AN ECOLOGICAL EXPLORATION OF YOUTH PERCEPTIONS
OF SEXUALITY EDUCATION NEEDS

by

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DEDICATION

I would like to dedicate this dissertation to my husband Walter Hill. There are no words to adequately express how grateful I am for your unceasing encouragement. You have given me such amazing love and support to fulfill my dreams. You help make my life full, balanced, and beautiful.
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# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>DEDICATION</td>
<td>iii</td>
</tr>
<tr>
<td>ACKNOWLEDGMENTS</td>
<td>iv</td>
</tr>
<tr>
<td>LIST OF TABLES</td>
<td>ix</td>
</tr>
<tr>
<td>LIST OF FIGURES</td>
<td>x</td>
</tr>
<tr>
<td>ABSTRACT</td>
<td>xi</td>
</tr>
<tr>
<td>CHAPTER</td>
<td></td>
</tr>
<tr>
<td>1. INTRODUCTION TO THE STUDY</td>
<td>1</td>
</tr>
<tr>
<td>Statement of the Problem</td>
<td>5</td>
</tr>
<tr>
<td>Statement of Purpose</td>
<td>5</td>
</tr>
<tr>
<td>Research Questions</td>
<td>6</td>
</tr>
<tr>
<td>Research Instrument</td>
<td>7</td>
</tr>
<tr>
<td>Significance of the Study</td>
<td>7</td>
</tr>
<tr>
<td>Theoretical Framework</td>
<td>8</td>
</tr>
<tr>
<td>Definition of Key Terminology</td>
<td>9</td>
</tr>
<tr>
<td>Summary</td>
<td>9</td>
</tr>
<tr>
<td>2. REVIEW OF THE LITERATURE</td>
<td>12</td>
</tr>
<tr>
<td>Approaches to Sexuality Education</td>
<td>14</td>
</tr>
<tr>
<td>Abstinence-Only Sexuality Education</td>
<td>15</td>
</tr>
<tr>
<td>Comprehensive Sexuality Education</td>
<td>22</td>
</tr>
<tr>
<td>Effectiveness of In-School Sexuality Education</td>
<td>22</td>
</tr>
<tr>
<td>School-Based Sexuality Education</td>
<td>25</td>
</tr>
<tr>
<td>Adult Support for School Sexuality Education</td>
<td>27</td>
</tr>
<tr>
<td>Effectiveness of Sexuality Education</td>
<td>27</td>
</tr>
<tr>
<td>Adolescent Sexual Health and Behaviors</td>
<td>34</td>
</tr>
<tr>
<td>Adolescent Development</td>
<td>39</td>
</tr>
<tr>
<td>The Adolescent Brain and Risk-Taking Behaviors</td>
<td>40</td>
</tr>
<tr>
<td>Perceptions of Sexual Behaviors of Peers</td>
<td>44</td>
</tr>
</tbody>
</table>
TABLE OF CONTENTS (Continued)

CHAPTER                        Page

Consequences of Risky Teen Sexual Behaviors                           45
    Teen Pregnancy and HIV                                                46
    Other Sexually Transmitted Diseases                                  47
    Teen Pregnancy                                                        49
Theoretical Framework                                                   54
Adolescent Voice                                                        64
Summary                                                                  69

3. METHODOLOGY .................................................................................. 71

    Research Questions Reiterated                                       72
    Research Design                                                       73
    Research Setting                                                      74
    Research Participants                                                 75
    Data Collection                                                       76
    Data Analysis                                                         79
    Researcher Bias                                                       80
    Summary                                                               81

4. RESULTS ............................................................................................ 82

    Description of the Adolescent Participants                           83
    Perceived Peer Sexual History                                         87
    Content Most Supported by Youth Participants                          92
    Topics Rating of High Importance to Youth                            92
    Controversial Versus Noncontroversial Topics                          95
    Responses by Perceived Sexual History of Friends                     99
    Summary                                                               101

5. DISCUSSION ......................................................................................... 103

    Range of Topics Supported                                             106
    Topics with Highest Ratings                                           108
    School-Based Sexuality Education to Address Teen Pregnancy and STIs.... 109
    Relationship between Participant Attitudes and Perception of Friends 115
    Limitations                                                           120
    Implications for Practice and Research                                120
    Final Thoughts                                                         124
# TABLE OF CONTENTS (Continued)

<table>
<thead>
<tr>
<th>REFERENCES</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>125</td>
</tr>
<tr>
<td>APPENDICES</td>
<td>137</td>
</tr>
<tr>
<td>A   IRB APPROVAL</td>
<td>138</td>
</tr>
<tr>
<td>B   PARENTAL PERMISSION FORM</td>
<td>140</td>
</tr>
<tr>
<td>C   STUDENT INFORMED ASSENT</td>
<td>144</td>
</tr>
<tr>
<td>D   FAMILY LIFE SEXUALITY EDUCATION GOAL QUESTIONNAIRE II</td>
<td>148</td>
</tr>
<tr>
<td>E   DEMOGRAPHIC QUESTIONS</td>
<td>155</td>
</tr>
<tr>
<td>F   GEORGIA BOARD OF EDUCATION RULE 160-4-2-.12</td>
<td>159</td>
</tr>
<tr>
<td>G   PARTICIPANT RATINGS ON ALL FLSEGQ ITEMS</td>
<td>164</td>
</tr>
<tr>
<td>H   PERMISSION TO USE FLSEGQ</td>
<td>169</td>
</tr>
</tbody>
</table>
# LIST OF TABLES

<table>
<thead>
<tr>
<th>Table</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Age of Participants by Gender</td>
</tr>
<tr>
<td>2</td>
<td>Participant Reported History of In-School Sexuality Education</td>
</tr>
<tr>
<td>3</td>
<td>Reported Perceptions of the Number of Friends Who Are or Have Been Sexually Active by Participant Age</td>
</tr>
<tr>
<td>4</td>
<td>Reported Perceptions of the Number of Friends Who Have Been Pregnant or Gotten Someone Pregnant by Participant Age</td>
</tr>
<tr>
<td>5</td>
<td>Goals that 50% or More of Participants Rated “Very Important” or “Somewhat Important”</td>
</tr>
<tr>
<td>6</td>
<td>Sexual Decision-Making: Controversial Factor Dimension</td>
</tr>
<tr>
<td>7</td>
<td>Secondary Prevention: Controversial Factor Dimension</td>
</tr>
<tr>
<td>8</td>
<td>Physical Development: Noncontroversial Factor Dimension</td>
</tr>
<tr>
<td>9</td>
<td>Respect for Diversity: Noncontroversial Factor Dimension</td>
</tr>
<tr>
<td>10</td>
<td>Family Life and Personal Growth: Noncontroversial Factor Dimension</td>
</tr>
<tr>
<td>11</td>
<td>Results for Controversial Goals</td>
</tr>
<tr>
<td>12</td>
<td>Comparison of Georgia Sexual Health Standards and Participants’ Perceived Sexual Health Needs</td>
</tr>
<tr>
<td>13</td>
<td>Connection to Ecological Influences</td>
</tr>
</tbody>
</table>
LIST OF FIGURES

<table>
<thead>
<tr>
<th>Figure</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Levels of Influence in Bronfenbrenner’s Ecological Systems Theory</td>
<td>57</td>
</tr>
<tr>
<td>2</td>
<td>Reported History of No In-School Sexuality Education by Participant Age</td>
<td>86</td>
</tr>
<tr>
<td>3</td>
<td>Percentage of Participants Who Reported They Perceived that “None” of Their Peers Have a History of Sexual Activity</td>
<td>89</td>
</tr>
<tr>
<td>4</td>
<td>Percentage of Participants Who Reported They Believed that “None” of Their Peers Have Been Pregnant or Gotten Someone Pregnant</td>
<td>91</td>
</tr>
</tbody>
</table>
ABSTRACT

KERI MCDONALD-HILL
AN ECOLOGICAL EXPLORATION OF YOUTH PERCEPTIONS OF SEXUALITY EDUCATION NEEDS
Under the direction of KAREN W. SWANSON, Ed.D.

In recent years, there has been a significant decline in teen pregnancy rates in the United States, but the decline is substantial among ethnicities other than African-Americans, suggesting a need for better understanding of the sexual health education needs specific to African-American youth. The purpose of this investigation was to extend the limited existing knowledge of adolescents’ perceived sexual health education needs as well as explore the impact of perceptions of friends’ sexual history on stated needs by drawing upon the Ecological Systems Theory (EST).

This quantitative study focused on the impact of social and environmental factors associated with preferences of sexual health information of youth. The cross-sectional quantitative study utilized a voluntary, self-report survey methodology by incorporating the Family Life Sex Education Goal Questionnaire (FLSE-GQ II). The first hypothesis of this study suggested that, based on Bronfenbrenner’s ecological systems theory, the community where study participants reside impacts their perceptions of their need for sexual health information. The participants responded as predicted with an endorsement of all topics within the survey, demonstrating support of a comprehensive approach to
school-based sexuality education. These results are reflective of the high rates of teen pregnancy and sexually transmitted diseases in the community.

The Ecological Systems Theory was applied in the second hypothesis to assess the extent to which perceived sexual behaviors of peers influence adolescents’ support of sexuality education content. With respect to furthering our understanding of the extent to which perceptions of peers influence adolescent perceptions of their sexuality education needs, this study demonstrates that perceptions of the sexual history of peers does not have substantial influence on support of sexual health content.

