of the respondents surveyed indicated that students had any input at all about sex education decisions within their respective districts.

Of the individuals and agencies that operate outside of the school system, doctors and nurses were cited most frequently as having authority over sex education decisions within the districts. However, even they were only cited by about half of the respondents. In general, the respondents noted that individuals and agencies outside the school system do not have any authority over these decisions. As discussed previously, organizations like family planning groups or abstinence-only-until-marriage groups occasionally have influence over the decisions that are made, but do not have the power to make the decisions themselves. However, individuals (either on their own or as representatives of organizations) did, in fact, have authority over making decisions about sex education when they served as members of panels or committees responsible for the development of programs and/or policies. Such was the case in all four school
districts that indicated that religious leaders had this authority (Franklin City, Parkland, Trenton, and West Millerstown).

### Table 5-4: Sex Education Decision-Making Authorities*

<table>
<thead>
<tr>
<th></th>
<th>Abstinence-Only (N = 4)</th>
<th>Abstinence-Plus (N = 17)</th>
<th>Safer Sex (N = 4)</th>
<th>Other (N = 3)</th>
<th>Total (N = 28)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Internal</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Superintendent</td>
<td>3 (75%)</td>
<td>3 (18%)</td>
<td>3 (75%)</td>
<td>3 (100%)</td>
<td>12 (43%)</td>
</tr>
<tr>
<td>School Board</td>
<td>2 (50%)</td>
<td>9 (53%)</td>
<td>2 (50%)</td>
<td>3 (100%)</td>
<td>16 (57%)</td>
</tr>
<tr>
<td>Principal</td>
<td>1 (25%)</td>
<td>10 (36%)</td>
<td>1 (25%)</td>
<td>3 (100%)</td>
<td>15 (54%)</td>
</tr>
<tr>
<td>Teachers</td>
<td>2 (50%)</td>
<td>14 (82%)</td>
<td>4 (100%)</td>
<td>2 (67%)</td>
<td>22 (79%)</td>
</tr>
<tr>
<td>Students</td>
<td>3 (75%)</td>
<td>5 (29%)</td>
<td>3 (75%)</td>
<td>0 (0%)</td>
<td>11 (39%)</td>
</tr>
<tr>
<td>Other</td>
<td>1 (25%)</td>
<td>10 (36%)</td>
<td>2 (50%)</td>
<td>2 (67%)</td>
<td>15 (54%)</td>
</tr>
<tr>
<td><strong>External</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parents</td>
<td>1 (25%)</td>
<td>5 (29%)</td>
<td>2 (50%)</td>
<td>1 (33%)</td>
<td>9 (32%)</td>
</tr>
<tr>
<td>Religious Leaders</td>
<td>0 (0%)</td>
<td>2 (12%)</td>
<td>2 (50%)</td>
<td>0 (0%)</td>
<td>4 (14%)</td>
</tr>
<tr>
<td>Politicians</td>
<td>0 (0%)</td>
<td>4 (24%)</td>
<td>1 (25%)</td>
<td>0 (0%)</td>
<td>5 (18%)</td>
</tr>
<tr>
<td>Family Planning Groups</td>
<td>0 (0%)</td>
<td>3 (18%)</td>
<td>1 (25%)</td>
<td>1 (25%)</td>
<td>5 (18%)</td>
</tr>
<tr>
<td>AOUM Groups</td>
<td>0 (0%)</td>
<td>2 (12%)</td>
<td>1 (25%)</td>
<td>0 (0%)</td>
<td>3 (16%)</td>
</tr>
<tr>
<td>Doctors &amp; Nurses</td>
<td>1 (25%)</td>
<td>9 (53%)</td>
<td>2 (50%)</td>
<td>1 (33%)</td>
<td>13 (46%)</td>
</tr>
</tbody>
</table>

*Each item in this section of the survey asked “How involved was/were ________ in deciding what topics your district’s sex education curriculum would cover?”*
“Enough Time” and “Enough Training” are Subjective Designations

The wide array of responses on these surveys to the questions about amounts of time on sex education instruction or sex education training reveal that the term “adequate” means very different things to different people. For instance one Health and Physical Education teacher indicated that sex education in Kilwin School District consists of a few classes in the ninth and eleventh grades and she believed this to be an adequate amount of time to teach the subject properly. In contrast, Potterville School District’s tenth grade Family and Consumer Science classes consist of approximately three weeks of sex education instruction (and is in addition to any sex education instruction they receive in their eighth and tenth grade Health classes) and the instructor feels this amount of time is inadequate to teach it properly. With regard to training a Health and Physical Education teacher in Montgomery Vale School District indicated that she received very little sex education training in college and does not get to attend any conferences or take part in any professional development opportunities pertaining to sex education, but nevertheless feels that she is adequately prepared to teach the subject well. On the other hand, a Pratt School District Health education teacher who received a similar amount of training, found it to be inadequate. Table 5-5 presents the respondents’ perceptions of the sufficiency of sex education instruction time in their districts as well as their perceptions of the sufficiency of the training they received to teach sex education.
Regardless of their various interpretations of the word “enough,” the majority of survey respondents (68%) felt that the amount of time spent on sex education instruction for the youth was in need of an increase and half of the respondents believed that teachers do not receive enough training to teach sex education properly. On the issue of training, many of the respondents provided more in depth information about what they felt was lacking from their respective programs. Most of the teachers in this sample only received a course or two during their college education that pertained to teaching sex education. Instructors with graduate training may (or may not) have received more than this amount. Trenton School District’s Health and Physical Education Specialist feels that Health and Physical Education teachers do not receive enough content knowledge during their training to teach Health classes properly:

It varies across the board. Most Health/Phys Ed certified teachers definitely have more education when it comes to teaching the students in the Physical Education part. Very few undergrad schools that I’ve noticed—and I’ve worked with three different undergrad schools with student teachers, and all the three schools that I worked with, their student teachers come to me and have extremely lacking...Health Education experience. Whenever they come to be a teacher in our district, they do not have—I don’t feel they have enough education when it comes to teaching Health class...Some of these dudes who are coming in as teachers to this school to teach may have four or five classes when it comes to teaching Health Education.

Beyond issues of content, teaching methodology was also an issue. In other words, teacher training programs would instruct on what to teach, but not necessarily how to teach it. Greater Sackerton School District’s survey respondent, for instance, feels that the biggest component missing from her (and her peers’) training was how to communicate this kind of information effectively to students at different age levels.
Overall, teachers felt that both their collegiate training and professional development in this area were significantly lacking. The respondents from Pratt, Potterville, and Queensboro School Districts all cited a need for professional development pertaining specifically to statistics on adolescent pregnancy and STI acquisition because this information changes yearly. Professional development opportunities (and the ability of teachers to take advantage of them) varied. Foxburgh School District’s respondents, for example, noted that the time of year that these opportunities are offered and/or the availability of substitute teachers are major factors in determining whether or not they can participate in them.

These findings echo those of Geubtner-May’s (2002) dissertation research on perceptions of training on sex education among Pennsylvania Health and Physical Education teachers. As in the present investigation, teachers surveyed in Geubtner-May’s study similarly indicated feeling under-prepared with regard to content knowledge and teaching methodology. Many also expressed discomfort with the delivery of the material. Her recommendations for improving sex education teacher training programs include incorporating more opportunities for prospective teachers to teach sexuality education within their own classes, requiring and making available additional classes covering human sexuality topics, employing and modeling a variety of teaching methods in these classes, and covering more subjects and in greater depth. Geubtner-May’s recommendations apply in the context of the present study as well given the similarity in teacher responses.
The Sex Education Controversy?

A major thesis proposed by this study is that sex education, as a morality policy issue, is by its nature more contentious and controversial than other school subjects, such as mathematics or social studies. The results of these surveys provide both support as well as opposition for this thesis. The respondents were asked if they felt that sex education had become more controversial within their districts over the past

<table>
<thead>
<tr>
<th>Instruction Timea</th>
<th>Abstinence-Only (N = 4)</th>
<th>Abstinence-Plus (N = 17)</th>
<th>Safer Sex (N = 4)</th>
<th>Other (N = 3)</th>
<th>Total (N = 28)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sufficient</td>
<td>2 (50%)</td>
<td>3 (18%)</td>
<td>2 (50%)</td>
<td>1 (33%)</td>
<td>8 (29%)</td>
</tr>
<tr>
<td>Insufficient</td>
<td>2 (50%)</td>
<td>14 (82%)</td>
<td>1 (25%)</td>
<td>2 (67%)</td>
<td>19 (68%)</td>
</tr>
<tr>
<td>Unsure</td>
<td>0 (0%)</td>
<td>0 (0%)</td>
<td>1 (25%)</td>
<td>0 (0%)</td>
<td>1 (4%)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Trainingb</th>
<th>Abstinence-Only (N = 4)</th>
<th>Abstinence-Plus (N = 17)</th>
<th>Safer Sex (N = 4)</th>
<th>Other (N = 3)</th>
<th>Total (N = 28)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sufficient</td>
<td>3 (75%)</td>
<td>8 (46%)</td>
<td>1 (25%)</td>
<td>2 (67%)</td>
<td>14 (50%)</td>
</tr>
<tr>
<td>Insufficient</td>
<td>1 (25%)</td>
<td>9 (32%)</td>
<td>2 (50%)</td>
<td>1 (33%)</td>
<td>13 (46%)</td>
</tr>
<tr>
<td>Unsure</td>
<td>0 (0%)</td>
<td>0 (0%)</td>
<td>1 (25%)</td>
<td>0 (0%)</td>
<td>1 (4%)</td>
</tr>
</tbody>
</table>

aOverall, do you think your school district spends too little time, too much time, or the right amount of time to teach sex education properly?
bHow much training have these teachers in your school received for teaching sex ed? Do you think this amount of training is adequate?

Table 5-5: Perceptions of Adequacy of Sex Education Instruction Time and Training
two years. They were then asked whether there had been controversy or debate over whether their districts should teach sex education at all, what topics their districts’ sex education programs should cover, whether their districts should teach abstinence-only sex education, and/or about parent opt-in/out policies regarding sex education. Finally, each respondent was asked whether their district provided condoms to students who asked for them. Table 5-6 summarizes the respondents’ answers to these survey questions pertaining to controversy over sex education, depicting counts and percentages of respondents by sex education approach who answered in the affirmative to each of these questions.

Overwhelmingly, survey respondents indicated that sex education was not an issue of contention in their school districts. Parkland School District’s Health and Physical Education department head believes the level of controversy over sex education in his district has actually declined over the past few years. One of the reasons provided for why sex education is not a controversial issue is because it is simply not important enough to be a source of controversy; it is not on most people’s radars because it is such a low priority within the schools. As Potterville School District’s Family and Consumer Science teacher put it, “We’ve got bigger fish to fry.” Districts in which sex education was considered to be controversial were the exception rather than the rule and the content and degree of this controversy varied considerably. The fact that no school district had more than a handful of students opted out of sex education classes over the past several years offers further evidence that sex education is not as contentious as was originally thought.
Table 5-6: Controversy over Sex Education

<table>
<thead>
<tr>
<th></th>
<th>Abstinence-Only (N = 4)</th>
<th>Abstinence-Plus (N = 17)</th>
<th>Safer Sex (N = 4)</th>
<th>Other (N = 3)</th>
<th>Total (N = 28)</th>
</tr>
</thead>
<tbody>
<tr>
<td>More controversiala</td>
<td>0 (0%)</td>
<td>2 (12%)</td>
<td>0 (0%)</td>
<td>0 (0%)</td>
<td>2 (7%)</td>
</tr>
<tr>
<td>Teach sex education at allb</td>
<td>1 (25%)</td>
<td>1 (6%)</td>
<td>0 (0%)</td>
<td>0 (0%)</td>
<td>2 (7%)</td>
</tr>
<tr>
<td>Topics coveredc</td>
<td>1 (25%)</td>
<td>5 (29%)</td>
<td>1 (25%)</td>
<td>0 (0%)</td>
<td>7 (25%)</td>
</tr>
<tr>
<td>Teaching abstinence-onlyd</td>
<td>1 (25%)</td>
<td>2 (12%)</td>
<td>0 (0%)</td>
<td>1 (33%)</td>
<td>4 (24%)</td>
</tr>
<tr>
<td>Parent opt-in/oute</td>
<td>0 (0%)</td>
<td>2 (12%)</td>
<td>1 (25%)</td>
<td>0 (0%)</td>
<td>3 (11%)</td>
</tr>
<tr>
<td>Condom provisionf</td>
<td>0 (0%)</td>
<td>1 (6%)</td>
<td>0 (0%)</td>
<td>0 (0%)</td>
<td>1 (4%)</td>
</tr>
</tbody>
</table>

a Do you think there has been more debate or controversy in your community over sex education during the last few years?
b Over the past couple of years, have there been discussions or debate in the PTA, the school board, or at any public meetings about whether or not to teach sex ed at all?
c Have there been discussions or debate about what topics to teach in sex ed, such as birth control or sexual orientation?
d Has there been discussion or debate over teaching abstinence only?
e Has there been discussion or debate over how parents give permission for their children to take or be taken out of sex ed?
f Does your school’s health program currently make condoms available to students who ask for them?

To put it bluntly, sex education was not important enough in the context of the myriad other school and district issues and concerns to elicit much debate or controversy. This finding has immense implications for morality policy theory. Hilgartner and Bosk’s (1988) public arenas model suggests that attention is a scarce resource and various social problems and/or issues must compete for it. This model helps explain why sex education would not raise the type or degree of controversy one
might expect of morality policy issues. School districts have a fixed amount of attention that they can devote to the myriad problems facing them and sex education often does not make the cut as an issue worthy of that attention and an issue must first be considered important (or worthy of attention) before it can be considered controversial.

Interestingly though, even in districts where sex education was not perceived to be controversial, fear of controversy or reprisal often drove curricular decisions; no one wanted to “rock the boat,” so to speak. West Millerstown School District’s respondent said that “there are certain things we try not to cross over, you know, like let’s not push the issues.” Cleaver School District’s Health and Physical Education department head said, “We have to be very careful in this district...for us to open up and bring an entire new curriculum in could causes us more grief.” While the results would indicate that sex education is not a controversial issue after all, it appears as though it is only uncontroversial so long as the teachers stay within a set of (often unwritten and unspoken) parameters. Despite the fact that most participants did not believe sex education was a controversial issue within their districts, the fear of controversy expressed by some of the participants provides support for morality policy theory. Even though in most cases no actual controversy arose over sex education, their fear that there could be is based on the fact that sex education is a morality policy issue, and therefore is by its nature, innately contentious.