To advance the capacity of prevention efforts to address the disproportionate rates of teen pregnancy and sexually transmitted infections among African-American youth, future school-based sexual health interventions could benefit from a collaborative approach that provides youth with the opportunity to voice their opinions on the best content to be included in discussions. This can be achieved by first replicating studies such as the current study then incorporating a series of qualitative approaches that can inform later collaborative efforts.
CHAPTER 1
INTRODUCTION TO THE STUDY

The developmental period of adolescence is often associated with youth exploring, experimenting, and testing boundaries. Risky sexual behaviors, such as early initiation of sexual intercourse and sex without a condom, commonly emerge and peak during the period of adolescence (Kahn, Holes, Farley, & Kim-Spoon, 2015). Although risky behaviors are common for adolescents among all racial and socioeconomic groups, there are significant disparities in the prevalence and the consequences of such behaviors (Griese, Kenyon, & McMahon, 2016). African-American inner-city adolescents are a particularly vulnerable population for early and risky sexual behaviors that can have significant psychological and public health consequences (Clemons, Wetta-Hall, Jacobson, Chesser, & Moss, 2011). Of the many documented consequences of early sexual involvement, the two that are most commonly cited include teen pregnancy and sexually transmitted diseases due to their potential for immediate and ongoing adverse social and economic impacts (Lee, Cintron, & Kocher, 2014).

In recent years, there has been a decrease in the number of reported youth engaging in sexual activity and the number of teens becoming pregnant. However, the United States continues to have considerably higher rates of teens who become pregnant and teens with sexually transmitted infections (STIs) than in comparable developed countries (Danawi, Bryant, & Hasbini, 2015; McKee, Ragsdale, & Southward, 2011).
Moreover, despite the decrease in the rates of teen sexual activity among all ethnic groups in the United States, racial and ethnic minority groups continue to have higher rates of teenage pregnancy and birth rates than their counterparts (Shoff & Yang, 2012). Four out of ten African-American teens will become pregnant before the age of 20 years (Danawi et al., 2015). Consequently, STI and unplanned pregnancy rates have remained significantly higher among African-American adolescents compared to White adolescents (Lee et al., 2014).

HIV and other STIs greatly impact the health and well-being of low-income African-American communities (Sznitman et al., 2011). In 2009, 65% of HIV infection incidents in the U. S. were among African-American adolescents between the ages of 13 and 24 years (Lee et al., 2014). African-American adolescents also have a higher rate of sexually transmitted infections than other ethnic groups, which increases their chances of HIV infection. One in four sexually active adolescent females between the ages of 14 and 19 years is infected with at least one of the most common sexually transmitted infections. This impact is even greater for African-American females: one in two African-American females among the same age group acquire a common STI (Forhan et al., 2009; Sales et al., 2014). These disparities in HIV and other STIs call for prevention interventions than can impact larger portions of at-risk, African-American teens (Sznitman et al., 2011).

In addition to these disparities are disparities in teen births across different races. The 2014 teen birth rate per 1,000 for nonHispanic Whites was 17.3 compared to a rate of 34.9 (more than double) for nonHispanic Black teens (Hamilton, Martin, Osterman,
Curtin, & Mathews, 2015). Rates also vary greatly across states, with the highest rates consistently being in the southern and southwestern United States. In Georgia, the teen birth rates per 1,000 women between the ages of 15 and 19 years was 117.7 in 1991 for nonHispanic Blacks and 55.1 for nonHispanic Whites. The rates declined among all ethnic groups, but remained higher among Blacks, with a rate of 42.4 for nonHispanic Blacks in 2012 compared to 26.0 for nonHispanic Whites (Ventura, Hamilton, & Mathews, 2014). The rates of teen pregnancy and teen births are highest among not just African-American teens, but African-American teens who reside in low-income, urban communities also have substantially higher rates than any other demographic group in America (Secor-Turner, Sieving, & Garwick, 2011; Tanner et al., 2013).

One of the primary means of addressing high rates of teen pregnancy and sexually transmitted diseases is formal, school-based, sex education programs, initially offered in the 1970s (Elia & Tokunaga, 2015; Kirby, 2000; Peter, Tasker, & Horn, 2015; Suleiman, Johnson, Shirtcliff, & Glavan, 2015). For example, in 1979, at least 90% of schools provided some kind of sex education (Luker, 2006). This trend has continued, and in 2015, nearly 95% of adolescents reported receiving some form of school-based sexuality education before age 18 (Guttmacher Institute, 2016).

Although in-school sexuality education at some level is almost universal, for decades there has continued to be a political debate on the content of school-based sexuality education (Eisenberg, Madsen, Oliphant, Seiving, & Resnick, 2010; Luker, 2006). School-based sexuality education is both an education and health issue that is relevant to a wide audience, including academics, public health professionals, policy
makers, and educators. When compared to most other areas of the school curriculum, the topic has generated greater and more consistent controversy, received more media attention, and been the focus of heated and complex political disputes for decades (Eisenberg et al., 2010; Simovska & Kane, 2015). One reason school sexuality education has been a contentious issue is that it is a topic closely intertwined with individual interpretations of right versus wrong, religion, and feelings of personal autonomy (Collins, Alagiri, & Summers, 2002).

Several factors influence the sexuality education provided in U.S. public schools, including policy decisions (Peter et al., 2015). Variations exist between states regarding the required types of sexuality education (Peter et al., 2015). While other subjects taught in schools, such as literature and algebra, are regulated and similar in schools across the country, sexuality education programs vary dramatically. Because control over content is localized, there is not only wide variation in the sexuality education curriculum from state to state, but also between districts and schools, and in some cases between classrooms within the same building (Eisenberg et al., 2010; Elia & Tokunaga, 2015).

In the United States, 29 states and the District of Columbia mandate school-based sex education. Georgia is one of the states that mandates sex and HIV education but does not require discussions on healthy relationships. Additionally, the information is not explicitly required to be medically accurate, age-appropriate, or culturally appropriate and unbiased (Guttmacher Institute, 2016, Sexuality Information and Education Council of the United States, 2017). Georgia sex and HIV education programs emphasize and discuss the negative outcomes of teen sex. However, the programs are not required to
include information on contraception, sexual orientation, avoidance of coercion, healthy
decision-making, and family communication (Guttmacher Institute, 2016, Sexuality
Information and Education Council of the United States, 2017).

The Georgia State Board of Education determines minimum guidelines for
sexuality education, as delineated in the Georgia Board of Education Rule 160-4-2-.12
(see Appendix F). According to these guidelines, the following topics should be included
in sexuality education: peer pressure, self-esteem, community values, abstinence as
prevention of HIV and the only guaranteed method of preventing STIs and pregnancy,
and abstinence until marriage and fidelity in marriage (Georgia Department of Education,
2015).

Statement of the Problem

Early debates of sexuality education pertained to conflicting views regarding the
appropriate delivery setting. Since schools have become widely accepted as the primary
setting for the delivery of sexuality education, current debates focus on the type of
sexuality education that should be taught (Donovan, 1998; Pittman & Gahungu, 2006).
However, these debates often involve adults and rarely solicit the opinions of the primary
stakeholders—adolescents. Therefore, limited literature exists that describes how
adolescents feel about current sexuality education or indicates what they want from
school and community-based sexuality education programs (Kimmel et al., 2013).

Statement of Purpose

The primary purpose of this study was to explore adolescent opinions on what
should be included in family life and sex education courses offered in public schools.
The views of youth on what topics are most important in school-based sexual health discussions are compared to what is currently expected of teachers, as demonstrated by the Health Education Performance Standards for the state of Georgia. Additionally, this study examined whether perceived peer sexual experience norms are related to adolescent perceptions of sexual health education needs. Specifically, by comparing the level of perceived peer engagement in sexual behaviors, this study determined whether there are significant differences between the attitudes and opinions about sexuality education goals between respondents who believe their peers are sexually active and those who do not believe that their peers are engaged in sexual activities. Information about the topics that youth in the community think are most important can be used by school administrators to select the most appropriate sexuality education interventions and determine the necessary modifications to help suit the unique needs of youth from different demographics.

Research Questions

The following research questions guided this investigation:

1. What content do low-income, urban African-American youth consider to be most important for family life sexuality education course(s) delivered in public schools?
   
   $H_a1$: All participants will support a comprehensive approach to sexuality education including the support of both noncontroversial and controversial topics in family life and sexuality education course delivered in public schools.
2. To what extent does the level of perceived peer history of engagement in sexual activity influence the support of content to be included in public school family life sexuality education courses?

Hₐ₂: Adolescents who perceive their peers as having a higher level of engagement in sexual behaviors will be more likely to endorse a wider range of content.

Research Instrument

The Family Life Sex Education Goal Questionnaire (FLSE-GQ II) is a comprehensive sexuality tool designed to measure the attitudes of school personnel and community members toward the goals of family life and sex education delivered in a public-school setting. Utilizing a 5-point Likert-type response format, the 60 items of the FLSE-GQ II address a broad set of topics. The FLSE-GQ II includes items for assessing current family life sexuality education needs and understanding local needs and the level of community support and perceived priority for different content areas. To the knowledge of the researcher, the FLSE-GQ II has not been applied to assess the perspectives of adolescents regarding in-school sexuality education.

Significance of the Study

Whether a sexuality education program addresses the needs of young people is a key criterion for quality programming (Walker, Green, & Tilford, 2003). Understanding adolescents’ perspectives about current sexuality programs in order to better match the content of programs to young peoples’ needs can improve sexuality education programming (Eisenberg, Wagenaar, & Neumark-Sztainer, 1997; Kimmel et al., 2013).
However, few studies have examined the opinions of adolescents, particularly low-income African-American adolescents, on current sexuality education and topics to include in sexuality education instruction. As a result, researchers may not possess knowledge regarding the most appropriate sexuality education and ways that school, family, peer, and community-based programs can best support adolescents (Kimmel et al., 2013). Therefore, best practices in sexual education remain unrealistic for effectively addressing the needs of African-American teens from disadvantaged communities (Lee et al., 2014).