Further, the hypothesis that sex education is an issue that sparks great controversy because it involves people’s fundamental beliefs about right and wrong cannot be dismissed based on these results because we have little to no information
about the sex education policies and programs in the school districts that declined to participate in the study. For example, the superintendent of one of these districts would not participate expressly because of the controversial nature of the subject. A teacher from another of these districts who had initially agreed to participate was extremely hesitant and anxious throughout the entire survey because she was afraid that she would be identified as the respondent and face harsh consequences; she would not allow me to audio record the survey for transcription purposes or make use of any of her direct quotations. She subsequently requested to have her completed survey destroyed and her district removed from the sample. A third district indicated that it did not participate in surveys of any type, and a fourth would have required school board approval to take part. Responses such as these provide additional evidence that school based sex education is still evidently an issue of contention in many areas and unfortunately, it was impossible within the parameters of this investigation to determine exactly how, why, or to what extent.

Some of the respondents did offer examples of controversy in their areas. One interesting example comes from Hirsch School District. A Hirsch school board member had petitioned for the seventh grade Health classes to offer a more comprehensive sex education curriculum, but the seventh grade Health teacher acknowledged that the board member’s recommendation was based on “research out there saying that you should do beyond abstinence,” but was nevertheless opposed to making any modifications to her curriculum; she kept referring to the fact that the legal age of consent in Pennsylvania is 13 years old, and noted that because her students were only
12 years of age, it would be inappropriate for her to provide them with any information beyond abstinence. This example demonstrates how personal beliefs about right and wrong can (and do) outweigh and overpower research-based approaches and methodologies.

**Condoms in Schools are a Laughing Matter**

Only one school district surveyed in this sample indicated that the schools in their districts provided condoms to students who requested them. In several instances, the respondents expressed shock or laughed when asked. (Specifically, three expressed shock and three laughed.) Kilwin School District’s Health and Physical Education teacher, Parkland School District’s Health and Physical Education department head, and Prothero School District’s Director of Curriculum each responded, “Absolutely not!” to the question. Redmont School District’s Assistant Superintendent of Secondary Education laughed as he said, “Not to my knowledge!” Jamestown Area School District’s school nurse also laughed at the question and added that she would lose her job for such an action.

This theme is particularly evocative of American attitudes about adolescent sexuality. Based on these responses, it seems as though the action of condom provision is equated with the sanction of adolescent sexual behavior. Despite the empirical evidence that indicates that condom provision in schools neither hastens onset of sexual activity nor increases its frequency, condom dispersal in U.S. schools remains
anomalous. Had this survey been administered in countries like The Netherlands or Sweden, the respondents would have likely expressed shock or laughed at the notion that schools did not provide condoms to students. In Pennsylvania (and likely the rest of the United States as well), the situation is quite clearly the reverse. This issue will be discussed in greater detail in Chapter 7.

**Time, Money, and “PSSA Robots”**

The most prevalent theme that arose from these school district surveys is that Health education is not a priority within most public schools. Teachers often cited time as a major constraint to good instruction. Health teachers see their students very infrequently and generally only for one semester during middle and/or high school. In this time frame they must cover a variety of issues, including nutrition, tobacco, drugs and alcohol, sickness and disease, and mental health in addition to sex and sexuality.

“There’s just too much information that four weeks out of four years just isn’t enough,” said the Health and Physical Education specialist in Trenton School District. The general theme, as a West Millerstown School District Health and Physical Education teacher put it, is that the teachers “just don’t have enough time in the day.” Health education falls very low on the priority totem pole of which subjects receive more class time and resources.

The Pennsylvania System of School Assessment (PSSA) examinations and NCLB accountability requirements only perpetuate this situation. Health teachers consistently
complained that if a subject or activity did not involve math or reading, administrators did not consider it important. Prothero School District’s Director of Curriculum and Instruction commented that sex education was “under [their] radar” as a result of the district’s need to “[maintain] good academic standing in...the Language Arts and Mathematics with regard to the PSSAs.” Jamestown Area School District’s school nurse noted that school districts worry so much about the PSSAs and focus so much time and energy on math and science that the students do not learn enough about “the most important thing,” their bodies. “Looking at our pregnancy rates here,” she said, “I think there’s much more we could be doing and at a younger age.” In Fulton Area School District, Health teachers (as well as teachers in disciplines such as art, music, and foreign language) must write how their lesson plans incorporate and improve math and reading skills, as opposed to how they convey the actual subject matter of the class.

In many districts, any in-service professional development opportunities, conferences, trainings, and workshops that teachers attend must pertain to improving PSSA scores. Such is the case for Elmville School District’s Health and Physical Education teachers, Jeremy Tyler. A Health and Physical Education teacher in Fulton School District echoed these sentiments: “With all the PSSA stuff going on, everything is geared toward the core courses,” she explained. All of her professional development has focused on improving reading scores. The Health and Physical Education department head in Parkland School District has had a similar experience. “It’s all about boosting literacy,” he said, “because...literacy is being assessed with PSSAs. Very little of our in-service time has been dedicated...toward health issues.” He also fears that Health
education may disappear completely as other electives are eliminated to devote more
time to subjects assessed on the PSSAs. His district has already eliminated 13 courses in
order that the students can receive two math and two English classes each. Fulton Area
School District has eliminated classes in art, music, and even geography as a result of the
focus on improving PSSA scores. “We’re making little PSSA robots,” said Fulton Area’s
survey respondent.

Health education is of little importance within many school districts due in large
part to the PSSA examinations. As a consequence, less class time is devoted to courses
in this arena. However, the PSSAs interfere with Health Education classes in other ways
as well. A Wellness and Fitness teacher in Eastern School District explained that the
given number of Health class periods in a semester can vary based on when the PSSA
tests are administered. Hence, the teachers must modify their planned curricula to
account for the new time frame. As long as the accountability measures tied to the
PSSAs remain in place, the priority placed on Health Education is unlikely to change, and
in a system with a fixed amount of time and resources, there is not much that can be
done to improve the plight of Health education and Health educators. “It’s very difficult
to rob Peter to pay Paul,” as he put it. “No one wants to lose their subject time, so
basically other subjects have other courses that would have to go away for us to add
more time.”
The Unsung Heroes of Sex Education

Three of the respondents from this sample are Family and Consumer Science teachers and based on their responses on this survey, I now refer to Family and Consumer Science teachers as “the unsung heroes of sex education.” If Health education is a discipline that flies beneath the radar, Family and Consumer Science is practically invisible. For this reason, Family and Consumer Science teachers felt much freer to discuss a wider variety of issues pertaining to sex and sexuality and spend far more of their class time covering them. It might even be fair to say that the sex education obtained in Health classes is often a supplement to that obtained in Family and Consumer Science classes rather than the other way around. Queensboro Area School District’s teacher felt that she went into far more depth with sex education than her colleagues in the Health department. Blue Hills School District’s teacher indicated that her sex education unit is safer sex focused, even though she believes the district would prefer an abstinence-plus focus. The Family and Consumer Science teachers mentioned many sex education topics that went above and beyond the information covered by most of the Health teachers in the sample. They also tended to have more time that they could devote specifically to sex education.

“Liberal” versus “Conservative” School Districts

While describing the process of sex education curriculum development, several of the survey respondents in this study used the same liberal-conservative dichotomy
language that Luker’s (2006) interview participants had used in her investigation of attitudes on sex education. The usage of this terminology evokes the culture war analogy and an “us versus them” mentality. Several of the teachers who responded to this survey made some kind of remark about feeling “lucky” that their administrators and/or school boards gave them the “freedom” to design and implement the program of their choice, particularly when they deemed their districts as being either “conservative” and/or “rural.” For instance, the Assistant Superintendent of Secondary Education in Redmont School District, explained how introducing more contraceptive information into the district’s sex education curriculum was such a significant accomplishment in his “small community” that is “essentially conservative in its thinking.” The Family and Consumer Science teacher in Blue Hills School District remarked that “for a very rural area we’re very fortunate that people allow us to treat their sons and daughters as mature young adults.” Occasionally, words like “liberal” or “progressive” were used to describe certain practices that their districts permitted; one Health and Physical Education teacher described to me how West Millerstown School District invited a physician from the community to come in and do a school-wide assembly about STIs and remarked that West Millerstown must be “a pretty liberal district” to allow such an activity to take place.

On the flip side from the individuals who felt they could implement good sex education programs in spite of their rural and/or conservative school districts were individuals who felt constrained by them. A Health and Physical Education teacher in Fulton Area School District explained that she felt very limited in the kinds of
information she could provide to her students because of district norms and politics.

Another Health and Physical Education teacher in Elvin School District lamented that what she was “allowed” to teach was limited by the attitudes of “our society, our school, our town...our school board and their attitudes.” As an example, she described that the school board forbade her from covering homosexuality in her curriculum (unless it was to address a question posed by a student). “In this day in age,” she said such restrictions are “ridiculous.” The school nurse in Jamestown Area School District described her district’s approach to sex education as being “conservative” and added that “our educators want to be more proactive and do a little more than abstinence, but our school board is strictly...abstinence-only.”

A fascinating question arises from these two distinct scenarios. The respondents from each of these districts referred to the districts as being either “conservative” and/or “rural” in an attempt to convey what they perceived was an environment unreceptive to sex education programs or activities they considered “progressive.” Why would the former districts have more freedom in their sex education curriculum design and implementation than the latter if their communities’ ideologies and/or locales are similar? Perhaps the answer comes back to Hunter’s (1991) premise that the liberal-conservative dichotomy is not synonymous with the progressive-orthodox spectrum. As was discussed in Chapter 3, while the tendency may be to use the terms interchangeably, “liberal” and “conservative” imply political ideologies, whereas “progressive” and “orthodox” apply to individuals’ conceptions of moral truths. Compromise is a possible outcome when there is a clash between liberal and
conservative political values; it is not when it occurs between those who see the world in black and white (i.e., with unequivocal rights and wrongs) and those who see several shades of grey (i.e., without prescribed, fixed conceptions of right and wrong).

For instance, in Jamestown Area School District, the school board simply would not waver from its strict abstinence-only stance, despite pleas from teachers and the school nurse to provide a more comprehensive approach. On the other hand, the Health teachers made a similar appeal to Foxburgh School District’s school board and were successful in their attempt. This paradox is at the core of the second research question in this study and was therefore the basis for case study selection. The survey results presented in this chapter addressed the study’s first research question regarding what is happening in Pennsylvania schools with regard to sex education. The second research question regarding why these particular policies and programs were decided upon is the subject of the next chapter on the results from the district case studies.
Chapter 6

School District Case Studies

To better understand the factors that influence the adoption or design of sex education policies and programs at the local school district level, I took a closer look at two of the 29 originally sampled districts. The survey results from these two relatively similar districts indicated that individuals in each had made attempts to shift the foci of their respective sex education curricula from strictly abstinence-only to more comprehensive and/or inclusive of condom and contraception education. Only one of these two districts, however, was successful in accomplishing this goal. Examining these two districts more closely allowed me the opportunity to understand how and why such a shift was possible in the one district, but not the other.

To begin my case studies, I analyzed the district level data obtained during the survey portion of this study (i.e., locale type, racial composition, student-teacher ratio, per pupil expenditure, percentage of students on the Free and Reduced Lunch Program, percentage of students with IEPs, and percentage of ELL students), as well as other socioeconomic data on the regions that comprise these districts, including levels of educational attainment, occupations held, household income levels, and political affiliations. I also obtained data on these districts’ performance on the PSSA examinations based on the survey results that revealed their influence on sex education policy adoption. County level data is presented for characteristics that are not
measured at the school district level. I searched for articles and letters to the editor in their local newspapers pertaining to sex education and adolescent sexual health in the *America's Newspapers* database using the search terms “sex education,” “teen pregnancy,” and “abstinence” along with each district’s name. I also investigated sexual health indicators in their communities, such as adolescent pregnancy, birth, and STI acquisition rates. I reviewed the findings from their initial sex education surveys and finally conducted in-depth interviews with several key informants in each district about their respective sex education policies and programs. In this chapter I will discuss all of the aforementioned data for each district and provide an analysis of how it helps us to understand the adoption of sex education policy at the local school district level.

**Background and Demographics**

Jamestown Area School District is a large town district (too large to be considered “rural,” but too small to be considered a “suburban” by U.S. Census code designations) located in southeastern Pennsylvania in what is known as the Coal Region. Mining was the major industry in this region (which is labeled such due to its abundance of anthracite coal) until the Great Depression when many of the state’s single industry towns experienced extremely high rates of unemployment and economic downturn. Approximately 2,100 students are enrolled across five schools in this district, only 1% of whom are non-white. In the 2006-2007 school year, the district spent just over $10,000 per student annually and had a student-teacher ratio of 15.2 to 1. Approximately 25%
of its students participate in the National School Lunch Program and receive free or reduced lunches. Only 1% of its students are English language learners (ELLs) and 20% have individualized education plans (IEPs). In 2006, the district received more than half of its budget from local tax revenue, 40% from the state, and the remainder from the federal government.

Foxburgh School District is a rural school district located in northern-central Pennsylvania. It consists of only two schools, one elementary and one combination junior-senior high school, serves just over 850 students, and spans two counties. One interesting feature of Foxburgh School District is that every single one of its students is white. Consequently, it has no ELL students. The district has a student teacher ratio of about 13 to 1 and its annual per pupil expenditure is approximately $12,000. Nearly half of Foxburgh’s students receive free and reduced lunches and about 20% have IEPs. Foxburgh School District receives only 30% of its budget from local sources, compared to the greater than 50% in Jamestown Area School District. The majority of Foxburgh’s budget (over 60%) comes from state funding. Table 6-1 summarizes each of these characteristics.
PSSA Scores

As discussed in the previous chapter, the testing requirements and demands of NCLB can indirectly impact sex education policies and/or programs by limiting the time and resources that can be devoted to untested subjects. Therefore, in examining sex education policy adoption in these two districts, it is important to assess how successful they have been at meeting these requirements and demands. Figures 6-1 and 6-2 depict the percentages of students in grades 6, 7, 8, and 11 in both Jamestown Area and Foxburgh School Districts scoring proficient or higher on the math and reading PSSA examinations, respectively, during the 2008-2009 school year compared with overall state percentages. In 2003, Jamestown Area School District did not make adequate
yearly progress (AYP) and was therefore in the “warning” phase; in a district’s first year of not making AYP, it receives no sanctions, but only has the next school year to demonstrate improvement. The next year, the district failed to make AYP again and entered the “School Improvement I” phase. During this phase of AYP, schools must make plans for improvement, permit students to transfer to better performing schools, and provide training to its teachers to improve student achievement. The district made AYP in 2005 and therefore entered the “making progress” phase. It has since made AYP every year from 2006 to 2009. Foxburgh School District made AYP each year from 2003 to 2009 except 2004.

![Fig. 6-1: Jamestown Area and Foxburgh Students Achieving Proficiency on Math PSSA (2008-2009)](source: Pennsylvania Department of Education)
Fig. 6-2: Jamestown Area and Foxburgh Students Achieving Proficiency on Reading PSSA (2008-2009)

Source: Pennsylvania Department of Education

**Socioeconomics**

Several of the types of information that I sought out are not available at the school district level. The closest proxy for this information, therefore, is county data, which is accessible via the Pennsylvania Department of State and the United States Census Bureau. Most counties in Pennsylvania consist of multiple school districts, so it is important to keep in mind that county level information will only provide a rough estimate of what these characteristics might look like in this one particular school district. Jamestown Area School District is located in Mission County. However, in many cases in Pennsylvania, school districts do not fall neatly within county borders and can
therefore serve students from more than one county. Such is the case in Foxburgh School District, which serves students from both Wheeler and Stetson Counties. In instances in which the data from these two districts are relatively similar, the average between the two districts is provided. During the key informant interviews, I asked each participant to describe the demographics of the district to gain clearer insight as to how closely these county level data represented the characteristics of the school district.

Figure 6-3 depicts levels of educational attainment in Mission County and Wheeler and Stetson Counties (averaged), both of which are lower than the overall state averages. The vast majority of residents have at least their high school diplomas (or equivalent degrees), but fewer than 10% are college educated, compared to over 15% statewide. Figure 6-4 illustrates categories of employment in Mission County and Wheeler and Stetson Counties (averaged). It indicates that nearly a third of Mission County residents are employed in management, professional, and related occupations (compared to over a third statewide). One quarter of the county’s residents are employed in sales and office occupations and another quarter in production, transportation, and material moving occupations. Blue collar occupations (e.g., production, transportation, and material moving) are more common in Wheeler and Stetson counties in relation to the state averages. For example, fewer than 9% of Pennsylvania residents are employed in construction, extraction, maintenance, and repair occupations compared to 13% of the residents in Stetson County.
Fig. 6-3: Educational Attainment in Mission, Wheeler, and Stetson Counties (2008)

Source: United States Census Bureau
Mission County’s percentage of low and middle income households exceed the state averages, but its percentage of high income households (those earning more than $75,000 per year) falls below the state numbers. Mission County’s median and mean income statistics also fall below the state averages. In 2008, Pennsylvania’s median income was approximately $50,000; Mission County’s was approximately $42,000. The mean income across the state was nearly $67,000, whereas Mission County’s was approximately $51,000. As in Mission County, higher level incomes ($75,000 and above) are less common in Wheeler and Stetson counties as compared to the state averages.
well. Total household incomes for both Mission and Wheeler/Stetson Counties are displayed in Figure 6-5.

Finally, with regard to political affiliation, of Mission County’s 90,000 registered voters, just fewer than half are registered Republicans and more than 40% are registered Democrats. Wheeler and Stetson Counties, which are quite similar on each of the previously described demographics, differ more so with regard to political affiliation. Wheeler County is predominantly Democratic (61%) whereas Stetson County has an equal percentage of registered Republicans and Democrats (45% and 46%, respectively). When averaged together, the breakdown of party affiliation is very similar to the state averages. However, the members of each political party are not
equally distributed across the state. It is therefore very important to keep in mind that we do not have data on the particular cross section of individuals that reside within the borders of the Foxburgh School District. Figure 6-6 illustrates the breakdown of political affiliations in Mission, Wheeler, and Stetson Counties.

![Fig. 6-6: Voter Registration in Mission, Wheeler, and Stetson Counties (2010)](source: Pennsylvania Department of State)

**Media**

The search for news items pertaining to sex education and adolescent sexual health in the Jamestown Area School District elicited seven regional newspaper articles dating from 1995 to 2007. Two articles from the late 1990s pertained to adolescent parenting and the programs in the area that existed to assist pregnant and parenting teens. Four of the articles from 2003 to 2007 discussed the federally funded
abstinence-based sex education program implemented in this and other nearby districts by a county agency. The remaining article, from 2003, discussed an incident in which the school board president expressed discomfort with the HIV education lessons being taught to the fifth grade students. HIV education is mandated by the state for students in fifth grade, but the board president’s opinion was that these lessons need not cover sexuality issues, which he felt were inappropriate for students of that age. The board president brought his concerns to the attention of the local media and it garnered both press and television news coverage. An extensive search for news items pertaining to sex education or adolescent sexual health in Foxburgh School District yielded no results. In fact, the only news items on this district produced by this search discussed its innovativeness in a variety of areas, including technology, foreign language, and excellence in rural education.

Sexual Health Indicators

Adolescent sexual health indicators (i.e., pregnancy, birth, STI acquisition) are measured by the Pennsylvania Department of Health at the county and municipality levels, but not at the school district level. Hence, the counts and rates provided here are at best rough estimates for the sexual health outcomes of the students in the two school districts in question. Table 6-2 displays counts and rates for pregnancy, birth, Chlamydia, and gonorrhea in Mission, Stetson, and Wheeler Counties.
Mission County, the county in which Jamestown Area School District is located, had a teen pregnancy rate of approximately 43 per 1,000 15-19 year olds, placing it in the top 20 counties with the highest rates in the state, though right in line with the state average (43.7 per 1,000). The 2007 birth rate in this age group was 33.4 per 1,000.

Rates of bacterial sexually transmitted infections (i.e., chlamydia, gonorrhea, and syphilis) are also assessed by the Pennsylvania Department of Health, but the youngest age bracket comprises 15 to 24 year olds, a range that incorporates the young adult demographic with the adolescent demographic. Because there is a lower incidence of bacterial STIs in all age brackets than of either pregnancy or birth among teenagers, these figures are expressed in terms of rates per 100,000. In Mission County in 2007 there were approximately 150 new cases of chlamydia (a rate of nearly 850 per 100,000), and ten new gonorrhea cases (a rate of about 65 per 100,000) in the 15-24 age group.

Table 6-2: Sexual Health Indicators in Mission, Stetson, and Wheeler Counties (2007)

<table>
<thead>
<tr>
<th></th>
<th>Teen Pregnancies</th>
<th>Teen Births</th>
<th>Chlamydia</th>
<th>Gonorrhea</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Count</td>
<td>Rate&lt;sup&gt;a&lt;/sup&gt;</td>
<td>Count</td>
<td>Rate&lt;sup&gt;a&lt;/sup&gt;</td>
</tr>
<tr>
<td>Mission County</td>
<td>183</td>
<td>43.1</td>
<td>142</td>
<td>33.4</td>
</tr>
<tr>
<td>Stetson County</td>
<td>86</td>
<td>36.4</td>
<td>74</td>
<td>31.3</td>
</tr>
<tr>
<td>Wheeler County</td>
<td>178</td>
<td>35.5</td>
<td>155</td>
<td>30.9</td>
</tr>
<tr>
<td>Pennsylvania</td>
<td>20,090</td>
<td>43.7</td>
<td>13,820</td>
<td>30.1</td>
</tr>
</tbody>
</table>

<sup>a</sup>Rate per 1,000  
<sup>b</sup>Rate per 100,000  

Source: Pennsylvania Department of Health
year old age bracket.\textsuperscript{19} Records of new viral STI acquisition (i.e., HPV, HIV, herpes, hepatitis) are not publicly accessible.

Because Foxburgh School District is situated in two different counties, the data compiled here provide an even rougher picture of adolescent sexual health in this district. The figures happen to be relatively similar, an unsurprising fact given that the two counties are adjacent to one another. The averaged teen pregnancy rate in 2007 for Wheeler and Stetson Counties, the two counties that house Foxburgh School District, was 36 per 1,000 15-19 year olds. The averaged teen birth rate in these two counties that year was approximately 31 per 1,000. Unlike the teen pregnancy and birth rates, rates of adolescent STI acquisition in the two counties in which Foxburgh School District is located did differ somewhat markedly. In 2007 in the 15-24 year old age bracket, Wheeler County had nearly 200 new chlamydia cases (a rate of about 1,000 per 100,000) while Stetson County had approximately 75 new cases (a rate of less than 750 per 100,000). Wheeler County had about 30 new gonorrhea cases (a rate of fewer than 150 per 100,000), but Stetson County had so few new cases that a rate per 100,000 could not be calculated.

\textsuperscript{19} There were no new syphilis infections in any of the counties discussed here over the past five years.
Summary of Survey Results

Jamestown Area School District

Sex education is currently being taught in the Jamestown Area School District and has been taught prior to the past two years. The survey respondent and initial interview contact from this district was school nurse, Cindy Greene. Within the past two years, the district partnered with a countywide agency to implement a federally funded abstinence-only curriculum for the sixth, seventh, and eighth grades. Jamestown Area School District was one of four school districts in Mission County to work with this agency as a result of a federal abstinence education grant the agency received. Greene indicated in the telephone survey that sixth, seventh, and eighth graders received this curriculum in their Health classes. In addition to providing the district with the curriculum, the agency also sent in two of their own educators. Eleventh graders also receive sex education content in their Health classes (though not this curriculum specifically) and tenth graders receive some sex education information in their Biology courses as well. Students in the fifth grade receive HIV education (as mandated by the state) as separate lessons taught independently of any of their classes. Ms. Greene offered some additional commentary on these HIV lessons for the fifth graders:

We pull in [our local United Way\textsuperscript{20} chapter] to come in and do the HIV lessons in fifth grade, which is kind of ridiculous cuz we have an integrated health curriculum in elementary school, which, you know, it depends on the classroom teacher how much they want to talk about health...but to just go in and teach kids about HIV education in fifth grade

\textsuperscript{20} Additional information on the United Way can be found at its web site: http://www.liveunited.org/
is kind of ridiculous I think...and the reason we do it is because of the standards. They require that in Pennsylvania, as you probably know, but we’re looking at doing some other things. I don’t know how much fifth graders are getting out of the 30-minute HIV program at that age without anything else.

Greene’s comment that HIV education for fifth graders was “ridiculous” pertained to its disconnectedness in the fifth grade curriculum as opposed to it being inappropriate content-wise; the aforementioned 2003 newspaper article on the school board president’s objection to the fifth grade HIV lessons, on the other hand, indicated that his disagreement with the lessons was based on his belief that information of this nature was inappropriate for students at that age.

When I asked Ms. Greene to describe her district’s approach to sex education, she immediately replied, “conservative.” She continued by saying, “What’s happening here is I think our educators want to be a little more proactive and do a little more than abstinence, but our school board is strictly, you know, abstinence-only. That’s it. They don’t want us—they kind of have the idea like they don’t want us giving kids any ideas (laughs).” Despite using the term “abstinence-only” in her open-ended description of the district’s approach to sex education, she nevertheless selected the abstinence-plus option from the list of approaches described in the survey. She offered some clarification later on as to why she did so:

Along with [the] STI information that we do...that includes contraception and they do that in the eleventh grade health class and I know prior to this year, the eighth grade health class, they did do like contraceptive education. I think it was almost kinda sorta presented in a way like—that it was in the curriculum as though you’re not supposed to do this, but hey this is out there, you know, in case you want to. You need to know about it.
I then asked if she could elaborate as to whether the discussions about contraceptives were to highlight failure rates or to provide them as a viable option and she responded as follows:

I guess I’ll say both, but I guess they kind of discreetly do the second one, to provide it as an option...For instance, the one day that I sat in they talked about condom use and they talked about how abstinence—they reinforced that, you know, abstinence is the best method and they talked about—she tried to relate it to like a Maury Povich show...[and] relate it to like what if you were that girl that was sitting on the stage like all excited cuz you were about to find out which one of the ten guys in the back was the father of your baby, and then they talked about, you know, like condom use and they were trying to relate to like commercials, how you see commercials on TV and then it as kind of such an interactive session that the kids were asking, ‘Well why would they sell condoms if you’re telling us that they’re not 100% effective, then why would they even sell them? Why would they advertise them?’ So, I know they get into it and probably more than maybe the school board would like.

Greene was essentially trying to point out that even if the lessons were designed to provide the students with a strict abstinence-only perspective, the nature of the discussions permitted the presenters and/or Health teachers to offer additional information. Her description of the Maury Povich show lesson, however, reflects a shame-based message about pre-marital and/or adolescent sexual activity.

Greene estimates that sex education lasts for about a week and a half to two weeks per year for the middle school students and approximately the same amount of time for the eleventh graders. The federally funded abstinence education curriculum specifically was a total of eight sessions and is followed up by the Health teachers with some additional material. Ms. Greene believes that this is not enough time to teach sex education properly:
I think [it is an insufficient amount of time] because we do little to nothing at the elementary level and...when we look at other countries, European countries, their teen pregnancy rates are lower and they’re believing that to be because their education starts much younger. It starts in Kindergarten. I just think that we spend so much time worrying about the, you know, the PSSAs and are kids learning enough of the right math and science and everything and we’re not teaching them about the most important thing, which is their bodies, and you know, even looking at our pregnancy rates here, I think that there’s much more we could be doing at a younger age.

Students in Jamestown Area School District are required to take sex education and their parents are not notified prior to the implementation of these lessons. To the best of her knowledge, Greene cannot recall a single student being opted out of sex education within the past year.

The Health teachers are responsible for teaching sex education in the Jamestown Area School District, but because Ms. Greene was a nurse and not a teacher, she was not completely sure about the specifics of teacher training requirements around sex education. She did, however, note that the middle school Health teachers attend a teen pregnancy prevention conference each year and do professional development on their own, and was of the opinion that “they probably do not only what everybody else does, but I think they probably have a little bit more specialized training.” Even though the district does not provide trainings, workshops, or other professional development opportunities, it does send teachers and others school personnel to take part in these types of opportunities when they are offered elsewhere. The main examples Ms. Greene could think of were the annual teen pregnancy prevention conference sponsored by the Pennsylvania Coalition to Prevent Teen Pregnancy, a statewide
organization that does advocacy work and provides education and support around adolescent pregnancy prevention\textsuperscript{21}, and seminars offered by Rutgers University in New Jersey.