**Theoretical Framework**

To explore the sexuality education needs and the multilevel dimensions of influences on sexual decision-making of youth in an urban, African-American community, this study utilized the Ecological Systems Theory (EST) framework by administering the FLSE-GQ II with youth from disadvantaged neighborhoods in Upper County, Georgia (pseudonym). The EST provides a way to explore the variety of factors at the individual, peer, family, community, and societal levels that impact teen pregnancy (Wright, Duffy, Kershner, Flynn, & Lamont, 2015). EST is one of the most widely used theoretical frameworks for investigating individuals in ecological contexts (Neal & Neal, 2013). It is based on the premise that the interaction of multiple levels of social and environmental contexts influences behavior (George et al., 2013; McLeroy, Bibeau, Steckler, & Glanz, 1988). The emphasis of the EST is on the individual’s perception of his/her ecological environment and the influence of the individual’s exposure to his/her environment. The most immediate environmental activities that happen to an individual
or in an individual’s presence are most impactful and can inspire an individual to engage in similar activities (Bronfenbrenner, 1979). By understanding cultural meanings of experiences, environmental toxins, and the connection between individual behavior and social norms and rewards, curriculum developers can create interventions that are more effective (Israel, Schulz, Parker, & Becker, 2001; McLeroy et al., 1988).

Definition of Key Terminology

Although the terms sex education and sexuality education have different definitions, they are used interchangeably in the literature. The term sex usually represents gender or sexual behavior, whereas the term sexuality represents a broader and more holistic view that refers to not only gender and behavior, but also an individual’s attitudes, values, and knowledge regarding sexual expression. Additionally, the phrases sexually transmitted disease (STD) and sexually transmitted infection (STI) are synonymous and used interchangeably. The use of the term STD can be found more often in earlier literature, while STI, which is more inclusive of all forms of sexually transmitted bacterial and viral conditions, is used in more recent conversations because not all sexually transmitted infections lead to diseases. The terms Black and African-American are also used interchangeably in the literature to describe the same racial/ethnic group that is the target audience for this study.

Summary

The long, complicated history of school-based sexuality education and variance of policies at the state and district level have resulted in an inconsistency of sexuality information delivered in U.S. schools. The differences in expectations have contributed
to a lack of uniformity in the content and approaches (Barr, Moore, Johnson, Forrest, & Jordan, 2014). Decisions regarding the content and presentation of courses in sexuality do not typically involve feedback from adolescents. Failure to afford an opportunity for those who are directly impacted to voice their opinions raises the question of whether the material is relevant and delivered in a manner that adolescents consider to be meaningful (Barker, 2005). This investigation applied the Ecological Systems Theory to further explore the opinions of youth on school-based sexuality education and determine the extent of the impact of the perceptions held by the low-income, urban youth participants of their friends’ sexual history on what they believe should be included in family life and sex education courses. This study has the potential to provide school administrators and policy makers with additional insight on the sexuality education needs of adolescents, which could potentially result in considerations of broader changes to sexuality education to reflect a more culturally relevant, age-appropriate, holistic approach to school-based sexuality education.

This research is presented in five chapters. Chapter 1 is an introduction to the study, including the background, statement of the problem, purpose for the study, research questions, survey instrument, theoretical framework, and definition of key terms. Chapter 2 presents a comprehensive review of the literature on approaches to adolescent sexuality education, effectiveness of sexuality education approaches, statistics on adolescent sexual health, the effects of the changing adolescent brain, consequences of risky sexual behavior, the ecological systems theory, and the importance of adolescents having a voice in issues affecting them. Chapter 3 delineates the research methods and
design. Chapter 4 includes the results of the study. Chapter 5 provides a summary of the findings and discussion of the results.
CHAPTER 2

REVIEW OF THE LITERATURE

This chapter presents a review of existing literature on the sexual health of American adolescents, with emphasis placed on African-American youth, since the potential adverse consequences of risky sexual behaviors are more prevalent among the young African-American population that others in similar age groups. The information included in this review provides an overview of the literature that demonstrates the need for continued and expanded school-based sexuality education, as well as rationales for considering adolescent perspectives in decisions on what should be included in sexuality education discussions.

The literature included in this review is a combination of empirical research from various peer-reviewed journals, books, position statements, policy reports, and private foundation reports. The researcher incorporated several approaches to locate and select the most recent and relevant articles and resources. The approaches included a search of peer-reviewed articles using a variety of electronic databases for the fields of education, public health, sociology, health sciences, nursing, and psychology. The databases utilized include the following: Sage Publications, PubMed, Pro Quest, EBSCO, ERIC, PsychInfo, American Public Health Association, Google, and Google Scholar. The following search terms were used: adolescent voice; ecological systems theory; African-American adolescent sexual health; adolescent sexual health; sexuality education or sex
This chapter consists of seven sections that provide a broad overview of the literature on the sexual health of adolescents, with emphasis placed on the disparities among ethnic groups. Through this comprehensive search of extant literature, the researcher discovered a significant need for more opportunities for adolescents, especially African-American teens, to share their perspectives on issues related to their sexuality education experiences in order to best address sexual health disparities and further enhance the sexuality education provided in schools. To demonstrate the significance of sexuality education and provide a rationale for continuing to implement and improve sexuality education, the compilation of literature begins with the most recent data on adolescent sexual health, with emphasis on two important issues that are related to risky adolescent sexual behavior: teen pregnancy and sexually transmitted infections (STIs). The second section includes current data on the sexual health of adolescents and the information on consequences of risky sexual behaviors. Following this are explanations of why adolescents are more likely to engage in risky behaviors than other age groups as well as a discussion of peer influences. The next section presents an overview of prevention efforts that are being implemented to address risky sexual behaviors among teens. The prevention approaches, which vary greatly, are not always effective among marginalized groups such as African-American teens of low
socioeconomic status. The section that follows describes adult support for sexuality education.

The Ecological Systems theory posits that a number of factors, including environment, influence adolescents’ decisions of sexual behavior. Curriculum developers who understand social and environmental influences can use the information to help them design more efficacious and culturally sensitive programs for the population groups most impacted by adverse consequences of risky sexual behaviors such as higher rates of unintended pregnancy and sexually transmitted infections. The final section provides an argument for why there should be a focus on improving current school-based sexuality education practices and how giving youth opportunities for input is an appropriate approach to helping to improve the delivery of sexuality education, particularly among the African-American youth.

Approaches to Sexuality Education

Early debates regarding sexuality education centered on varying perspectives on the appropriate setting to deliver it. However, since widespread acceptance of schools as the principal setting for the delivery of sexuality education, current debates are centered around what should be included (Donovan, 1998; Pittman & Gahungu, 2006). The two primary, school-based sexuality education approaches most often discussed in sex education debates are comprehensive sexuality education (CSE), also referred to as abstinence-plus and abstinence-only-until-marriage, which is often referred to as abstinence-only (Collins, Alagiri, & Summers, 2002; Elia & Tokunaga, 2015; Hall et al., 2008). The premise of both comprehensive and abstinence-only school sex education is
to provide youth with information and skill building, as well as opportunities to shape attitudes and beliefs in an effort to improve sexual and reproductive health. Although holding a similar overarching goal, abstinence-only advocates discuss abstinence as morally correct, and comprehensive program supporters include discussion about abstinence as a preferred behavior, while also providing information on options for safer sex behaviors (Suleiman & Brindis, 2014).

Abstinence-Only Sexuality Education

A wide variety of abstinence-only programs is available, ranging from religious to secular, didactic to interactive. All abstinence-only programs have one common characteristic: they emphasize abstinence as the only appropriate choice for individuals who are not married. Some of the programs may deliver the message that sex outside of marriage is immoral, while others may encourage delaying sex for later in life. (Kirby, 2000; Luker, 2006).

Abstinence-only supporters believe that abstinence-only programs have the ability to instill moral values that will impact adolescent behaviors (McCave, 2007). Those who support abstinence-only and reject comprehensive sexuality education (CSE) have argued that CSE promotes condoms as safe without providing information on failure rates. These sources also argue that CSE encourages oral and anal sex, undermines parental authority, encourages sexual risk-taking behavior among youth, promotes abortion, and encourages promiscuity. The critics claim that CSE has exploited the AIDS pandemic to spread dangerous ideologies to children. Supporters of abstinence-only also state that comprehensive programs focus on contraceptives while providing limited information on
abstinence. Moreover, they contend that comprehensive programs teach students how to have sex and undermine parents (Donovan, 1998; McCave, 2007).

In 1996, under the Bush Administration, Congress committed $250 million over a five-year period to promote abstinence-only until marriage education (Donovan, 1998). From 1996 to 2007, over 1.5 billion state and federal dollars were committed to abstinence-only sex education programs (Suleiman, Johnson, Shirtcliff, & Glavan, 2015). During this period, schools that implemented abstinence-only programs received sizeable federal incentives (Lindau, Tetteh, Kasza, & Gillam, 2008). The federal government requires abstinence-only programs promote abstinence from all sexual activity until marriage as the expected standard. These programs cannot in any way advocate for contraceptives. If contraceptives are mentioned, the discussion is limited to reports of the ineffectiveness of birth control methods (Finer & Philbin, 2014; Lindberg, Santelli, & Singh, 2006; McKee, Ragsdale, & Southward, 2011; Suleiman et al., 2015). Although there is no clear research of positive emotional or social outcomes of abstaining until marriage, these programs state that sexual activity outside of marriage can result in psychological and physical harm (Finer & Philbin, 2014; Lindberg et al., 2006; Suleiman et al., 2015).

Olsen, Weed, Daly, and Jensen (1992) surveyed 1,878 students who participated in abstinence-only sexual education programs to determine the outcomes of three different abstinence-sex education programs on their attitudes toward premarital intercourse. Overall, the respondents had a positive change in attitude. Kirby, Korpi, Barth, and Cagampang (1997) later evaluated the effectiveness of the Postponing Sexual
Involvement (PSI) abstinence-only curriculum on a group of 10,600 seventh and eighth graders who were either part of the treatment or control group. Both groups participated in a posttest at three months and 17 months after the baseline survey. At the three-month posttest, there was a minimal, positive impact on attitudes related to sexual decision-making and intentions to refuse sex. At 17 months, there was no significant and positive effect on sexual or contraceptive outcomes or on pregnancy or STD rates. In that same year, Kirby and Coyle (1997) reviewed 35 published evaluations of sexuality education programs delivered in schools. The meta-analysis revealed that although abstinence-only programs may provide appropriate content, especially for middle school students, there was no evidence that the program resulted in delayed or reduced sexual intercourse.