Ms. Greene believes that the federal abstinence-only-until-marriage funding has had an impact on her school district’s sex education curriculum. “Given the fact that we have such a very conservative majority on the school board and because they have very strong opinions about abstinence-only, I think...if there were additional funding available...that they would want to take advantage of it because of their own personal beliefs.” Ms. Greene was unsure as to whether the district received any of this funding, but was under the impression that it nonetheless impacted the school board’s thinking on the matter. (The district itself does not directly receive federal abstinence-only funding, but the countywide agency it partnered with did, and it used that funding to offer their abstinence education program in this district.) She was also very vocal in discussing the school board’s influence over curriculum content and their resistance to anything beyond strict abstinence-only sex education programming:

[The school board] believe[s] that teenagers should not—I mean, they’re just very conservative and just believe that teenagers shouldn’t be sexually active, and they only want that taught. They only want abstinence taught in the schools. That’s all they want. They wouldn’t budge on anything different. I think they’re realistic in knowing that that’s not the case, but I think they feel that that’s not for the school district to address then, cuz I know when we tried to get the [county agency’s abstinence education] program in to get board approval, we spent countless hours preparing our presentation and really the only thing they wanted to know was [if it was] abstinence based.

\textsuperscript{21} Additional information on the Pennsylvania Coalition to Prevent Teen Pregnancy can be found at its web site: \url{http://www.pcptp.org}. In full disclosure, I have been employed with PCPTP since October 2008.
Ms. Greene recalls being contacted several times over the past few years by parents about the content of the district’s sex education curriculum. “Usually it’s more about what’s being taught,” she said. She has also been contacted by the school board president regarding her “sex talk,” referring to her puberty classes with the sixth graders. “He sits on the state board of education,” she informed me, “and they’re looking at changing the HIV instruction, so he’s contacted me specifically about what our kids are being taught about HIV education.”

The school board and building principals are responsible for sex education decisions in the Jamestown Area School District. Greene added that the district did involve parents in the planning of the abstinence education curriculum adopted from the county agency. The school board members were not involved with the selection of particular topics to be covered in the curriculum beyond stating that they wanted it to have an abstinence-only focus. The Health teachers ultimately are responsible for designing the curriculum and must submit it to the principals who, in Ms. Greene’s words, must “give their blessing.” As the school nurse, Greene served in an advisory capacity offering her expertise to the Health teachers when requested.

Greene’s recollections from the previously discussed fifth grade HIV lesson scandal in Jamestown Area School District suggest that there has been more controversy or debate on the issue over the past few years:

I would say it’s probably because of the shift in the board being more conservative. What happened was, I guess one of our board members happened to be at the school about five years ago when the HIV education was happening in fifth grade and he went up to see what was going on and [the next day] brought the local TV station to the school and
kind of made a big like negative—kind of like a little bit of negative press about it and I think because of that, I think it was shown to the public in kind of a negative light, so I think that caused some people to question what was happening, and I think recently there’s a lot of discussion that I hear among community members because we’ve had somewhat of an increase in teenage pregnancy, there’s been discussion kind of both ways, you know, what are they doing, what are they teaching, what aren’t they teaching, and those kind of discussions.

Despite the fact that her anecdote suggested that heated debate was raging in the Jamestown Area School District, Greene categorized these discussions as calm and indicated that these discussions are ultimately what led the district to adopt the county agency’s abstinence education program. She also indicated that there was some discussion over whether parents would need to give permission for their children to take part in the in this program, but that these discussions were also very calm and did not result in any major policy changes. Jamestown Area School District does not make condoms available to students who ask for them. Greene laughed at the question and added “I’d be losing my job!”

**Foxburgh School District**

Both the male and female Health teachers in the junior-senior high school in Foxburgh School District responded to the survey, Jim Cramer and Molly Winston. Sex education has been taught in Foxburgh during the past two years and prior to two years ago, but within the past two years, Cramer and Winston became proactive advocates for revisions to the existing program. “We actually went to the school board because it was just an abstinence program,” said Cramer, “Molly and I went to the school board and
presented that we were gonna talk about different things. We were gonna talk about contraception and discuss that as an alternative, not as promotion, but as an alternative for the kids, and just to have a better understanding of what it’s all about.” Winston added:

Before we went to the school board we did surveys with I think grades seven through twelve and it kind of gave us an idea of what they thought that we should teach them, and also if they had gotten any information from their parents, and if their parents would rather us teach them sex ed or if they would rather teach them, so we got some input there and then we went to the school board.

Eighth and eleventh graders receive sex education in Foxburgh School District in the Health curriculum, but Winston added that prior to their lobby efforts, it was taught only in the ninth grade. Neither Cramer nor Winston makes use of pre-packaged sex education programs or curricula or contracts with any outside individuals or agencies to provide sex education services; they are responsible for program design and implementation. When I asked how the two would describe the district’s approach to sex education, they both laughed as Cramer replied, “better than before!” Winston elaborated further:

Our sex ed used to be taught by the home [economics] teacher in a ninth grade class and I don’t think it was actually called sex ed...[The home economics teacher] went into how the fetus [goes] through the different months and child care after that, so it wasn’t just sex ed. She had done both and we thought it should be brought back to the Health teachers and that’s when we decided to teach it in our eighth grade and our eleventh grade health classes instead of doing the ninth grade. We thought it needed to be done earlier.

Cramer added:
Yeah, earlier the better. Eleventh grade’s too late and you know what? For a lot of things, you know, ninth grade sometimes is too, so we wanted to move it back into eighth grade to be more extensive, I guess? And Molly and I break it up. I’ll take the boys, she takes the girls, so our schedule really allows us to get maybe a little bit more personable with our kids. It works out real good. This year was probably better than before.

Winston elaborated on the benefits of the new single-sex classes, suggesting that the segregated classes permit the students to be more open and ask questions they might be otherwise too embarrassed to ask in a co-educational environment.

Cramer and Winston had different responses to the multiple choice question on sex education approaches. Winston chose the abstinence-plus option, indicating that she stressed abstinence but did cover “the other,” as she referred to it. Cramer, on the other hand, felt that his classes aligned more closely with the safer sex option. “If I had to pick one,” he said, “obviously I’d be right on the fence with that one, [because] I want our kids to be responsible...Abstinence is important, but it’s not realistic.” Winston then elaborated on Cramer’s response:

What we found in our school district is—and we have a very small school district. We have grades 7 through 12, we only have like 400 students and...the past three years we’ve had at least two pregnancies a year. That’s why we’ve been trying to take a more proactive look in the way that we’re teaching it because obviously the abstinence wasn’t working. We still teach the abstinence, but we’re saying okay, if you’re gonna do it—you know, quote-unquote do it—this is how you can protect yourself [from] getting STDs and hopefully not getting pregnant at a young age...We’re hoping when our eighth graders are tenth and eleventh graders that our pregnancy numbers have decreased, hopefully because of the way that we’re teaching it now.

The sex education units in Foxburgh School District consist of approximately 12 classes and last about a month, but both instructors feel that this amount of time is not
sufficient. “Obviously we’ve got [other] things that we’ve got to cover as well,” Cramer stated, “I would say sex ed lasts longer than any other unit that we have, but I mean, can it be integrated into other courses? Absolutely.” Foxburgh School District notifies parents when the teachers are about to cover sex education, but do not require them to return a signed permission slip. Within the last year, however, no parents had opted their children out.

Both Cramer and Winston felt that the amount of training they received in college for teaching sex education, like the amount of time they have to teach it, was also lacking. Winston indicated that the courses she had in college were not geared toward how to teach sexuality topics to middle and high school aged students. The district does not offer any trainings or professional development opportunities on sex education and while they do permit teachers to participate in opportunities offered elsewhere, Winston noted that that permission would be based on the time of year that the opportunities were offered and the availability of substitute instructors. Cramer mentioned that while the Pennsylvania State University offers an annual conference that covers this information, the time of year during which it is offered prevents him and Ms. Wilson from attending.

Cramer and Winston responded that the superintendent, school board, school principals, teachers, students, and parents all had decision-making authority over their district’s sex education curriculum. In their efforts to revise the previous curriculum, Cramer was referring to the same conference that Jamestown Area School District’s teacher attend, coordinated by the Pennsylvania Coalition to Prevent Teen Pregnancy.
they created a survey for students and a survey for parents to assess wants and needs in the district at both levels. They (the health teachers) then decided on the topics to be covered and wrote the curriculum, offered school and district level administrators an opportunity to provide suggestions and feedback, and then had to present what they designed to the school board for approval. The fact that Cramer and Wilson actively sought out and made use of student feedback and opinions in designing their curriculum is a distinctive feature of Foxburgh’s sex education program. These teachers placed a high value on the thoughts and ideas of the youth being served. In this way, the students had an active role in selecting the material they were taught. “We had [a] list of topics and they kind of agreed or disagreed,” Cramer indicated, “so yeah, they played a hand in [designing the curriculum].” Despite the overhaul of the curriculum and the inclusion of topics other than abstinence, neither Cramer nor Wilson believes that there has been more debate or controversy over sex education. Both agreed that given the small size of the district, if there had been any controversy, they would have certainly known about it. Finally, Foxburgh School District does not make condoms available for students who request them.

**Interviews**

In December of 2009, I conducted face-to-face interviews with key informants in both the Jamestown Area and Foxburgh School Districts. I spoke with four employees in the Jamestown Area School District. The first was with Cindy Greene, the high school
nurse who responded to the initial survey. Greene helped me to identify other individuals in the district with valuable insights on sex education in the schools. These individuals included the male and female middle school Health teachers, Kurt Hastings and Marissa Thompson, and the district’s assistant superintendent, Patrick Vitello, who had previously held the positions of high school principal and high school Health and Physical Education teacher. In Foxburgh School District, I conducted interviews with six employees. The first was with Jim Cramer, the male junior-senior high school Health and Physical Education teacher, who was one of the two respondents to the initial survey. Cramer assisted me in identifying others in the district with some degree of experience with and/or understanding of sex education. Among these individuals was Cramer’s female counterpart (who was the other respondent on the initial sex education survey), Molly Winston. The other interviewees, all of whom were employed in the junior-senior high school, included the school nurse, Jane Brooks, the Biology teacher, Joe Pfoutz, the Family and Consumer Science teacher, Alicia Witherspoon, and the assistant principal, Mark Williams. With both the surveys and interviews, the vast majority of those identified as key informants were teachers. Though there were clearly some exceptions, on the whole, administrators are seen as being less knowledgeable on or relevant to this issue.

Respondents from Jamestown Area and Foxburgh described their districts as being predominantly white, rural, blue collar, and low to middle income. Individuals in both districts also made note of the fact that having few social outlets for youth in their areas put young people at risk for negative social and physiological outcomes. “There’s
not a lot to do in [Mission] County” said Jamestown Area’s assistant superintendent, Patrick Vitello. He described that when this lack of structured and supervised activities leads drinking and drug use, “sex is right around the corner.” Foxburgh Family and Consumer Science teacher Alicia Witherspoon lamented the lack of activities for young people in her district as well, pointing out that the region does not even have a movie theater or bowling alley to entertain the students.

The lack of structured activities combined with the lack of adult supervision both put adolescents at risk for unplanned pregnancy and STI acquisition, a situation reminiscent of the now famous 1996 syphilis outbreak among high school students in Conyers, Georgia that became the subject of the PBS Frontline Documentary, The Lost Children of Rockdale County (Public Broadcasting Company, 1999). Rockdale County, like Mission County (the county in which Jamestown Area School District is located), also had among the highest teen pregnancy rates in its state and had been offered $150,000 by the state to implement a comprehensive sex education program to address these rates. Just as Jamestown Area School District’s school board refused to adopt a comprehensive sex education approach in their schools, the Rockdale County schools similarly refused the state’s offer on the grounds that the program in question provided contraceptives to students who requested them.

At the time that I conducted these interviews, the middle school abstinence education program in Jamestown Area School District that school nurse, Cindy Greene, described in the survey was no longer in place due to the agency losing its funding for the initiative. This phenomenon is not uncommon and not specific to sex education;
programs come and go with little consistently based on the availability of funding.

Middle school Health teachers Hastings and Thompson explained to me that at present, sex education occurs in the eighth and eleventh grades; sixth and seventh graders no longer receive any instruction in this area. Each interviewee agreed that sex education should start earlier, contain more information, and occur more frequently, but see their school board as the primary (if not sole) obstacle to such changes. They all referred to the board as being “conservative.” Hastings and Thompson spoke of the “push back” they receive any time they attempt to expand sex education instruction. Greene worries that the board members might not be the best individuals to make these sorts of decisions as they are not “in the trenches,” and do not see or fully appreciate the severity of the issues their students must deal with. “It’s easy to sit up there and dictate I don’t want kids hearing about this and I don’t want kids hearing about that,” she said, “but they’re not hearing about the kids going to the abortion clinics or the clinics to treat the STIs.” Vitello noted that the board members have “older values” and are “very protective of the younger students.” The board has shown objection to anything having to do with “the ‘S’ word,” as Greene put it, including the sexuality content in the state mandated HIV lessons in the fifth grade. The board was even wary of the federally funded abstinence education program that had been in place solely because it involved discussing sex and sexuality with the middle school students. Hastings and Thompson always feel they have to “watch it” and “protect [them]selves” with regard to the content they present to their students. No one wants to “kick up dust” or “cause trouble” as Greene mentioned.
While the assistant superintendent and school nurse did not necessarily feel that the PSSAs affected sex education in Jamestown Area School District, the middle school health teachers undoubtedly felt their impact. They explained how as a non-tested subject, students do not receive numerical grades in Health or any of their other “specials.” Additionally, when students perform poorly on their PSSAs, they are pulled from their specials for remediation. Hence, the PSSAs influence the amount of Health instruction these students receive. As Hastings put it, “we’re the low man on the totem pole.” When I asked whether they felt student health and health education were priorities in the district, Hastings replied sarcastically, “definitely not as important as their PSSAs!”

Several years ago in a different part of the state, junior-senior high school Health teachers Jim Cramer and Molly Winston began an initiative to change to their district’s sex education program. They started out by doing their homework. They constructed and administered student and parent questionnaires about their instructional wants and needs surrounding sex education. They then compiled all of the data they received and made a case to their school board that the existing abstinence-only curriculum was not only outdated and ineffective, but also not in line with the priorities of the families they served. They presented this information alongside the teen pregnancy and birth numbers for their small district over the past several years. Cramer and Winston prepared long and hard to make this plea because they knew that it involved a touchy subject and that what they were proposing was, in their minds, fairly progressive for their conservative, rural district.
Much to their surprise, they faced no resistance. The board approved their changes and no one received any backlash from parents or other community members. Assistant principal, Mark Williams, summed up his and the board’s position by saying that the district would be neglecting the students if they did not cover information that went above and beyond abstinence. He equated withholding such information with putting the students at greater risk. “You’ve got to educate,” he said, “it’s for their own good.” Winston added dejectedly that “this may be the only place they’ll get it.” On a more positive note, Winston believes that she has already seen a reduction in the number of new pregnancies in the district. The students are still sexually active, she believes, but they are “being safer.” Winston, Cramer, and many other educational professionals (in Foxburgh, Jamestown Area, and elsewhere) see a strong connection between school-based sex education and rates of adolescent pregnancy and STI acquisition. Despite the immense strides that Cramer and Winston have taken with Foxburgh School District’s sex education curriculum, they both agree that the district could to more to improve its efforts to reduce teen pregnancy and STI acquisition. For instance, Cramer believes condom distribution would help, but does not foresee it being politically feasible.

Each of the teachers in Foxburgh as well as the assistant principal acknowledged that the PSSAs have some influence over Health education due to the fact that it is not a tested subject. “It puts a pinch” on all subjects, according to Biology teacher, Joe Pfautz. Williams suggested that it “affects our whole curriculum.” “I don’t agree with it that much. I think there’s way too much emphasis put on it,” he said. “I truly believe in
accountability, but I think it takes away a lot from a teacher.” Winston pointed out that while sex education is not on the PSSAs, it is critically important. “If someone gets an STI like herpes,” she said, “they have it for the rest of their life.” While the PSSAs do impact the amount of instruction time in Health (and therefore also sex education) that students receive, they play no role in the determination of content. However, Winston indicated that she and Cramer do their best to incorporate math and reading into Heath classes wherever possible.

The Traditionalists and the Realists

What is so different about the Foxburgh and Jamestown Area School Districts?

The interview respondents in both districts recognized teen pregnancy and STI acquisition as problems in their respective regions and acknowledged that schools can play a part in reducing the incidences of both. Individuals in both districts requested that their school boards amend or pass policy to permit the expansion of sex education but Foxburgh’s board was considerably more amenable to such a proposition than the board in Jamestown Area. The survey and interview results from these districts suggest that the reason why was a difference of attitude on one very simple, yet critical issue. Without question, teenagers are sexually active in both districts, and while neither district condones or is pleased about adolescent sexual activity, Foxburgh School District acknowledged and accepted this fact as a reality of modern life that must be dealt with in a realistic manner, while Jamestown Area rejected it and refused to compromise their
traditional values about adolescent sexuality. In conventional prevention terminology, it is the classic debate between risk avoidance and risk reduction, whether the most effective means of preventing harm is to attempt to eliminate all exposure or to try and moderate and/or mitigate harm with the understanding that it is never entirely escappable (Hopkins, Tanner, & Raymond, 2004).

The most interesting facet of what differentiates Foxburgh from Jamestown Area is that the policy decisions in Foxburgh were not based on the personal, moral beliefs of those advocating the change or those authorizing it. Molly Winston in Foxburgh School District indicated that she personally believes in the abstinence-only message and wished it worked with the students, but she acknowledges that it is not an effective approach to preventing adolescent pregnancy or STI acquisition. Even though some of the information in their new comprehensive sex education curriculum conflicts with her religious beliefs as a Roman Catholic, she indicates that she wants the students “to be safer, rather than to be a teen mother or to have an STI.” She and her colleague therefore petitioned and convinced the school board to make changes that would have the most positive outcomes on the students being served. Consequently, religiosity and political conservatism are not direct correlates of opinions on sex education. As Cindy Greene in Jamestown Area School District said, “I’m a registered Republican, but my husband tells me I’m a liberal...[but] I like to call it being open minded and living in not the ideal world, but in this very political area.” Molly Winston and Cindy Greene both attend church and identify as conservative, but when it comes to adolescent sexual health, they are realists. The Foxburgh School Board agreed with this stance on the
issue; the Jamestown Area School District did not. Based on the responses provided by
the interviewees and the news items collected in this district, the Jamestown Area
school board members are traditionalists. They believe in a fixed morality and a
dogmatic adherence to a strict moral code without exceptions. Sex is a taboo subject
that they only address on a need-be basis (e.g., the mandatory HIV lessons in the fifth
grade).

On my drive back from my interviews in Foxburgh School District, I made note of
the fact that it was a fairly churched and religious region. In addition to the many
churches I passed, both large and small, I noticed several signs along the roadsides
proclaiming “Jesus is Lord,” and “Have no other gods before God.” The interview
respondents in Jamestown Area School District spoke of their school board’s vehement
religiosity as being a primary reason for their refusal to allow more frank discussions of
sexuality with the students, but the region served by Foxburgh School District is without
question a faith-based community. The interviewees in Foxburgh indicated that they
were surprised to receive no backlash or protest from the community following the
alteration of their sex education curriculum, but they speculate that the reason has to
do with the fact that the parents are more comfortable with the schools teaching their
children about sex than they are with themselves.

These findings are consistent with the theory on culture wars, which indicates
that orthodoxy and progressivism are not synonymous with religiosity and secularism or
political conservatism and liberalism. The culturally orthodox view morality as external,
definable, and transcendent; the culturally progressive view morality as flexible,
indefinite, and open to interpretation. Further, culturally orthodox individuals believe in boundary setting while their culturally progressive counterparts encourage autonomous, independent decision-making. Molly Winston and Cindy Greene both believed that regardless of their personal beliefs, there was a greater issue at hand and that ideology alone would not solve their district’s teen pregnancy and STI problems. They both felt the best course of action was to provide their students with as much information as possible and foster good decision-making skills. Winston’s school board agreed with these sentiments; Greene’s did not.
Chapter 7

Conclusion

The purpose of this study was to learn more about the types of sex education policies and programs in place across the state of Pennsylvania and uncover and explain the factors that influence their adoption. The results from the telephone surveys provided the answer to the first question and were a springboard for the district case studies, which corresponded with the second. The results of this investigation have both practical and theoretical implications; they can inform policy revisions and future policy adoption and also contribute to the theories on culture wars and morality policy by illustrating how morality policy issues are addressed and resolved both in the educational arena and on the local level. In this concluding chapter I will discuss both the policy and theoretical implications of these findings and offer suggestions for future research and thoughts on the future of sex education.

Policy Implications

The results of this study have implications for policy at the federal, state, and local levels, but the appropriate suggestions are dependent upon the manner in which the questions or problems are framed. The goal of these recommendations could be to reduce the incidence of adolescent pregnancy and STI acquisition (a public health goal). Alternatively, it could be to improve adolescent decision-making skills and overall
adolescent health and well-being (a goal of comprehensive sex education). A third potential goal could be to reduce the incidence and prevalence of adolescent sexual activity (a goal of abstinence-only sex education). These three goals are not necessarily mutually exclusive; achieving the goal of reducing the incidence and prevalence of adolescent sexual activity, for instance, could simultaneously achieve the goal of reducing the incidence and prevalence of adolescent pregnancy and STI acquisition. The point here is not to suggest mutual exclusivity, but rather to depict three distinctly different schools of thought on the aim(s) of sex education.

When President Barack Obama took office in January of 2009, there were three federal funding streams for abstinence-only sex education: AFLA, Title V, and SPRANS-CBAE. The combined allotment of dollars allocated for abstinence-only education in Fiscal Year (FY) 2009 equaled $160 million. The Title V portion of this amount ($50 million for FY 2009) was dispensed to state health departments and as of November 2009, 25 states had turned it down in response to the mounting evidence on the ineffectiveness of abstinence-only programs. The funds allocated for each of these states, therefore, went unspent because they could not be dispensed for any programs that did not strictly adhere to the A-H guidelines (located in Appendix A). Most of the states that refused the funding did so because of its restrictive guidelines. In other words, if programs were permitted to address the topic of birth control in a positive manner, for example, states would have been more likely to accept the monies.

It stands to reason that policy should be developed, revised, or eliminated based on the needs and desires expressed by the public as well as on the policy-makers’
assessments of what is in the public’s best interest. On the former point, we have seen twenty-five states reject funding for abstinence-only-until-marriage programs in addition to studies that indicate that the vast majority (82%) of the American public supports comprehensive sex education and is displeased with abstinence-only sex education (Bleakley et al., 2006; National Public Radio et al., 2004a). On the latter point, it is undoubtedly in the public’s best interest to reduce the incidence of adolescent pregnancy and STI acquisition. The social and economic costs of these issues place an unnecessary burden on society that can be easily ameliorated by implementing more effective prevention strategies on a larger scale. In the subsections that follow, I discuss the policy implications of this research and propose recommendations that reflect both American public opinion and public good with regard to school-based sex education. Specifically, I focus on how the results of this study have illuminated the impact of standardized testing and condom and contraception availability in schools on the sex education policy environment.

**The Role of Standardized Testing**

Local control remains a central, if not the central feature of the American education system. The federal government cannot make mandates pertaining to education. Instead, it carries out its educational agendas via grant programs. The most well known of these grant programs is No Child Left Behind. States or districts opt in to federal programs such as NCLB and agree to adhere to their guidelines to receive
funding, but can be penalized if they fail. One of the major findings of this research pertains to the NCLB law and the role that it plays in sex education program and policy development and implementation at the local level. In order to make AYP, districts devote extraordinary amounts of time and money toward preparing students to take the state standardized tests. (In Pennsylvania, these are the PSSA examinations.) Because Health education is not a tested subject, it is a low priority and receives little attention or resources. This circumstance raises a more fundamental, philosophical question about the purpose(s) of education and the nature of accountability.

The accountability movement heralded in by the No Child Left Behind Act is based on a market-based model in which performance is assessed via standardized testing. High performing institutions are rewarded and low performing institutions are sanctioned. School districts that do not make adequate yearly progress for three or more consecutive years begin to receive sanctions that range from provision of supplementary education services (SES) to students to complete replacement of staff and governance structure. Appendix F provides more detailed information on each of the sanctions imposed upon districts not making AYP. This model is based on an assumption that schools, like businesses, must improve themselves to stay competitive. Schools that fail to make AYP must offer the opportunity to send their children to better performing schools at the failing district’s expense. The goal of sanctions such as school choice is to motivate schools to increase their performance, but the unintended consequences of the sanctions often overshadow the mechanisms’ original intents. As Schafft (in press) points out:
These reform measures have not only changed the roles played by educators and administrators, but similarly have weakened schools themselves along with the school-community bond through school closures; the cutting of “nonessential” (i.e., untested) classes such as art, history, and physical education in the effort to increase math and reading scores; decreased local control and local parental involvement; and the implementation of curricula disembedded from place, local context, and community experience. These changes have also transformed educators and educational leaders from autonomous, responsive practitioners of a living craft to technocrats enacting sets of prescribed, rationalized tasks. That is, “if it doesn’t raise test scores, it’s just not relevant to my job.”

The unintended consequences of standardized testing are many and great. Its impact on sex education programming is but one of these consequences. Data indicate that minority and lower income students perform the poorest on these tests (Au, 2009). These groups incidentally also have the highest teen pregnancy, birth, and STI rates. Hence, the present system of standardized testing results in a never-ending cycle in which low performing schools with large minority and low income populations consistently under-perform on the tests. Therefore, more time and attention is directed on test preparation and away from non-tested subjects (i.e., health, which research has demonstrated can have very positive effects on teen pregnancy and STI rates). Further, research by Nichols and Berliner (2007) indicated that not only does high-stakes testing not improve achievement, but in some circumstances it may actually erode it. In a sense, because of its numerous unintended consequences, which are in many cases detrimental to the educational process, standardized testing often does more harm than good.

Regardless, local school districts will likely not give more priority to sex and Health Education until they are held accountable for doing so. There are currently no
measures in place for holding schools and districts accountable for their students' health
knowledge and outcomes, but adding Health Education to the PSSA examination seems
a suboptimal solution to the problem. A common complaint in the educational
community is that preparation for standardized testing is more about “teaching to the
test” than about instilling students with real subject knowledge. Hence, it seems
unlikely that making Health a tested subject will do much to improve student Health
knowledge and/or outcomes.

The expression “money talks” speaks volumes in the realm of American public
education. New federal appropriations, state budget line items, federal and state laws,
and revised national and state Health Education standards for evidence-based sex
education all have the ability shift focus onto this critical subject that too often gets
pushed to the wayside. School districts are extremely loath to refuse money of any
kind. Further, administrators concerned with increasing test scores should be motivated
by the connection between health and achievement. Pregnant and parenting teens are
far more likely to fail or drop out of school. Sick youth are unlikely to perform at their
highest capacity. Healthy students are higher performing students. Higher performing
students are more likely to meet AYP and districts meeting AYP do not receive sanctions
and penalties. While standardized test score improvement is certainly not the modus
operandi of sex education, under the current NCLB standards and requirements, it is
undoubtedly a convenient and valid justification for the adoption of more effective sex
education programming.
Ultimately, those intrigued or concerned by the current standardized testing scenario must question to whom education is ultimately accountable and whose purposes it serves (Schafft, in press). Education is not a value-neutral enterprise. As Corbett notes, “education is fundamentally about learning things that someone, somewhere decides to be important” (as cited in Schafft, in press). The present market-based model of accountability is unlikely to disappear or change. While it may be possible that NCLB and the need to make AYP could be excuses to avoid tackling a controversial morality policy issue, the data collected here suggest otherwise. Thus, in the near term at least, sex education advocates (be they teachers, administrators, policy-makers, community members, or other) must work within the structure of the high-stakes testing environment or determine ways to work around it.

The “C” Word

Among the most unexpected and fascinating findings of this study is the shock over and disparagement of the notion of condom distribution in American schools. Many nations in Western Europe have been dispensing condoms to adolescents in schools for decades. In these nations, individuals in similar positions to those surveyed and interviewed in this study would likely express shock or sarcasm in response to the notion that schools do not distribute condoms to students. Despite vast amounts of evidence to suggest otherwise, Americans still fear that making condoms more available and accessible to youth will encourage or increase the frequency of sexual activity.
Studies indicate that condom education and provision does not hasten the initiation of sexual activity or increase its frequency; the only thing that increases when condoms are made available in schools is the frequency of protected sex (American Academy of Pediatrics, 2001; Blake et al., 2003; Dodge et al., 2009; Furstenberg et al., 1997; Kirby, 2002a; Schuster, et al., 1998). Hence, the increasing incidence of adolescent pregnancies and STI acquisitions indicate a pressing need for available and accessible contraception for young people.