Kerr (2003) evaluated the impact of virginity pledges (commitments to remaining abstinent until marriage) made by youth participants. Of the 16% of high-school participants who had taken virginity pledges, 60% later reported that they did not follow through with their vows. However, these programs had an impact on sexual debut, for these students delayed sexual initiation an average of one year longer than those who did not pledge. In a number of these cases, the delay was in vaginal intercourse and not in oral sex and other sexual activities. Students often view virginity as abstaining from vaginal-penile penetration. With abstinence-only programming, omitting information that would clarify all forms of sexual activity leaves students confused and ill informed. Therefore, these students may attempt to abstain by their definition while engaging in risky sexual behaviors such as oral sex and consider themselves virgins (Kerr, 2003).
In 2004, Representative Henry Waxman of California undertook a systematic evaluation of the content of abstinence-only curricula most widely used in schools. Findings indicated that more than 80% of the programs contained information about reproductive health that was completely or partially inaccurate. Several the curricula included outdated and incorrect information on condoms and the transmission of HIV (Greenblatt, 2008).

Bearman and Brückner (2005) further explored sexual activities outside of intercourse among those who took virginity pledges. The results of this study were that the rates of oral and anal sex were significantly higher for teens who had taken virginity pledges than virgins who had not pledged. Those who took virginity pledges were much less likely to use condoms at first intercourse, which placed them at greater risk, particularly since studies indicate that an individual who chooses to use condoms at first intercourse has a greater chance of consistently using condoms (Bearman & Brückner, 2005). Fortunately, despite these differences, the rate of STD infection was not significantly different among those who pledged and those who did not. Additionally, in a similar study, those who pledged and later became sexually active reported contraceptive use at a rate of 33% less than those who did not take the pledge. These youth also reported more engagement in risky sexual behaviors, such as unprotected sexual intercourse, than those who did not take a pledge (McCave, 2007).

Kirby, Laris, and Rolleri (2007) took a global approach by reviewing 83 published studies that evaluated sexuality education programs from both developed and developing countries throughout the world. Ninety-three percent of the programs took a
comprehensive approach. The remaining 7% were abstinence-only programs—all implemented in the United States. There were no statistically significant results of the abstinence-only programs. Of the studies reviewed by Kirby et al. (2007), 83% utilized a theory to form the basis of the curriculum, with 54% utilizing social learning or social cognitive theory. The length of the programs ranged from one hour to 48 hours with 12 hours being the mean length of the programs. Overall, Kirby et al. (2007) found that the evaluations demonstrated a greater likelihood for the programs to have a positive impact (65%) than a negative impact (7%). With very few evaluations on abstinence available, only two of the studies on abstinence-only met the criteria of having a rigorous evaluation design. These two studies evaluated five abstinence-only programs and found that one program reduced the number of sexual partners. Results of the comprehensive programs showed that 44% of the programs contributed to delayed sexual initiation, 35% were effective in decreasing the frequency of sex, and 47% reduced the number of partners. None of the programs increased sexual behavior. Of the 54 studies that measured change in condom use, 48% showed an increase in condom use among participants, and no studies found a decrease in condom use. None of the programs were found to increase sexual risk-taking. These results supported earlier research (Kirby et al., 2007).

Pittman and Gahungu (2006) surveyed 104 participants between the ages of 18 and 30 who received comprehensive sexuality education, abstinence-only, or both. There was no statistically significant difference between both groups in the mean of the educational programs helping them to delay sexual activity. However, those who participated in comprehensive sexuality education reported being more aware of the
adverse consequences of sexually transmitted diseases compared to those in the abstinence-only group. Those in the comprehensive sexuality education group also reported more feelings of being responsible regarding their sexual health, and they were more likely to recommend the teaching of comprehensive sexuality education in their schools compared to participants of abstinence-only education programs (Pittman & Gahungu, 2006).

Critics of abstinence-only programming have voiced concern that some programs implement from a fear-based approach and that by not teaching proper contraception use, the programs actually increase rates of contraceptive failure (Donovan, 1998). These critics also claim that by not discussing sexual negotiation skills and contraception skills, programs are withholding potentially life-saving information, which violates human rights (Fonner, Armstrong, Kennedy, O’Reilly, & Sweat, 2014). Other critics claim these programs limit the topics included in discussions, emphasize heterosexual relationships without regard to other sexual identifications, and deliver a moral instead of a health approach (Stevens et al., 2013).

Abstinence-only critics have also argued that abstinence-only programs reject the principle that individuals should make their own decisions about what they believe is proper sexual behaviors. Abstinence-only supporters have attempted to establish abstinence from sex until marriage as a social norm, prescribing a single value for all and assuming that individuals will enter into marriage at a relatively young age (Finer, 2007; Luker, 2006). However, abstinence-only programs overlook the trends of increasing age of first marriage. From 1970 to 2004, the median age of first marriage for women
increased from 22.1 to 25.8 years and 24.4 to 27.4 for men. The conditions of life have changed for young people in the contemporary world. The onset of puberty is beginning earlier than ever before, while the average age of marriage is increasing. The result is a longer interval between puberty and marriage, which is now around 13 years (Finer & Philbin, 2014). Additionally, Finer (2007) reviewed a 50-year period of data from the National Survey of Family Growth (NSFG) and found premarital sex as highly normative and almost universal by age thirty. Eight in ten of those surveyed who abstained from sex in their adolescent years eventually engaged in premarital sex. Earlier puberty, later marriages, declines in the family structure resulting in less adult control and more child autonomy, and increased access and exposure to sexual stimuli have contributed to greater acceptance and occurrences of premarital sexual activity (Finer & Philbin, 2014).

The significant decline in the use of abstinence-only curricula in recent years is due in large part to the decrease in federal funding for abstinence-only programs and the numerous studies that demonstrated the ineffectiveness of the abstinence-only approach (Elia & Tokunaga, 2015). Although the implementation of abstinence-only programming continues, the Consolidated Appropriations Act of 2010, passed during President Obama’s administration, committed federal funding of comprehensive sex education while reducing funding for abstinence-only programs (Suleiman et al., 2015). This happened after 30 years of advocacy for comprehensive sex education by leading health organizations, such as the American College of Obstetricians and Gynecologists (ACOG) and American Academy of Pediatrics (Lindau et al., 2008).
Comprehensive Sexuality Education

No universal definition of comprehensive sexuality education (CSE) exists. However, the following definition from the Sexuality Information and Education Council of the United States (SIECUS) is widely utilized:

Comprehensive sex education includes age-appropriate, medically accurate information on a broad set of topics related to sexuality including human development, relationships, decision making, abstinence, contraception, and disease prevention. They provide students with opportunities for developing skills as well as learning. (SIECUS, 2009, para. 2)

Comprehensive sexuality education presents all prevention options, including the use of condoms and the reduction of sexual partners (Fonner et al., 2014). A wide variety of topics and approaches can be used in CSE, but they can be narrowly defined as programs that stress abstinence, but also include information about contraceptives (Eisenberg, Madsen, Oliphant, & Sieving, 2013). Supporters of comprehensive sexuality education proclaim that the postponement of sexual involvement is optimal, but adolescents should receive information on how to protect themselves with proper use of contraceptives if they choose to engage in sexual activity (McCave, 2007).

Effectiveness of In-School Sexuality Education

Continued high levels of teen pregnancy and adolescent sexually transmitted diseases suggest that the sexuality education practices are either insufficient, untimely, or provided by those who are inadequately trained (Bourton, 2006). In 1997, the Division of Adolescent and School Health (DASH) of the Centers for Disease Control and
Prevention convened a panel of experts to conduct a careful review of research on sexuality education programs delivered in schools. After reviewing 23 studies, the experts found that the ineffective programs covered a broad range of topics, but did not emphasize facts, values, and skills to avoid sex or risky sexual behaviors. Ineffective programs also taught steps to decision-making, while effective programs emphasized behavioral values and norms by including techniques such as asking students to identify and assess reasons why teens should wait. Common characteristics in effective programs were a basis in social learning or social influence theories, utilization of experiential activities, and reinforcement of individual values and group norms (Bourton, 2006).

Building on the findings of the DASH review, Kirby and Coyle (1997) reviewed 35 published evaluations of sexuality education programs delivered in schools. Kirby and Coyle (1997) realized that teens in the United States have a considerable amount of knowledge of the risks associated with unprotected sexual intercourse, as well as ways to prevent those risks, through a variety of sources such as school sex education, parents, peers and other adults, and media. Their goal was to determine if the additional instruction provided by the sexuality education curricula about a variety of aspects of sexuality impacts sexual decision-making among adolescents in either a positive or a negative way. Kirby and Coyle (1997) considered the differences in quality of the studies while formulating their conclusions on the impact of the programs evaluated by each study. Results showed that almost all evaluations demonstrated that students had an increase in knowledge about sexuality and contraception. Additionally, the studies showed that participants of the sexuality education programs did not report earlier onset
or increase in frequency of sexual intercourse as critics of sexuality education have proposed. Results of some studies indicated that the programs either delayed first sexual intercourse experience or reduced the frequency of sexual intercourse. Half of the studies that measured the impact of the program on condom use were found to increase condom use.

Overall, the results of the evaluations conducted by Kirby and Coyle (1997) were encouraging, but there were limitations in the evaluations. For example, the majority of the studies did not involve random assignment and had small sample sizes. Long-term follow-up and measurement of behavior were also not part of most of the evaluations. Kirby and Coyle (1997) concluded that some programs can moderately impact sexual behaviors and recommended the continued implementation of sexuality and HIV education programs as part of a larger, more comprehensive approach to reducing sexual risk behaviors among adolescents.