Condom availability programs and school-based or school-linked health clinics that provide condoms as well as other sexual health services have demonstrated immense potential in increasing condom use among students without increasing the frequency of sexual activity or hastening its onset, yet the results of this study indicate that many educational professionals feel that such programs are politically unfeasible in their school districts. However, just as the public opinion data on sex education suggests that the majority of parents support classes that provide their children with information about condoms and contraception, there is also research to suggest that a majority of parents support the idea of making condoms and contraceptives available to them as well. A recent study by Eisenberg, Bernat, Bearinger, and Resnick (2009) of parents with children in Minnesota public schools revealed that 60% of these parents believed that condoms should be made available in high schools. Sixty-two percent agreed that making condoms available in schools would reduce the risk of teen pregnancy and 58% disagreed that making condoms available would cause more student to become sexually active. Also similar to the public opinion data on sex
education, these data on condom availability in schools differed significantly across certain participant characteristics. For instance, Born Again (i.e., evangelical) Christians and politically conservative parents were less likely to believe that condom provision in schools would reduce teen pregnancy and less likely to support school-based condom availability programs. Overall, however, their data suggested that parents are more supportive of condom provision than the participants in this study may have previously thought.

Earlier in this dissertation, I introduced the concept of The Four As of Contraception: availability, accessibility, affordability, and acceptability. These four As are listed in sequential order. Availability is the first step. Young people cannot access what is not available to them, and even if contraception is both available and accessible to teens, these factors do not ensure that they will use it. At this point, cost and social norms (i.e., affordability and acceptability) influence the likelihood of usage. In other words, simply making condoms available in schools will not necessarily increase the frequency of protected sex. Research by Brown, Pennylegion, and Hillard (1997) on student perceptions of a condom availability program in Seattle public schools revealed that one of largest concerns students have about obtaining condoms at school is privacy; students favor obtaining condoms from baskets in private areas of school-based clinics over acquiring them from vending machines. The research suggests that most likely recipe for success in this area includes free condom availability in schools in conjunction with sex education that not only provides instruction on proper usage, but also promotes a culture of responsibility around condom use and safer sex practices.
While the expression, “easier said than done” may come to mind at the mention of such recommendations, it is important to remember that the public opinion data discussed here reinforce that educational professionals’ fear of backlash is predominantly speculative and unsubstantiated. Further, Santelli’s research on the reduction in teen pregnancy rates in the late 90s and early 2000s that indicated that three-quarters of the decline was due specifically to improved contraceptive usage reinforces the need for school-based condom education and provision.

**Theoretical Implications**

School district level policy making is a function of multiple competing interests. Schools in Pennsylvania and across the nation must operate with limited funding, weighty standardized testing demands, and a variety of unique student circumstances, including transience, language barriers, and poverty. As a result, Health (the subject within which sex education is typically offered) falls very low on the list of priorities. When sex education is addressed, it tends to be for a very short period of time. As a consequence, not very much content can be covered. The data collected in this study suggest that in most cases, time and resources constrain sex education course content more than controversy does. Most of the Health teachers that I surveyed indicated that they felt they had a great deal of freedom in curriculum design and/or program selection, but have very little class time with their students. During this limited amount
of class time, these teachers must cover a variety of Health topics (e.g., nutrition, drugs and alcohol) in addition to sex education.

Most teachers and administrators see a connection between the sex education their schools provide and the teen pregnancy, birth, and STI rates in their communities, but feel that there are simply other more pressing needs that must be attended to first. Consider Maslow’s hierarchy of needs (1943), according to which all human beings have a need for respect and self-esteem, but must meet their more basic physiological needs (e.g., food, water, shelter) first. In much the same way, in the educational hierarchy of needs, all schools wish to improve the quality of their students’ lives and communities, but first they have to keep their lights on and doors open, which ultimately means improving student standardized test scores. Making AYP directly affects the survival of the organizations; improving adolescent sexual health indicators, on the other hand, does not.

While the time, money, and testing conundrum has a premiere role in the sex education policy process, it is by no means the only star in the show. Beliefs and values about adolescent sexuality also affect this process in many school districts. The theory that attitudes and decisions about morality policy issues differ from non-morality policy issues is still relevant to this particular topic, but there are several additions and conditions that must be applied. Sex education is without question a morality policy issue. It is divisive and controversial because it involves the perceived inherent rightness or wrongness of adolescent sexual activity, but its controversiality and importance are overshadowed by the behemoth of NCLB. In attempting to determine
the factors that influence the design or adoption of morality policies at the local school district level, we require an expanded model that accounts not only for the controversial aspects of these issues and the moral beliefs of the individuals within the communities, but also the other policy issues and concerns with which the morality policy issue must compete, and the perceived priority or relative importance of each.

Hilgartner and Bosk’s public arenas model (1988) may offer some insight into what additional components this revised model would need to contain. According to the public arenas model, public attention is a scarce resource and issues compete with one another for that attention. Issues compete in different arenas, or environments, each of which has a fixed carrying capacity, meaning that each arena can only deal with so many issues at a time. The model also purports that a variety of institutional, political, and cultural factors influence an issue’s likelihood of “selection,” as do interactions and communications between arenas and actors within those arenas. A classic example of natural selection in the policy environment, the issues that are perceived as stronger and more powerful survive, while those that are seen as being weaker and of lesser importance die out, or fail to receive attention. AYP is not objectively more important or more serious than adolescent pregnancy or STI prevention, but the public arenas model illustrates how it has come to be seen that way and how it has managed to continue beating out other issues for attention and maintain its priority status. Given that educational institutions (like all institutions) have finite carrying capacities, certain principles drive the selection of issues to be addressed,
including drama, novelty and saturation, culture, politics, and characteristics specific to
the organization in question (i.e., school or district characteristics).

Rogers’ (2003) Diffusion of Innovations theory, which describes how ideas or
innovations spread through a social system, purports that there are five elements that
influence an innovation’s adoption: (1) relative advantage, (2) compatibility, (3)
complexity, (4) triability, and (5) observability. Wilson, Pruitt, and Goodson (2008) used
the Diffusion of Innovations theory to assess the indicators that influence the adoption
of abstinence-only-until-marriage sex education programs in Texas middle schools and
found that relative advantage and compatibility were the two most significant
predictors; the middle school principals most likely to adopt these programs strongly
believed that they provided important advantages and perceived them to be consistent
with their beliefs and values. The findings of this study helped break these two
elements down even further.

The relative advantage of a sex education program or policy is a function of the
perceived needs or problems needing to be addressed and any constraints or competing
issues or interests. Its compatibility is a function of the degree to which it is consistent
with the values and desires of the decision-makers and the larger community. This
study has demonstrated that sex education policy adoption is not solely determined by
the progressive or orthodox proclivities of the decision-makers, but also by the
perceived needs and problems in the community pertaining to adolescents and sexual
health, local environmental characteristics (e.g., racial demographics, political
ideologies, religiosity, and wealth), and constraints and conflicting issues/interests
within the districts (e.g., funding constraints, standardized testing requirements). Each of these influential indicators is illustrated in Figure 7-1. The surveys demonstrated that individuals and organizations outside the district (e.g., parents, interest groups, politicians) do not exert much influence on the process of program selection or design unless those within the district are already amenable to their opinions and/or services. They are therefore not included in this model.

Fig. 7-1: Influences on Sex Education Program/Policy Adoption
Relative advantage is defined by Rogers (2003) as the degree to which an innovation is perceived as better than the idea that precedes it. The data yielded by this study suggest that the relative advantages of sex education approaches (e.g., abstinence-only, comprehensive) and/or features (e.g., duration, content) are not only influenced by the manner in which they respond to perceived needs or problems needing to be addressed, but also by the other issues and interests they must compete with or are constrained by. Sex education approaches and features are not always the “innovations” in question; sometimes the innovation is sex education in and of itself. The most common competing interest according to the participants in this study is the need for schools and school districts to make AYP. Consequently, the need to improve standardized test scores constrains the time and resources that can be devoted to Health (and sex) education and in effect, the sex education program with the greatest relative advantage is one that is cheap and takes a minimal amount of time to implement; regardless of approach or content, there are opportunity costs associated with spending time and resources on sex education.

Earlier in the survey results chapter I explained that many teachers felt that they had a great deal of freedom and autonomy in designing the content of their curricula, and that they were the “street level bureaucrats” who made the final decisions about the sex education that was provided to the students. However, their freedom and autonomy are also constrained by these larger competing issues, and their curriculum topic choices are hence affected by these constraints. In other words, they may have the freedom to choose the topics they wish to cover in their classes, but when the
amount of face time they have with students is so brief, the issue becomes less about which approach to sex education they wish to adopt and more about how much (or how little) time will they have to teach sex education (in addition to other Health topics) at all.

The moral beliefs component of the model reflects the orthodox or progressive inclinations of the individual decision-maker him or herself, whereas the environment component involves the cultural norms (i.e., orthodox or progressive inclinations at the community level) of the larger community. Rogers (2003) defines compatibility as the degree to which an innovation is perceived as being consistent with the existing values, past experiences, and needs of potential adopters. The contribution of these results to this theory is the distinction between the values, experiences, and needs of the individual decision-maker versus those of the community at large.

Let us look once more to Foxburgh School District. The Health teachers perceived a problem with teen pregnancy in their district and a need for sex education that would do a more effective job in combating it. Their school board agreed and therefore approved their request to implement a comprehensive sex education curriculum. Both Health teachers recognized that there was more the district could be doing to improve its efforts (e.g., start with younger grade levels, spend more time covering sex education), but cited several constraints that got in the way of these types of changes, including competition with other subject areas and standardized testing demands. Hence, shifting to a comprehensive approach had a relative advantage over the status quo because of the perceived teen pregnancy problem, but the advantages of
expanding into additional grades or increasing the time frame allotted in the existing grades were outweighed by the impacts of the PSSAs along with other constraints. With regard to compatibility, Jim Cramer and Molly Winston’s advocacy for comprehensive sex education was not connected to their personal beliefs about the (im)propriety of adolescent sexual activity, but rather to their belief that they and their district had a moral obligation to provide their students with the information they need to reduce their risk of unplanned pregnancy and STI acquisition; they believed that keeping this information from the students would be the immoral act. Given the lack of controversy or complaints from the community, this shift was obviously compatible with the larger community served by this school district as well.

At the national and state levels, advocates of more abstinence-heavy sex education as well as those of more comprehensive sex education both have the best interests of the youth at heart, but they disagree on what those best interests are, and as a result, feel that their opponents are doing young people some kind of harm. The battles in the war over sex education are not shouting matches in which the person who shouts the loudest wins; the combatants are speaking different languages. Their arguments are incompatible with one another and hence result in a stalemate every time. From a policy perspective, the sex education debate is all a matter of framing; there are clear solutions, but they are dependent upon how the problem is phrased. From a theoretical perspective though, while American attitudes about the normality and/or propriety of premarital and adolescent sexuality are generally shifting more toward the left, as are our attitudes on many other social issues (Page & Shapiro, 1992),
we are far from reaching consensus on the topic. On the local level, we find that some of the rhetoric and controversy at the national and state levels filter down and affect school district sex education decisions, but that they are far less crucial than the regular, everyday obstacles faced by public school teachers and administrators, the largest of which are the standardized testing demands of NCLB.

The Future of Sex Education

Future Research

To obtain a complete picture of sex education in Pennsylvania schools, a larger scale investigation is needed. Due to time and resource constraints, I examined the policies and programs in place in a sample of 29 districts. Future research should focus on investigating the policies and programs in place in the remaining 471 districts. The classic quantity versus quality debate is undoubtedly a concern; the most efficient method of conducting a census type investigation is with paper or e-mail surveys. Such an investigation would elicit information from a great deal more districts, but would not necessarily gain as much information per district as I obtained in this study. Further, the quality of the information I obtained was far richer and more vivid because speaking with participants (either over the phone or in person) allowed me the opportunity to probe for more detailed information and hear and/or see the participants’ emotional and physical reactions to certain topics or questions that I would not have been privy to
on print or electronic surveys. Prospective researchers looking to pick up where this investigation left off will need to strike the balance between breadth and depth based on their specific research questions and resources.

Future research on this topic should also attempt to capture the perspectives of a wider range of individuals involved in the sex education policy adoption process. The inclusion of school board members in future research is critical given their great deal of decision-making authority over sex education policies and programs. Also, while a fair amount of research has been done to assess the attitudes of parents and community members on school-based sex education, very little has been done to assess student attitudes on the subject. While endeavoring to survey minors on any topic involving sex and sexuality is a complicated and tenuous undertaking, future research should aim to take into account the role of students in the sex education policy adoption process.

Additional research is also desperately needed in the arena of program evaluation. At present, there are few evidence-based teen pregnancy, HIV, and STI prevention and/or sex education programs that were designed for and/or evaluated in school settings. Of those that do exist, the settings and/or populations they were designed for and/or evaluated in/with are not generalizeable to other settings or populations. For example, programs designed for and evaluated with inner city African American youth in Philadelphia that have demonstrated effectiveness may not produce similar outcomes with rural white students in Mifflin County. Given the current push for more evidence-based prevention programming at the federal level, additional research
on program evaluation is key in order to expand the selection of effective program offerings available for adoption and implementation at the local school district level.

As of February of 2010, a new study revealed that a theory-based abstinence-only intervention designed for middle school students was effective in delaying the onset of sexual activity (Jemmott, Jemmott, & Fong, 2010). The study had immense implications for the field of adolescent sexual health as it was the first of its kind to demonstrate lasting behavioral outcomes from an abstinence-only program. While this particular program would not have qualified for the federal abstinence-only-until-marriage funding (because it did not satisfy the stringent A-H criteria), it offers the public its first glimpse of what an effective abstinence-only intervention looks like; an abstinence-only program rooted in academic theory\textsuperscript{23} that promotes abstinence \textit{until ready} as opposed to \textit{until marriage} and that does not disparage condom or contraceptive use can play an important role in delaying sexual initiation among adolescents. This results of this study prompt a need for more research on theory-based abstinence-only interventions such as the one described here. It would also be valuable to understand how these programs might be incorporated to larger comprehensive prevention strategies.