School-based sex education is an important approach to impacting adolescent health, and there is a need to increase its impact (Elia & Tokunaga, 2015; Suleiman & Brindis, 2014). There is current pressure at the national level for schools to deliver quality sex education (Walker, Green, & Tilford, 2003). In the United States, in-school and community-based education programs for adolescents have a history of being constrained. Policies inhibit instruction, teachers lack adequate autonomy or qualifications, and funding is limited (Stevens et al., 2013). Critics of school-based sex education address the variations between schools, the didactic delivery of information focused on biological aspects, the facilitation of instruction by staff who do not specialize
in the subject matter and are often unconfident and disengaging, the provision of limited information, and the late delivery of information to older teens (Selwyn & Powell, 2007). Researchers, providers, and advocates have criticized some formal sexuality education programs in the United States for insensitivity to the changing needs of adolescents (Peter, Tasker, & Horne, 2015). To improve sexuality education programming, Kimmel et al. (2013) promoted understanding adolescents’ perspectives about sexuality education to achieve a better match between the content of programs and young peoples’ needs.

Unlike the history of evaluation for abstinence-only programs, CSE programs have been the focus of a number of rigorous studies for decades. These studies reveal clear evidence supporting comprehensive sexuality education for reducing risky sexual behaviors that can result in teen pregnancy. These programs delay the initiation of sexual activity, reduce the number and frequency of partners, increase contraceptive use, and reduce risk-taking (Boonstra, 2014).

International and U.S. health experts strongly support granting access to comprehensive sexuality information to adolescents (Peter et al., 2015). Sexuality education proponents argue that CSE is needed to respond to the many teens who engage in unprotected sex and/or sexual activities at an early age (Woloshyn & Rye, 1995). It is important to deliver accurate, current sexuality information to adolescents in response to the prevalence of risky sexual behaviors (Haignere, Gold, & McDaniel, 1999).

School-Based Sexuality Education

Although in-school sexuality education at some level is almost universal, for decades it has generated greater and more consistent controversy than most other areas of
the school curriculum. Because it is both an educational and a health issue, it is pertinent to a range of audiences, including academics, educators, and policy makers (Simovska & Kane, 2015). From its impetus, critics of school sex education argued that sexuality education discussions should not take place in schools, but instead should occur in the home or the church. Other critics maintain that, instead of deterring immoral sexual behaviors, sex education promotes them. In response to these debates, the goals of sex education were expanded and euphemisms such as social hygiene, human relations, character education, and family life education were used instead of the label sex education (Luker, 2006; Zimmerman, 2015).

Policy decisions are one of the numerous factors that influence the sexuality education being delivered in U.S. public schools (Peter et al., 2015). The current policies regarding the content of in-school sexuality education vary substantially across the United States (Eisenberg, Madsen, Oliphant, Seiving, & Resnick, 2010). Of the 24 states that require sex education, only 13 require medically accurate content (Guttmacher Institute, 2017). In 2015, of the 184 bills related to school-based sexuality education introduced in 42 states, only 34 bills included provisions requiring instruction related to sexual health to be medically accurate, age-appropriate, and culturally appropriate. Twenty-four bills in 12 states contained provisions requiring instruction in both abstinence and contraceptives. This demonstrates that while states are recognizing the need for mandated sexuality education, more work is necessary to ensure that the delivery of information in these programs is accurate and relevant to youth (Guttmacher Institute,
2016). Additionally, no accountability measures are in place to ensure that mandates are met in the states with sexuality education policies (Gelperin & Schroeder, 2008).

To complicate matters, variations between states exist regarding the required types of sexuality education (Peter et al., 2015). While other subjects taught in schools (such as literature and algebra) are regulated and similar in schools across the country, sexuality education programs vary dramatically. Because control over content is localized, there is not only wide variation in the sexuality education curriculum among states, but also between districts and schools and, in some cases information delivered differs among classrooms within the same building (Eisenberg et al., 2010; Elia & Tokunaga, 2015). The long, complicated history of school-based sexuality education and variance of policies at the state and district level have resulted in an inconsistency of sexuality information delivered in U.S. schools, which has contributed to a lack of uniformity in the content and approaches (Barr, Moore, Johnson, Forrest, & Jordan, 2014). The array of state policies creates gaps in student learning, as well as challenges for sexuality education teachers and advocates (Centers for Disease Control & Prevention, 2015).

Adult Support for School Sexuality Education

Despite the controversy surrounding the content of school sex education, public support for teaching in-school sexuality education is increasing (Barr et al., 2014; Walker et al., 2003). For many reasons, schools have the potential to greatly impact risky adolescent sexual behaviors (Kirby & Coyle, 1997). Schools serve to prepare youth not just academically, but also physically and socially for adulthood (Eisenberg et al., 2010).
With 95% of all U.S. children attending primary or secondary schools, no other single institution can have a greater impact on the well-being of children and youth than schools (Eisenberg et al., 2010; Kealey, Peterson, Gaul, & Dinh, 2000; Woloshyn & Rye, 1995).

In addition to the ability of schools to reach the greatest number of young people, presentation of the information occurs in a setting that is equipped for group, educational lessons (Fonner et al., 2014). Schools are viewed as a source of valid and reliable information for youth (Barr et al., 2014). This also should generalize to sexuality education. Teachers can provide an environment where parents and youth feel confident that youth will receive accurate and appropriate sexuality information (Wilson, Wiley, Housman, McNeill, & Rosen, 2015).

Including sex education as part of the school curriculum is a concept supported by the majority of parents, teachers, and students (Pandey, 2015). National and state polls continue to show that 80 to 90% of adults support in-school sexuality education that includes discussion on abstinence, as well as contraception and disease prevention (Donovan, 1998). In a 1999 public opinion survey, 84% of adults were in support of sex education in junior high, and 93% supported high school students receiving in-school sex education. Eighty-four percent felt that information on contraceptives should be taught to 9th and 10th graders (Collins et al., 2002).

Researchers of the Kaiser Family Foundation conducted the 1999 Benchmark Survey on Sex Education in America with 313 principals, 1,001 teachers, and 1,501 pairs of parents and students involved in sex education instruction at public secondary schools across the United States. Parents stated that while they supported the core messages of
reproduction, abstinence, HIV, and other STDs, they also wanted sex education courses to cover more information, such as safer sex and condom negotiation skills. They also wanted programs to last longer. Students also expressed a desire for more sexual health information, with communication and negotiation skills, handling emotional issues related to sexual relationships, and sexual violence as topics most often cited (Hoff, Green, McIntosh, Rawlings, & D’Amico, 2000).

A follow-up survey entitled Sex Education in America was conducted in 2004 as part of a partnership between National Public Radio, the Henry J. Kaiser Foundation, and Harvard University’s John F. Kennedy School of Government. Nationwide, 1,759 adult participants, 1001 of which were parents, participated in telephone surveys. The majority of these adults (77%) believed that providing information on where to get and how to use condoms would increase the likelihood of teens’ decisions to practice safe sex in the short-term and long-term. Respondents stated that sex education discussions should not avoid sensitive topics but provide a fair and balanced discussion. Seventy-four percent reported that they trusted that the sex education that their children were receiving in their schools aligned with their values (National Public Radio, 2004). Similar results were found by Bleakley, Hennessy, and Fishbein (2006), who surveyed a nationally representative sample of U.S. adults and found 8 in 10 of respondent reported being in support of comprehensive sex education.

Although the overwhelming majority of Americans in numerous surveys support school-based sexuality education, a small minority speak vociferously about their opposition to its implementation. More specifically, they disagree about the content that
should be included in discussions on sexuality (Kirby, 2000). The main arguments of critics of school-based sexuality education is that sexuality education leads to promiscuous behavior, sexuality education lacks focus on morals, and unqualified teachers are instructors of sexuality education (Scales, 1987). In the 1980s, arguments against sex education lost legitimacy as more attention focused on teen pregnancy and the HIV/AIDS epidemic sparked a new urgency (Zimmerman, 2015). During this time, sexuality education regained public support (Gelperin & Schroeder, 2008).

Designed by Godin, Frank, and Jacobson (1984), the Family Life Sex Education Goal Questionnaire (FLSE-GQ) measures the attitudes of school personnel and community members about the goals of family life and sex education delivered in a public school setting. One study conducted in the Midwest utilized the FLSE-GQ with a sample of 337 elementary and high schoolteachers and 248 parents of elementary and high school students. Another study conducted in a rural Northeast area involved 175 high school teachers and 157 parents of high schoolchildren. Separate factor analyses resulted in the identification of five themes found in common among both samples: (a) building skills on sexual decision-making and life skills; (b) discussing male and female physical development; (c) encouraging respect for diversity; (d) offering secondary prevention to help pregnant females to stay in school; and (e) teaching about the family and integrating sexuality in personal growth. The largest factor for the Midwest sample at 31% of the variance with parent participants was “sexual decision making and life skills” (Godin, Frank, & Jacobson, 1998, p. 213). The largest factors among teachers from that study were “family life” and “personal growth” (Godin et al., 1998, p. 213)
with 30% of the variance. In the Northeast sample the only large factor identified was “sexual decision making and life skills” (Godin et al., 1998, p. 213) at 32% of the variance. For the five goal dimensions, the Cronbach alphas for the sample of teachers ranged from .60 to .79 and from .65 to .85 for the sample of parents (Godin et al., 1998). Field (2013) stated that the Cronbach alpha is the most widely used measure of reliability. Higher Cronbach scores demonstrated more reliability of the scale.

Razzano (2005) tested the stability of the revised instrument (FLSE-GQ II) by examining whether the original factor dimensions remained constant with a sample of teachers and parents in Pennsylvania. In addition, the study compared the results of the responses from teachers and parents in support of controversial versus noncontroversial topics among the following populations in Pennsylvania: public school teachers of grades 6-12; parents of children in grades 6-12 enrolled in public schools; private religious school teachers of grades 6-12; and parents of children in grades 6-12 enrolled in a private religious school. Razzano (2005) utilized the Pennsylvania Education Directory to identify public school teachers from a selection of schools from different districts of the state and recruited teachers of religious schools through an online database. After obtaining permission from the schools to survey the parents, Razzano (2005) mailed 2,062 surveys to teachers and parents, of which 332 were completed and returned in prepaid envelopes.