\textsuperscript{23} This particular intervention was based on Bandura’s social cognitive theory, Fishbein and Ajzen’s theory of reasoned action, and Azjen’s theory of planned behavior.
A New Paradigm

To date, sex education in the United States has focused on the prevention of pregnancy and disease and/or on the reinforcement of a moral code or set of values around the (im)propriety of pre-marital sex. According to researcher Amy Schalet, there can and should be another way. Schalet’s research on cross-cultural comparisons of perceptions of adolescent sexuality suggests shifting our view of sex education as disease prevention to sexuality education as health promotion (2004). Such is the model adopted by the Dutch, who view sexuality as a natural and normal part of the developmental process and view adolescents as autonomous beings fully capable of making thoughtful and rational choices and of experiencing mature romantic relationships. It is difficult to imagine such a dramatic cultural shift occurring in the United States, but the Dutch have not always adopted this mindset. According to Schalet (2004), Dutch society possessed very traditional attitudes about the impropriety of sex outside of marriage through the mid 1960s. The onset of the sexual revolution and the availability of oral contraceptives (i.e., “the pill”) contributed to a shift in public opinion in which sex outside of marriage was considered normal so long as it was within the context of a relationship. Healthcare professionals, the media, academia, and even clergy facilitated this shift by framing the issue as a public health issue, whereby the logical response to increasing rates of premarital sexual activity was the provision of affordable contraceptives and more in-depth and longer-term education. Several decades later, the Netherlands has among the lowest rates of adolescent pregnancy,
birth, and STI acquisition in the developed world and adolescents are respected as capable and responsible members of society.

There are many complications involved with shifting to such a drastically different paradigm within the United States, however. For one, Dutch society is fairly racially and ethnically homogenous, whereas the U.S. is the most racially and ethnically diverse nation in the world. Second, wealth is for more evenly distributed in the Netherlands than in the United States, where the top 1% of the American population controls nearly half of the country’s wealth. Third, and perhaps most importantly, American culture is not Dutch culture. On this third point, however, one must recognize that modern Dutch culture is much changed from Dutch culture 50 years ago; their attitudes then were just as restrictive (if not more restrictive) as American attitudes about adolescent sexuality then and now. In the case of the Netherlands, cultural change occurred because of the combined efforts of a range of social institutions (health, family, religion, education, government, and media) and while attitudes on adolescent sexuality are now extremely accepting, the initial impetus for change was not attitudinal change, but rather public health concerns.

In much the same way I believe the United States is capable of shifting to such a paradigm if we, like the Dutch, first address the issue of adolescent sexuality as a public health issue as opposed to as a moral issue. Further, this approach must be adopted and accepted by most, if not all, of the aforementioned social institutions. The American medical establishment has endorsed the public health position for nearly a century, but has faced opposition from religious and governmental establishments,
ignorance and/or incapacity from the educational and familial institutions, and conflicting messages from the media. At a national summit on sex education in Washington, D.C. in November of 2009, William Smith, Vice President of Public Policy at the Sexuality Information and Education Council of the United States (SIECUS), echoed the sentiments expressed by Cahn and Carbone (2008), Doan and Williams (2008), Irvine (2002), and Luker (2006). He asserted that the abstinence-only sex education movement was never really about having sex or not having sex; it has always been about a larger agenda involving women’s rights, gay rights, reproductive rights, and youth rights, issues at the heart of the American culture wars. While these wars are by no means fading, there is evidence to suggest that the battles over the issue of providing young people with information about sex are dying down. One of the reasons for this occurrence, however, has nothing to do with individual attitudes and beliefs about adolescent sexuality, but more to do with competing priorities and a finite pool of resources. Regardless, public opinion data is demonstrating a desire amongst most Americans for school based sex education that is medically accurate and provides young people with information and skills pertaining to abstinence as well as condoms and contraceptives. Even in a hypothetical environment where limited resources and competing priorities are non-issues, sex education’s volatility as a morality policy issue would still exist. The degree to which and how this volatility will impact and/or constrain programming in the future will depend on the desire and ability of decision-makers at the national, state, and local levels to conceive of sex education as a matter of public health, as the Dutch have done. In the meantime, we will continue to be subject
to the shouting matches between the heathens who want to sexualize our children and
the ideologues who deny youth their rights to life-saving information.


Maternal and Child Health Federal Set-Aside Program; Special Projects of Regional and National Significance; Community-Based Abstinence Education Project Grants, 42 U.S.C. 701(a)(2) (2000).


National Public Radio, Kaiser Family Foundation, & Kennedy School of Government.  

National Public Radio, Kaiser Family Foundation, & Kennedy School of Government.  


Pennsylvania Department of Health. Epidemiologic query and mapping system.
Retrieved from http://app2.health.state.pa.us/epiqms/Asp/ChooseDataset.asp


U.S. Const., amend. X.


Appendix A

Section 510 of Title V of the Social Security Act

SEPARATE PROGRAM FOR ABSTINENCE EDUCATION

SEC. 510. [42 U.S.C. 710] (a) For the purpose described in subsection (b), the Secretary shall, for fiscal year 1998 and each subsequent fiscal year, allot to each State which has transmitted an application for the fiscal year under section 505(a) an amount equal to the product of—

(1) the amount appropriated in subsection (d) for the fiscal year; and

(2) the percentage determined for the State under section 502(c)(1)(B)(ii).

(b)(1) The purpose of an allotment under subsection (a) to a State is to enable the State to provide abstinence education, and at the option of the State, where appropriate, mentoring, counseling, and adult supervision to promote abstinence from sexual activity, with a focus on those groups which are most likely to bear children out-of-wedlock.

(2) For purposes of this section, the term “abstinence education” means an educational or motivational program which—

(A) has as its exclusive purpose, teaching the social, psychological, and health gains to be realized by abstaining from sexual activity;

(B) teaches abstinence from sexual activity outside marriage as the expected standard for all school age children;

(C) teaches that abstinence from sexual activity is the only certain way to avoid out-of-wedlock pregnancy, sexually transmitted diseases, and other associated health problems;

(D) teaches that a mutually faithful monogamous relationship in the context of marriage is the expected standard of human sexual activity;

(E) teaches that sexual activity outside of the context of marriage is likely to have harmful psychological and physical effects;
(F) teaches that bearing children out-of-wedlock is likely to have harmful consequences for the child, the child's parents, and society;

(G) teaches young people how to reject sexual advances and how alcohol and drug use increases vulnerability to sexual advances; and

(H) teaches the importance of attaining self-sufficiency before engaging in sexual activity.

(c)(1) Sections 503, 507, and 508 apply to allotments under subsection (a) to the same extent and in the same manner as such sections apply to allotments under section 502(c).

(2) Sections 505 and 506 apply to allotments under subsection (a) to the extent determined by the Secretary to be appropriate.

(d) For the purpose of allotments under subsection (a), there is appropriated, out of any money in the Treasury not otherwise appropriated, an additional $50,000,000 for each of the fiscal years 1998 through 2003[14]. The appropriation under the preceding sentence for a fiscal year is made on October 1 of the fiscal year.

Appendix B

Teen Pregnancy, Teen Abortion, Divorce, and Church Attendance by State

<table>
<thead>
<tr>
<th>State</th>
<th>Teen Pregnancy Rate Rank&lt;sup&gt;24&lt;/sup&gt;</th>
<th>Teen Abortion Rate Rank&lt;sup&gt;25&lt;/sup&gt;</th>
<th>Divorce Rate&lt;sup&gt;26&lt;/sup&gt;</th>
<th>Church Attendance&lt;sup&gt;27&lt;/sup&gt;</th>
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<sup>24</sup> Year: 2000  
<sup>25</sup> Year: 2000  
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<sup>27</sup> Year: 2006
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<td>West Virginia</td>
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<td>46</td>
<td>5.0</td>
<td>46%</td>
</tr>
<tr>
<td>Wisconsin</td>
<td>42</td>
<td>43</td>
<td>3.0</td>
<td>43%</td>
</tr>
<tr>
<td>Wyoming</td>
<td>24</td>
<td>14</td>
<td>5.2</td>
<td>36%</td>
</tr>
</tbody>
</table>
Appendix C

United States Census Bureau New Urban-Centric Locale Codes

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>City, Large</td>
<td>Territory inside an urbanized area and inside a principal city with population of 250,000 or more.</td>
</tr>
<tr>
<td>City, Midsize</td>
<td>Territory inside an urbanized area and inside a principal city with population less than 250,000 and greater than or equal to 100,000.</td>
</tr>
<tr>
<td>City, Small</td>
<td>Territory inside an urbanized area and inside a principal city with population less than 100,000.</td>
</tr>
<tr>
<td>Suburb, Large</td>
<td>Territory outside a principal city and inside an urbanized area with population of 250,000 or more.</td>
</tr>
<tr>
<td>Suburb, Midsize</td>
<td>Territory outside a principal city and inside an urbanized area with population less than 250,000 and greater than or equal to 100,000.</td>
</tr>
<tr>
<td>Suburb, Small</td>
<td>Territory outside a principal city and inside an urbanized area with population less than 100,000.</td>
</tr>
<tr>
<td>Town, Fringe</td>
<td>Territory inside an urban cluster that is less than or equal to 10 miles from an urbanized area.</td>
</tr>
<tr>
<td>Town, Distant</td>
<td>Territory inside an urban cluster that is more than 10 miles and less than or equal to 35 miles from an urbanized area.</td>
</tr>
<tr>
<td>Town, Remote</td>
<td>Territory inside an urban cluster that is more than 35 miles from an urbanized area.</td>
</tr>
<tr>
<td>Rural, Fringe</td>
<td>Census-defined rural territory that is less than or equal to 5 miles from an urbanized area, as well as rural territory that is less than or equal to 2.5 miles from an urban cluster.</td>
</tr>
<tr>
<td>Rural, Distant</td>
<td>Census-defined rural territory that is more than 5 miles but less than or equal to 25 miles from an urbanized area, as well as rural territory that is more than 2.5 miles but less than or equal to 10 miles from an urban cluster.</td>
</tr>
<tr>
<td>Rural, Remote</td>
<td>Census-defined rural territory that is more than 25 miles from an urbanized area and is also more than 10 miles from an urban cluster.</td>
</tr>
</tbody>
</table>
Appendix D

Sex Education Policies and Programs Survey

I have several questions to ask you about sex education in your school district. By sex education I’m referring to any classes or talks in school that discuss the basics of human reproduction, dating and relationships, abstinence, AIDS, pregnancy prevention, and the like. These topics may have been taught in a separate sex education course, as part of another course, like health or science, or as independent lessons in the school auditorium or gym.

1. Using this definition, has sex education been taught in your school district during the last two years?

☐ Yes
☐ No
☐ Don’t know
☐ Refused

2. Was sex ed taught in your school district PRIOR to two years ago?

☐ Yes
☐ No
☐ Don’t know
☐ Refused

3. Does your school district have a formal written policy about sex education?

☐ Yes
☐ No
☐ Don’t know
If yes... can you provide a copy?

4. Have there been any significant changes in your school district’s sex ed curriculum over the past two years?

☐ Yes
☐ No
☐ Don’t know
☐ Refused

If yes...

a. Can you describe these changes for me?

5. What grade or grades receive sex education in your school district?

☐ Kindergarten
☐ First grade
☐ Second grade
☐ Third grade
☐ Fourth grade
☐ Fifth grade
☐ Sixth grade
☐ Seventh grade
☐ Eighth grade
☐ Ninth grade
6. In your school district, is sex ed taught as a separate sex ed course, as part of another course, or as specific lessons taught independently of any other course?

☐ Separate sex ed course

☐ Part of another course

☐ Specific lessons taught independently of any other course

☐ Don’t know

☐ Refused

*If part of another course...*

a. What course is it part of?

☐ Health class

☐ Physical education/gym

☐ Biology/Science

☐ Family/Consumer science

☐ Life management/Living skills

☐ Taught in more than one course

☐ Other (Specify:  )

☐ Don’t know
7. Many companies and organizations put together pre-packaged programs or curricula for sex education. Does your school district or do any of the schools make use of pre-packaged sex education programs or curricula?

☐ Yes
☐ No
☐ Don’t know
☐ Refused

*If yes...*

a. Which pre-packaged sex education programs or curricula does your district use?

*If no...*

b. Who designs the content of your sex education programs or curricula?

8. Sometimes school districts or individual schools will hire outside individuals or agencies to provide sex education services. Does your school district or any of the schools within it contract with an outside individual or organization to provide sex education classes or programs?

☐ Yes
☐ No
☐ Don’t know
☐ Refused

*If yes...*
a. What is the name of the person or organization that the school or district contracts with to provide sex education services?

If sex ed was not taught as part of a class...

b. If no sex education classes are offered, are there other assemblies, guest speakers, or other events related to sex ed in any of the schools in the district?

☐ Yes
☐ No
☐ Don’t know
☐ Refused

9. How would you describe your school district’s approach to sex ed?

10. I’d like to read you a series of statements and ask you to state which of these statements you believe best corresponds with your school district’s approach to sex education?

☐ A) Abstinence from sexual intercourse is best for teens. Sex ed classes do not provide information about condoms and other contraceptives.

☐ B) Abstinence from sexual intercourse is best for teens but some teens do not abstain, so information about condoms and other contraception is provided.

☐ C) Abstinence from sexual intercourse is not the most important thing. We teach teens to make responsible decisions about sex.

☐ D) Something else:

☐ Don’t know
☐ Refused
11. How long does sex education typically last for students in your school district?

☐ One class period

☐ Several class periods or special sessions

☐ One to two weeks

☐ Half of a semester or a quarter

☐ Entire semester

☐ A school year

☐ Something else:

☐ Don’t know

☐ Refused

12. Overall, do you think your school district spends too little time, too much time, or the right amount of time to teach sex education properly?

☐ Too little time

☐ Too much time

☐ The right amount of time

☐ Don’t know

☐ Refused

a. Why?

13. Who is responsible for teaching sex education in your district?

☐ Health teacher

☐ Physician or nurse
14. How much training have these teachers in your school received for teaching sex ed?

   a. Do you think this amount of training is adequate?

   *If no...*

   b. Why not? What do you think is missing?

15. Can you describe the training that these teachers receive for teaching sex ed?

16. Does the district or do any of the schools in the district offer trainings, workshops, or other professional development opportunities for teachers or other school personnel regarding sex education?

   □ Yes
   □ No
   □ Don’t know
   □ Refused
If yes...

a. Could you describe what these trainings, workshops, or other professional development opportunities entail?

17. Does the district or do any of the schools in the district send teachers or other school personnel to trainings, workshops, or other professional development opportunities regarding sex ed offered elsewhere?

[ ] Yes
[ ] No
[ ] Don’t know
[ ] Refused

If yes...

a. Who offers these trainings, workshops, or other professional development opportunities?