Data analysis revealed that Cronbach alphas ranged from $r=.69$ to $r=.79$ for the 337 teachers and $r=.65$ to $r=.85$ for the parent sample. A One-Way Analysis of Variance using a Post-Hoc Test with a $p=.05$ determined the means of the four groups that were
significantly different in each factor dimension. All four samples reported support for the inclusion of discussions on HIV and other sexually transmitted infections. Compared to teachers, parents were more in support of controversial issues, such as counseling expectant fathers, pregnant females, referring students to community agencies, discussing family issues and growth and development, and meeting parents with children who are having difficulties. Compared to religious teachers both parents and public school, teachers were more in support of accessing information about planned parenthood, contraception, homosexuality, abortion, and how far to go in sexual behaviors (Razzano, 2005).

Kim (2009) assigned general education and special education teachers to either a control group or experimental group who received training on sexuality education. The purpose of the study was to determine the effectiveness of two interventions addressing sexuality education attitudes, goals, and knowledge of sexuality education for people with intellectual disabilities. The FLSE-GQ II was edited to relate to the sexuality of individuals with intellectual disabilities. The final instrument included 65 instead of 60 questions. The means and standard deviations for the teachers’ total pretest scores on the FLSEGQ were analyzed. In both pre- and posttest there were no statistically significant differences between groups.

Brown (1997) administered the FLSE-GQ II to the principal, supervisor of instruction, school director, teachers, teachers’ aides, and the social worker of middle school students at a special education school. The purpose of the study was to determine the nature of sexuality education received by special education students. Brown (1997)
used participant observation, interviews, student surveys, staff surveys, and student and staff feedback evaluations. During the process of developing a curriculum for the study, some administrators and staff expressed discomfort with some of the topics that the researchers planned to include in the intervention, as reflected in their responses to the questionnaire. Those who completed the survey ranked Family Life and Personal Growth as the most important factor dimension. Next was Physical Development. Sexual Decision Making and Respect for Diversity were ranked third and fourth.

Utilizing responses from Certified Rehabilitation Counselors (CRCs), Kazukauskas and Lam (2009) modified the FLSE-GQ II to address disability populations. Individuals with disabilities often receive limited assistance or education to help them deal with the plethora of sexuality-related issues that may be associated with their disabilities. This is particularly true for those who acquire a disability later in life. Slight adaptations of the FLSE-GQ II addressed sexuality in the general disability population. A factor analysis resulted in a six-factor structure to address the concept of sexuality during the rehabilitation process. Cronbach’s alpha values suggested good internal consistency reliability to utilize the tool with CRCs. Kazukauskas and Lam (2009) conducted a comparison of means analysis to determine if CRCs’ rating of the importance of including sexuality during the process of rehabilitation and the issues that they believed were most important. Counseling and Education rated most important, followed by Contraception, Pregnancy, & STDs. Sexual Development & the Body came in third. Family Inclusion and Traditional Values were fourth and fifth, respectively. Contemporary Values was rated least important.
Kazukauskas and Lam (2009) reviewed each item in the FLSE-GQ II individually to determine 10 items—based on having a mean score of 4.50 or greater—to be most important to address during the process of rehabilitation: future goals planning, referral and awareness of community resources, self-esteem and body image improvement, and sexuality transmitted diseases education. Participants also had the opportunity to provide a response to an open-ended question about the types of sexuality-related issues that they had seen in their experience working with clients. The responses to the open-ended question were diverse due to the variety of disability populations that CRCs served. The results of this study reveal that CRCs identified addressing sexuality issues as important during the rehabilitation process (Kazukauskas & Lam, 2009).

Adolescent Sexual Health and Behaviors

The sexual behaviors of adolescents are a major public health concern in the United States (Danawi, Bryant, & Hasbini, 2016). In recent years, there has been a modest reduction in risky sexual behaviors (Herr et al., 2012), yet there continues to be considerably higher rates of teen pregnancy and sexually transmitted infections (STIs) in teens in the United States than in comparable developed countries (McKee et al., 2011). Additionally, the rates are significantly higher among ethnic and racial minorities (Centers for Disease Control and Prevention, 2015). Behaviors such as engaging in sexual intercourse early in life, having multiple sex partners, failing to utilize contraceptives, consuming alcohol, and utilizing drugs increase the chances of unintended pregnancies and sexually transmitted infections (Rhodes, Kirchofer, Hammig, & Ogletree, 2013).
Virtually all behaviors that contribute to the leading causes of death and disease among youth and young adults in the United States can be placed into six categories. Developed in 1990 by the Centers for Disease Control and Prevention, the Youth Risk Behavior Surveillance System (YRBSS) includes a national school-based Youth Risk Behavior Survey (YRBS). Administered biannually, the survey measures the six categories of priority health-risk behaviors practiced or experienced by students. One of the six categories is sexual risk behaviors, as the number of deaths continue to occur due to pregnancies and sexually transmitted diseases among youth and young adults (Kann et al., 2015; Raiford, Seth, & DiClemente, 2013; Rhodes et al., 2013). The YRBS provides the most current data on sexual behaviors of adolescents. The YRBS utilizes a nationally representative sample of students in grades 9 to 12 from public and private schools in the 50 states and the District of Columbia. The sample includes students from religious, charter, special education, vocational, and public alternative schools who participate voluntarily and anonymously in the self-administered, computer-based survey. In order to obtain a separate analysis of data for Black and Hispanic students, the students are captured by administering additional surveys in schools with high minority enrollment. Survey participation is anonymous and voluntary. Students input responses to the self-administered survey directly onto the computer (Kann et al., 2015).

The percentage of high school students who reported having engaged in sexual activity has decreased gradually over the years. For example, in 1991, the percentage was 54.1, but since 1997, it has remained below fifty percent. Results from the 2015 YRBS indicated that 41.2% of students nationwide had experienced sexual intercourse,
which was a reduction of the 46.8% in the 2013 YRBS. Although the rates have decreased among all ethnic groups, Black high school students remain more likely to have had sexual intercourse at the time of taking the survey. The prevalence of having ever engaged in sexual intercourse was 60.6% in the 2013 YRBS and 48.5% in the 2015 YRBS for Black teens as compared to 43.7% in 2013 and 39.9% in 2015 for White adolescents (Kann et al., 2015).

Using a sample of 7,000 to 10,000 women of childbearing age across the nation, the National Surveys of Family Growth (NSFG) provide data on sexual intercourse, contraceptive use, and timing of childbearing. The National Center for Health Statistics (NCHS) 2014 Data Brief utilized NSFG data from 1,037 females and 1,088 males between the ages of 15 and 19 years. From 2011 to 2013, 44% of never-married adolescent females and 47% of never married males reported never engaging in sexual intercourse in their lifetime (Martinez & Abma, 2015). These results are similar to the findings of the YRBS.

Black teens reported experiencing sexual intercourse earlier than other ethnic groups. In the 2013 YRBS, the percentage of Black students who reported having their first sexual experience before the age of 13 was 14.0% compared to 3.3% of White teens and 6.4% of Hispanic students. That rate continued to remain higher as 8.3% of Black students reported engaging in sexual intercourse before the age of 13 in the 2015 YRBS, compared to 5.0% of Hispanic students and 2.5% of White students (Kann et al., 2015). Preadolescents and early adolescents who engage in sexual intercourse encounter different biological ramifications, including increased risk of transmitting STDs.
Additionally, unlike older adolescents and adults, preadolescents and early adolescents experience increased influence of family, peers, and society that may impact attitudes and behaviors more than the influence of partners (Stanton et al., 1994).

In an effort to explore social and other external factors that influence sexual decision-making among African-American adolescents between the ages of 9 and 15 years who live in urban public housing developments, Stanton et al. (1994) utilized computer-based voice software via individual headphones to administer a risk assessment questionnaire to 351 youth. The median age of participants was 11 years. More than one third of participants, including 50% of the male respondents, reported that they had engaged in sexual intercourse. Of those who reported being virgins, one-fifth stated that they expected to start engaging in sexual intercourse within the next six months. The median number of sexual partners among participants who were sexually active was two, and nearly two-thirds of the participants reported using a condom during their last experience of sexual intercourse.

Similarly, 30.1% of high school students surveyed in the 2015 YRBS reported being currently sexually active, defined as engaging in sexual intercourse within three months prior to the survey. Of those individuals, 56.9% reported condom use by either themselves or their partner during their last sexual experience, which represents an increase from the 46.2% who reported condom use in 1991, but a decrease from the 59.1% in 2013 (Kann et al., 2015). According to the 2015 YRBS, 11.5% of high school students reported having sex with four or more people in their lifetime compared to 15% in 2013. This represents a significant decline from the 18.7% that reported having four or
more partners in 1991. Although there has been a steady decrease in sexual activities with multiple partners among adolescents, Black students were more likely to have sexual intercourse with four or more persons (26.1% in the 2013 YRBS and 19% in 2015) than White students (13.35% in the 2013 YRBS and 9.9% in 2015) (Kann et al., 2015).

Efforts of clinicians and prevention educators to increase consistent use of condoms among adolescents, especially African-American inner-city adolescents, remains a challenge and a priority for reducing negative health outcomes that may result from sexual intercourse (DiClemente et al., 1996). DiClemente et al. (1996) investigated the demographic, psychosocial, and behavioral factors associated with condom use among African-American teens of a San Francisco public housing development. The study involved 264 residents between the ages of 12 and 21 who completed culturally and linguistically appropriate, structured, personal interviews administered in private rooms by trained African-American interviewers. Respondents provided tracking information for researchers to contact them for a follow-up survey completed by 70% of participants six months later. Fifty-six percent of participants reported having vaginal intercourse at some point in their lives. Of those individuals, 78.3% reported engaging in sexual activity during the six months prior to the baseline survey. The mean age of initiation of sexual intercourse for participants was 13.3 years. The reported use of condoms during every experience of sexual intercourse was 41.4 percent. Of those individuals, 66.7% reported continued consistent condom use at the six-month postsurvey. At baseline, 28% reported use of condoms during less than half of the time that they engaged in sexual
intercourse, and 79.4% of those individuals remained infrequent condom users at follow-up, while 20.6% started using condoms consistently. Participants reported a median number of six partners in their lifetime and two within the six months prior to participating in the survey. These results demonstrate more unfavorable than favorable changes in condom use over time. The findings of this study suggest that a large proportion of African-American adolescents who reside in public housing are engaging in high-risk sexual behaviors (DiClemente et al., 1996).

Adolescent Development

Adolescence is a period of significant biological, physical, and psychological change. As individuals mature throughout the period of adolescence, they begin to experience new dimensions of sexuality, more intense feelings, and complex relationships. As youth attempt to create a mature individual identity during the developmental period of adolescence, they are more likely to engage in a variety of risk behaviors (Boustani, Frazier, Hartley, Meinzer, & Hedemann, 2015; Harper & Carver, 1999).

A complex web influences adolescent risk behavior (DiClemente, Salazar, & Crosby, 2007). There are a number of theoretical perspectives that together help create a holistic understanding of adolescent development (Benson, Roehlkepartain, & Rude, 2003). The period of adolescence begins the genital psychosexual stage, which is when attention is placed on resolving sexual tension. Withholding information and denying sexual instincts results in guilt and confusion for young people (Zimmerman, 2015).
Erikson (1964, 1968) later theorized that psychosocial development is a human process that follows a blueprint that includes eight stages. The adolescent phase, which is the fifth stage, is marked by struggles to find personal identity. During this stage, adolescents struggle to select roles, values, and plans for the future that provide a sense of direction and life purpose (Erikson, 1968). Erikson (1964) delineated the primary influences are parents, religion, and the environment during the early stages; peers become increasingly important during adolescence.

Adolescents are more likely to binge drink, smoke cigarettes, engage in casual sex, and evince violent behaviors than those individuals who are older and younger (Chein, Albert, O’Brien, Uckert, & Steinberg, 2011). Policy makers, educators, parents, and representatives in the public health field continue to attempt to understand and explain risk-taking behavior among teens (Suleiman & Brindis, 2014). Adolescent risk behaviors have often been attributed to peer pressure and willfulness, but scientific studies suggest that physiological factors also contribute to risky behaviors among teens (Allen, 2005). Consequently, researchers have begun to focus more attention on the neurobiological changes that take place during the hallmark of adolescence (Smith, Steinberg, & Chein, 2014).

The Adolescent Brain and Risk-Taking Behaviors

Physical, cognitive, hormonal, and emotional changes during adolescence significantly impact adolescent sexual risk-taking. Hormonal shifts at the onset of puberty impact not just physical maturation, but also the brain (Suleiman & Brindis, 2014). The combination of hormonal changes and brain development during adolescence
plays a primary role in the enhanced motivation to engage in sexual and romantic behaviors (Suleiman et al., 2015). The act of forming romantic relationships is an important part of healthy adolescent development as it helps youth gain an understanding of their own identity (Eisenberg et al., 2010).

The hormone testosterone is often associated with males; however, during puberty testosterone levels double for females. The elevated levels of testosterone have been linked to adolescents having a higher reward-response, which may motivate teens to seek arousing and exciting experiences that generate rewards (Suleiman et al., 2015). For this reason, teens may find the short-term benefits more important than the longer-term risks associated with engaging in sexual behavior (Suleiman & Brindis, 2014). Increased risk-taking is often the result of the increased motivation for rewards and sensations in combination with a decreased ability to control impulses in highly emotional situations, particularly those where peers are present (Suleiman et al., 2015).

The primary focus of neurobiological research has been on the developmental patterns of the prefrontal cortex (Smith et al., 2014). Between childhood and adulthood the wiring of the frontal lobe of the brain, which is the area responsible for functions such as learning and socialization, becomes more complex and efficient. The prefrontal cortex is an important part of the frontal lobe as it is responsible for skills such as how to set priorities, organize ideas, form strategies, control impulses, and divide attention (Weinberger, Elvevag, & Giedd, 2005). It appears that at around age 11, the prefrontal cortex and parietal lobes begin a period called pruning, resulting in thinning of grey matter. Researchers argue that the pruning results in more brain function in areas
associated with impulsivity and poor decision-making. While adolescents are engaging in novel and risky acts, it appears that the prefrontal cortex has not matured enough to assess risks adequately (Romer, 2009).

Adolescent brains embrace novelty, risk-taking, and peer acceptance as opportunities to sharpen thinking and build networks of support. These are all essential skills for productive adulthood (Varlas, 2014). The increased cognitive abilities that develop during adolescence prepares individuals to take on more adult-like responsibilities, but because of the neurological changes that they experience, they can be limited in their ability to make sound judgments, control impulses, and plan effectively (Suleiman & Brindis, 2014; Weinberger et al., 2005).

Researchers have proposed a number of factors related to brain development that potentially contribute to heightened risk-taking behaviors during adolescence (Chein et al., 2011). To test the hypothesis that adolescents are significantly more likely to engage in risky behaviors when in the presence of peers, Chein et al. (2011) measured the activity of the brain with different groups of participants (40 adolescents, 14 young adults, and 12 adults) as they were making decisions while playing a simulation game. The researchers asked each participant to report to the study site with two friends of the same age and gender. Initially, participants completed the simulated driving game without the involvement of their peers and then completed the task as their peers observed them from a monitor in the next room. The peers were asked to communicate details of their involvement (e.g., where they were located, what they could see) with the driver via intercom. At the end of the game, the participants completed a series of
questions used to assess differences in the levels of impulsivity. In assessing the
differences between the peer and alone conditions, Chein et al. (2011) found that the
adolescent participants had increased risk-taking behaviors during the time that they were
observed by their peers. The peers had no effect on the behavior of adult participants.
These findings have the potential to inform approaches to reducing risk-taking behaviors
among adolescents.

Although the period of adolescence is commonly described as a period of
heightened risk-taking, Galvan, Hare, Voss, Glover, and Casey (2007) contended that not
all teens can be classified as risk-takers. To assess whether differences in the areas of the
brain are responsible for processing rewards, Galvan et al. (2007) observed seven
adolescents between the ages of 13 and 17 years, 13 children between the ages of 7 and
11 years, and 10 adults. Participants responded to questionnaires by describing their
feelings about engaging in hypothetical scenarios involving risk-taking (e.g., riding in a
car with a driver impaired by alcohol, stealing from a store). The data showed that
children and adolescents who anticipated a negative consequence of a particular behavior
had diminished brain activity in anticipation of a reward, and they were not as likely to
engage in the risk behaviors (Galvan et al., 2007).

By understanding the adolescent brain, educators can better prepare and create
techniques that work with the learning needs of the teen brain (Varlas, 2014). Despite
their adult-like capacity, adolescents do not have the experience to rationally process and
evaluate sexual decisions. Adolescents need additional support and direction to help
them learn appropriate skills and behaviors and make healthier decisions in sexual situations (Suleiman & Brindis, 2014; Weinberger et al., 2005).

Perceptions of Sexual Behaviors of Peers

Peer group selection for adolescents is typically self-selection based on characteristics inherent to the adolescent. The selection of peers for adolescents may be an extension of the values, beliefs, and relationships of the parents (Smith, 2008). According to the social norms theory and theory of reasoned action, behavior is influenced by the social norms surrounding a particular behavior. The influence derives from the individual’s perception of social norms, although perceptions may not be an accurate reflection on actual norms (DiClemente et al., 2007). Teens who believe that their peers are engaging in sexual behaviors are more likely to engage in those behaviors themselves. Peers may also serve as a protective factor, for teens who believe their peers use contraceptives are more likely to use contraceptives, too (Kirby, 2002).

Originally, researchers utilized the notion of cognitive susceptibility to explore the factors associated with adolescents’ readiness to begin smoking cigarettes. L’Engle, Jackson, and Brown (2006) used cognitive susceptibility to present a measure of sexual risk for adolescents based on the premise that being susceptible does not indicate firm intentions to engage in the behavior, but the adolescent is more likely to engage if the opportunity presents itself. L’Engle et al. (2006) recruited 3,261 seventh- and eighth-grade students from 16 middle schools in three districts in the southeastern United States to participate in a questionnaire administered at baseline and follow-up after signed consent from parents and guardians. A trained interviewer set up laptop computers with
the audio-CASI software that allowed participants to listen to the survey questions read aloud to them through earphones as they read and recorded their answers. L’Engle et al. (2006) assessed construct validity through internal structure analysis and tests of relationships with variables and conducted a factor analysis for internal structure analysis. Logistic regression was used to determine if high susceptibility at baseline predicted higher levels of initiating intercourse at follow-up (two years later). The mean age of respondents was 13.7 years at baseline. Of the adolescents classified as nonsusceptible based on responses at baseline, only 10% reported initiating intercourse at follow-up compared to 43% of highly susceptible adolescents, demonstrating that the cognitive susceptibility index can be used to predict sexual behaviors. Those who were cognitively susceptible had greater perceptions that more of their peers were sexually active and reported less positive attachments with parents, school, and church (L’Engle et al., 2006).

Miller et al. (1997) used cognitive susceptibility to compare abstinent adolescents who reported a desire to remain abstinent and those who stated that they were thinking about or planning to engage in sexual activity within the next year. Compared to the delayers, the anticipators reported a perception that their peers were engaging in riskier sexual behaviors and they had less attachment to family, school, and church (Miller et al., 1997).

Consequences of Risky Teen Sexual Behaviors

Sexual activity during the adolescent years can have significant psychosocial and public health consequences. This section addresses the consequences of the risk-taking sexual behaviors of teenagers. Two commonly cited consequences of early sexual
involvement include teen pregnancy and sexually transmitted diseases due to their potential for immediate and ongoing social and economic costs to adolescents, their families, and their communities.