18. Are students required to take sex ed or is it optional?

[ ] Required
[ ] Optional
[ ] Don’t know
[ ] Refused

19. Which of the following best describes your school district’s policy about sex ed?

[ ] A) Parents have to give permission for their child to take sex ed.
[ ] B) Parents are notified of sex ed, but don’t have to sign a permission slip
[ ] C) Parents are not notified and do not have to sign a permission slip
20. Last year, roughly what percentage of parents, if any, did not allow their children to take sex ed either by not giving permission or taking them out of sex ed?

Don’t know
Refused

21. Do you think the federal government’s abstinence-only funding has had any influence in deciding what topics your district’s sex ed curriculum covers?

Yes
No
Don’t know
Refused

If yes...

a. How do you think the federal government’s abstinence-only funding has affected the topics covered in the sex ed curriculum? Can you describe the nature of that influence?

If no...

b. Why don’t you think so?

22. Do you think your state government had any influence in deciding what topics the sex ed curriculum covers?

Yes
No
Don’t know
Refused

If yes...

a. How do you think the state government has affected the topics covered in the sex ed curriculum? Can you describe the nature of that influence?

If no...

b. Why don’t you think so?

23. Do you think your school board had any influence in deciding what topics the sex ed curriculum covers?

☐ Yes

☐ No

☐ Don’t know

☐ Refused

If yes...

a. How do you think the school board has affected the topics covered in the sex ed curriculum? Can you describe the nature of that influence?

If no...

b. Why don’t you think so?

24. In recent years, how often has someone in your community written a letter to a newspaper regarding sex education?
If letters were written...

a. Can you describe the aim or content of these letters?

25. Has someone in the community ever contacted you, one of the teachers, or someone else regarding sex education?

☐ Yes
☐ No
☐ Don’t know
☐ Refused

If yes...

a. How many times did this occur?

b. Can you describe in more detail the nature of these discussions?

26. Has a political candidate ever raised sex education as an election issue in your district?

☐ Yes
☐ No
☐ Don’t know
☐ Refused

If yes...

a. How many times did this occur?
b. Can you describe in more detail the manner in which this political candidate raised sex education as an election issue?

27. Were you or someone else in your school district ever contacted by an elected official regarding sex ed?

☐ Yes
☐ No
☐ Don’t know
☐ Refused

If yes...

c. How many times did this occur?

d. Can you describe in more detail the nature of these discussions?

28. Were you or someone in your school district ever contacted by a community or religious leader about sex ed?

☐ Yes
☐ No
☐ Don’t know
☐ Refused

If yes...

a. How many times did this occur?
29. Were you or someone in your school district contacted by a family planning group such as Planned Parenthood about sex ed?

☐ Yes
☐ No
☐ Don’t know
☐ Refused

*If yes...*

a. How many times did this occur?

b. Can you describe in more detail the nature of these discussions?

30. Were you or someone in your school district contacted by an abstinence-only-until-marriage advocacy group about sex ed?

☐ Yes
☐ No
☐ Don’t know
☐ Refused

*If yes...*

c. How many times did this occur?

d. Can you describe in more detail the nature of these discussions?
31. Who is responsible for making decisions about sex education in this school district? Name all who apply. (Examples include...)

☐ Superintendent

☐ School board

☐ School principal(s)

☐ School teacher(s)

☐ Other; Specify:

☐ Don’t know

☐ Refused

32. How involved were parents in deciding what topics your district’s sex ed curriculum would cover?

a. Can you describe in more detail the nature of that involvement?

33. How involved was the school board in deciding what topics your district’s sex ed curriculum would cover?

a. Can you describe in more detail the nature of that involvement?

34. How involved were school administrators, such as the superintendent, in deciding what topics your district’s sex ed curriculum would cover?
35. How involved were teachers in deciding what topics your district’s sex ed curriculum would cover?

a. Can you describe in more detail the nature of that involvement?

36. How involved were students in deciding what topics your district’s sex ed curriculum would cover?

a. Can you describe in more detail the nature of that influence?

37. How involved were local religious leaders in deciding what topics your district’s sex ed curriculum would cover?

a. Can you describe in more detail the nature of that influence?

38. How involved were politicians, such as the governor or your local city council, in deciding what topics your district’s sex ed curriculum would cover?

a. Can you describe in more detail the nature of that influence?

39. How involved were other community members in deciding what topics your district’s sex ed curriculum would cover?
a. Can you describe in more detail the nature of that influence?

40. How involved were family planning groups such as Planned Parenthood in deciding what topics your district’s sex ed curriculum would cover?

a. Can you describe in more detail the nature of that influence?

41. How involved were groups advocating abstinence-only-until-marriage in deciding what topics your district’s sex ed curriculum would cover?

a. Can you describe in more detail the nature of that influence?

42. Finally, how involved were physicians and nurses in deciding what topics your district’s sex ed curriculum would cover?

a. Can you describe in more detail the nature of that influence?

43. We’ve discussed the involvement of a variety of groups in the sex education decision-making process, including parents, the school board, school administrators, teachers, students, religious leaders, politicians, community members, family planning groups, abstinence-only-until-marriage advocacy groups, and physicians and nurses. Can you think of any other individuals or groups who were involved in deciding what topics your district’s sex ed curriculum would cover?

☐ Yes

☐ No
If yes...

a. Specify:

b. Can you describe in more detail the nature of this group’s influence?

44. Do you think there has been more debate or controversy in your community over sex education during the last few years?

☐ Yes
☐ No
☐ Don’t know
☐ Refused

If yes...

a. Can you elaborate on this further?

b. Would you describe these discussions or debates as very calm, somewhat calm, somewhat heated, or very heated?

☐ Very calm
☐ Somewhat calm
☐ Somewhat heated
☐ Very heated
☐ Don’t know
c. Did these discussions result in any changes in the sex ed curriculum?
   - Yes
   - No
   - Don’t know
   - Refused

45. Over the past couple of years, have there been discussions or debate in the PTA, the school board, or at any public meetings about whether or not to teach sex ed at all?
   - Yes
   - No
   - Don’t know
   - Refused

   *If yes...*

   a. Can you describe the aim or content of these discussions or debates?

   b. Would you describe these discussions as very calm, somewhat calm, somewhat heated, or very heated?
      - Very calm
      - Somewhat calm
      - Somewhat heated
      - Very heated
      - Don’t know
      - Refused
c. Did these discussions result in any changes in the sex ed curriculum?

☐ Yes
☐ No
☐ Don’t know
☐ Refused

46. Have there been discussions or debate about what topics to teach in sex ed, such as birth control or sexual orientation?

☐ Yes
☐ No
☐ Don’t know
☐ Refused

If yes...

a. Can you describe the aim or content of these discussions or debates?

b. Would you describe these discussions as very calm, somewhat calm, somewhat heated, or very heated?

☐ Very calm
☐ Somewhat calm
☐ Somewhat heated
☐ Very heated
☐ Don’t know
☐ Refused

c. Did these discussions result in any changes in the sex ed curriculum?
47. Has there been discussion or debate over teaching abstinence only?

☐ Yes
☐ No
☐ Don’t know
☐ Refused

If yes...

a. Can you describe the aim or content of these discussions or debates?

b. Would you describe these discussions as very calm, somewhat calm, somewhat heated, or very heated?

☐ Very calm
☐ Somewhat calm
☐ Somewhat heated
☐ Very heated
☐ Don’t know
☐ Refused

c. Did these discussions result in any changes in the sex ed curriculum?

☐ Yes
48. Has there been discussion or debate over how parents give permission for their children to take or be taken out of sex ed?

☐ Yes
☐ No
☐ Don’t know
☐ Refused

If yes...

a. Can you describe the aim or content of these discussions or debates?

b. Would you describe these discussions as very calm, somewhat calm, somewhat heated, or very heated?

☐ Very calm
☐ Somewhat calm
☐ Somewhat heated
☐ Very heated
☐ Don’t know
☐ Refused

c. Did these discussions result in any changes in the sex ed curriculum?

☐ Yes
☐ No
49. Does your school’s health program currently make condoms available to students who ask for them?

☐ Yes
☐ No
☐ Don’t know
☐ Refused

50. Finally, is there anything you would like to add about sex education in your school district that we haven’t covered here?
Appendix E

School District Case Study Interview Protocol

1. What is your position in X School District? How long have you been in this position?

2. Describe for me what sex education consists of in your district?
   a. What grade levels get it?
   b. How long does it last in each grade?
   c. Where/how do students receive it?
   d. Who provides it? (e.g., teachers, outside agencies)
   e. Who designs the content? (e.g., teachers, pre-packaged programs?)

3. Describe the demographics of the students and families that your school district serves?
   a. Race
   b. Income
   c. Rural/Urban
   d. Political Ideology
   e. Religion
   f. Education Level

4. How do you think these different characteristics impact sex education in your district?

5. Has sex education ever been a topic of debate or controversy in your school district?
   a. Why or why not?
   b. Provide examples/anecdotes
   c. Was it controversial in the past (history)?
6. How does the sex education programs or curricula in your school district conflict or correspond with your attitudes and beliefs about adolescent sexuality?

7. In your opinion, what do you believe is the purpose(s) of sex education? What goals should it work toward?

8. How do you think your district is doing in achieving this goal(s)?
   a. How do you think you could improve your effects?
   b. What do you see as the biggest obstacles to reaching this goal(s)?

9. Are you concerned about teen pregnancy and childbearing in your community?
   a. Do you know the teen pregnancy and birth rates in this community?

10. Are you concerned about STI acquisition among teens in your community?
    a. Do you know the rates of STI acquisition among teens in your community?

11. Do you think the schools can do anything to reduce the rates of teen pregnancy, birth, and STI acquisition?

12. How, if at all, do you think the PSSAs and the need to make adequate yearly progress (AYP) impact the development of sex education policies and programs?

13. Do you think student health and health education more generally are viewed as priorities within this school district?

14. Do you think the student sexual health and sexual health education more specifically are viewed as priorities within this school district?
# Appendix F

## NCLB School Improvement Sanctions

<table>
<thead>
<tr>
<th>Year</th>
<th>Sanctions</th>
</tr>
</thead>
<tbody>
<tr>
<td>First year</td>
<td>• Did not make AYP (no sanctions)</td>
</tr>
<tr>
<td>Second year</td>
<td>• Did not make AYP (no sanctions)</td>
</tr>
<tr>
<td>Third year</td>
<td><strong>Year 1: Improvement</strong> &lt;br&gt;• School must write a school improvement plan  &lt;br&gt;• School must offer choice</td>
</tr>
<tr>
<td>Fourth year</td>
<td><strong>Year 2: Improvement</strong> &lt;br&gt;• School must offer choice  &lt;br&gt;• School must offer supplementary education services (SES)</td>
</tr>
<tr>
<td>Fifth year</td>
<td><strong>Year 3: Corrective Action</strong> &lt;br&gt;• School must offer choice  &lt;br&gt;• School must offer SES  &lt;br&gt;• School must take one corrective action</td>
</tr>
<tr>
<td>Sixth year</td>
<td><strong>Year 4: Restructuring</strong> &lt;br&gt;• School must offer choice  &lt;br&gt;• School must offer SES  &lt;br&gt;• School must plan to restructure</td>
</tr>
<tr>
<td>Seventh year</td>
<td><strong>Year 5: Implement Restructuring Plan</strong> &lt;br&gt;• School operates under alternative governance arrangement</td>
</tr>
</tbody>
</table>

### A School Improvement Plan must

- Be developed in consultation with parents, school staff, the local educational agency and outside experts;
- Cover a two year period;
- Be written within the first three months of being identified as a school In Need of Improvement;
- Incorporate strategies based on scientifically based research;
- Adopt policies and practices that have the greatest likelihood of ensuring that all groups of students meet the State's proficient level of achievement on the State academic assessment;
- Assure that the school will spend not less than 10 percent of their Title I allocation for each year they are in school improvement status for the purpose of providing to the school's teachers and principal high-quality professional development;
- Specify how the funds reserved as part of the Title I allocation will be used to remove the school from school improvement status;
• Establish specific annual, measurable objectives for continuous and substantial progress by each group of students enrolled in the school;
• Describe how the school will provide written notice about the identification to parents of each student enrolled in the school, in a format and, to the extent practicable, in a language that the parents can understand;
• Specify the responsibilities of the school, the LEA, and the State educational agency serving the school to promote effective parental involvement in the school;
• Incorporate, as appropriate, activities before school, after school, during the summer, and during any extension of the school year; and
• Incorporate a teacher mentoring program

Requirements for Public School Choice

• Extra academic assistance for low-income students who are attending Title I schools that have failed to make AYP for three or more years
• Allowable services include tutoring, remediation and academic intervention
• Instruction must be provided outside the regular school day
• Students should be given services for an extended period of time, preferably the entire school year
• Eligible students must be from low-income families, and attending Title I schools in the 2nd year of improvement
• When more students request services than the LEA can fund, the LEA must prioritize serving students from low-income families who are the lowest achieving
• Parents must select a provider from the State-approved list
• Supplemental Educational Service Providers must be approved by the state,
• The State must develop objective criteria, geographically relevant lists for LEAs to use and monitor the quality and effectiveness of the services
• Providers may be a school or LEA, institution of higher education, educational service agency, nonprofit or for-profit entity or a faith-based organization
• Providers must offer high quality instructional strategies, provide services consistent with the LEA's instructional programs and the State's academic content standards, be financially sound and that their instructional program has a demonstrated a record of effectiveness
• Providers that utilize distance learning technology do not have different criteria for eligibility
• Responsibilities of the provider include setting specific achievement goals, describing how the student's progress will be measured, and establishing a timetable for improving the student's achievement
• An LEA must spend an amount equal to at least 5% of its Title I allocation, or up to 20% depending upon the need for choice-related transportation
Requirements for Corrective Action

The district must take one of the following actions:
- Replace school staff relevant to the failure
- Institute and implement a new curriculum
- Significantly decrease management authority in the school
- Appoint outside experts to advise the school
- Extend school year or school day
- Restructure internal organization of the school

Requirements for a Restructuring Plan

School plan must include one of the following alternative governance arrangements:
- Reopen school as a public charter school
- Replace all or most of school staff, including the principal
- Enter into a contract with an entity, such as a private management company, with a demonstrated record of effectiveness to operate the school
- Any other major restructuring of the school's governance arrangement
VITA

Maryjo M. Oster

EDUCATION

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PUBLICATIONS


AWARDS

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