Teen Pregnancy and HIV

Two commonly cited consequences of early sexual involvement include teen pregnancy and sexually transmitted diseases due to their potential for immediate and ongoing social and economic costs to adolescents, their families, and their communities. The high rates of STDs and the association of STDs to morbidity (disease) and mortality (death) make acquiring an STD one of the most significant threats to the well-being of teens (Diclemente et al., 2007). Unplanned pregnancy and the rate of STIs continue to be higher among African-American teens than any other ethnic group (Lee, Cintron, & Kocher, 2014).

Almost 10,000 African-Americans between the ages of 13 and 29 become infected with HIV each year. Rates of HIV and other STDs are particularly high among minority populations in the southeastern United States (Lloyd et al., 2012). In 2009, 65% of the total incidences of HIV infection in the United States were among African-American adolescents between the ages of 13 and 24 years (Lee et al., 2014). African-American adolescents also have a higher rate of other sexually transmitted infections than other ethnic groups, which increases their chances of HIV infection. These disparities in HIV and other STIs call for prevention interventions than can impact larger portions of at-risk African-American teens (Sznitman et al., 2011). HIV and other STDs have a great
impact on the health and well-being of low-income African-American communities (Sznitman et al., 2011).

Other Sexually Transmitted Diseases

One of the most substantial threats to the well-being of adolescents is the risk of acquiring a sexually transmitted disease (STD). Untreated STDs may result in complications such as infertility, chronic pain, cancer, or death (DiClemente et al., 2007). Although efforts to reduce STD/HIV transmission among youth have been implemented for decades, adolescents remain at significant risk (MacDonald et al., 2011). Incidence and prevalence estimates suggest that of the 19 million new cases of STDs that occur each year, young people between the ages of 15 to 24 years account for half of all new sexually transmitted diseases (STDs). This is significant because this age group constitutes only 25% of the population of individuals between the ages of 15 and 44 who have ever been sexually active (Centers for Disease Control & Prevention, 2015). Consequently, the age group of sexually active individuals in the United States with the highest STD rates is the 15- to 19-year-old population (DiClemente et al., 2007).

According to Sales et al. (2014), one in four adolescent females between the ages of 14 and 19 years is infected with at least one of the most common sexually transmitted infections. Among the same age group, nearly one in two African-American females contract an STI (Sales et al., 2014). Using laboratory specimens from patients in 22 states over the age of 13 years newly diagnosed with HIV in 2006, Hall et al. (2008) conducted one of the first studies to provide direct estimates of HIV incidences in the United States and found that 45% of the 56,300 new infections were among African-
Americans. Furthermore, Hall et al. (2008) found the incidence of HIV among African-Americans to be seven times the rate among Whites.

Inequalities in social and economic conditions are reflected in STD rates among some racial and ethnic minorities. With each sexual encounter, individuals in these communities may be more likely to encounter an infected partner than in other communities. Chlamydia remains one of the most commonly transmitted STDs. Sixty-six percent of all reported cases of chlamydia in 2014 were among individuals between the ages of 15 and 24 years. In 2014, the rate of reported cases of chlamydia among Black females between the ages of 15 and 19 years was 4.9 times higher than the rate among White females. The rate of reported chlamydia cases among Black males in that same age group was nine times higher than the rate among White males (Centers for Disease Control & Prevention, 2015).

Numerous biological, behavioral, and cultural factors explain why sexually active adolescents are more susceptible to STDs. For example, adolescents may be at higher risk for certain STDs because of barriers to accessing quality prevention services, including inability to pay, lack of transportation, traditional clinic hours that do not accommodate the school schedule, embarrassment about seeking services or methods of collecting specimens, and concerns about confidentiality (Centers for Disease Control & Prevention, 2015). Most intervention efforts address individual-level and not higher-level factors associated with STD risk, such as the influence of peer norms and media on sexual behaviors. There is a need for prevention interventions for at-risk teens that
address social and cultural conditions that influence sexual behaviors (Centers for Disease Control and Prevention, 2015).

Teen Pregnancy

There continues to be rates of teen pregnancy and sexually transmitted diseases in the United States that are substantially higher than any other western industrialized country (Centers for Disease Control and Prevention, 2011; George et al., 2013). U.S. teen pregnancy rates are two to six times greater than the rates in France, Holland, Denmark, Sweden, and other parts of Western Europe (Hoffman, 2006). Additionally, U.S. teens are 10 times more likely to give birth than teens in Switzerland (Danawi et al., 2016).

Data from the National Center for Health Statistics calculate teen pregnancies by adding births, abortions, and fetal losses, such as miscarriages and stillbirths (Guttmacher Institute, 2016). The 2016 National Campaign to Prevent Teen and Unplanned Pregnancy fact sheet on U.S. teen pregnancy utilized these data. According to this report, despite the high ranking of teen pregnancies, the teen pregnancy rate has declined tremendously since its highest peak in 1991 (116.9 per 1,000 females between the ages of 15 and 19 years). In 2011, the teen pregnancy rate was 52.4 per 1,000 females between the ages of 15 and 19 years. The teen pregnancy rate of nonHispanic Black teens aged 15 to 19 years in 2011 was 92.6 per 1,000 females, which was more than twice the rate among nonHispanic White teens at 35.3 per 1,000 females. The National Campaign to Prevent Teen and Unplanned Pregnancy (2016) estimated that four in every ten nonHispanic Black adolescent females will have at least one pregnancy by the age of 20.
Data for the series of National Vital Statistics Reports are retrieved from filed birth certificates for all babies born in the U.S. (Ventura, Hamilton, & Mathews, 2014). These data include a large sample size of virtually all live births in the United States (Kearney & Levine, 2012). A 2014 National Vital Statistics Report of historical national and state trends of U.S. teen births demonstrated a long-term downward pattern of teen births. The 2014 birth rate for adolescents between the ages of 15 and 19 years was 24.2 births per 1,000, which was less than half the rate of 61.8 per 1,000 in 1991. There were significant differences in the number of births by ethnic groups. The 2014 teen birth rate per 1,000 for nonHispanic Whites was 17.3 compared to a rate of more than double at 34.9 for nonHispanic Black teens (Hamilton, Martin, Osterman, Curtin, & Mathews, 2015). In Georgia, the teen birth rates per 1,000 women between the ages of 15 and 19 years was 117.7 in 1991 for nonHispanic Blacks and 55.1 for nonHispanic Whites. The rates declined among all ethnic groups but remained higher among Blacks with a rate of 42.4 for nonHispanic Blacks in 2012 compared to 26.0 for nonHispanic Whites (Ventura et al., 2014).

The rates of teen pregnancy and teen births are highest among not just African-American teens, but African-American teens who reside in low-income, urban communities have substantially higher rates than any other demographic group in America (Secor-Turner, Sieving, & Garwick, 2011; Tanner et al., 2013). The individual contributing factors identified by researchers include initiation of sexual intercourse earlier in life, engagement in unprotected sexual intercourse, attitudes and beliefs about parenthood, contraceptive use, and gender-role expectations. Contextual factors
identified by researchers include influences of family, peers, partners, and the community (Secor-Turner et al., 2011). To gain a better understanding of the influential contextual factors on the social messages that low-income, urban African-American females receive about childbirth and pregnancy, Secor-Turner and colleagues (2011) surveyed African-American women between the ages of 18 and 22 years. They found that the broader contributing factors include residing in communities with limited economic resources, high levels of unemployment, low levels of income, racial segregation, high crime, and elevated community stress community (Secor-Turner et al., 2011).

The decreased rates of sexual activity, risk behaviors, and teen pregnancy in the recent years are encouraging. However, these rates still need to decrease more because the potential negative consequences of unprotected sex is still a reality for adolescents (Collins et al., 2002). The association between teen parenthood and a number of social, financial, academic, and emotional issues has been demonstrated in empirical studies (Boustani et al., 2015).

Academic achievement is especially challenging for adolescent parents (McCave, 2007). Teenage mothers face incredible obstacles in continuing their education. Even those with a strong support system face a level of stress well beyond that of their nonparenting peers. Teenage mothers have difficulty maintaining regular attendance, and graduating is even more challenging (Klerman, 2004). Parenting consumes a great deal of time and energy, and mothers tend to take on the primary role of childcare. For teenage mothers, taking the time and energy for their child while still maintaining the workload at school is often quite challenging (Hofferth, Reid, & Mott, 2001).
Growing evidence demonstrates a relationship between births to unmarried teens and levels of education. Issues such as school dropout, educational underachievement, and socioeconomic disadvantage are more prevalent among teen mothers compared to women who delay childbearing (Woodward & Ferguson, 2000). Teen pregnancy is the leading reason for dropout for females (National Campaign to Prevent Teen and Unplanned Pregnancy, 2016). Although a number of factors contribute to educational outcomes, studies have revealed that even after making statistical adjustments for the environmental influences, teen parenting alone has a significant impact on school achievement (National Campaign to Prevent Teen Pregnancy, 2012).

To investigate the changes over time of the impact of early childbearing on educational attainment, Hofferth and colleagues (2001) compared teen mothers during the 1960s to teen mothers of later periods. Utilizing data from the National Longitudinal Survey of Youth, the researchers determined that those who became mothers during their teen years were less likely to complete high school than their nonparenting peers. The study found that rates of high school graduation among teen mothers increased in the 1960s, leveled off in the 1970s and 1980s, then declined in the 1990s.

To compare the education levels of young mothers and those who delayed childbearing, Klepinger, Lundberg, and Plotnick (1999) conducted a 12-year follow-up study of 2,795 women using the National Longitudinal Survey of Youth. Participants originally responded to the survey in 1979 and participated in interviews annually through 1991. Those who became mothers before age 18 completed an average of 10.7 years of schooling compared to those mothers who waited until after age 20 and
completed an average of 13.5 years of schooling. Only 29% of participants who became parents before age 18 completed high school compared to 60% who delayed childbearing. The strong association between early childbearing and low educational attainment persisted after considering differences in the personal and social backgrounds of participants (Klepinger et al., 1999).

Hoffman (2006) of the National Campaign to Prevent Teen Pregnancy, which is a private nonprofit organization that receives financial support from private foundations, released a report on the public costs of teen childbearing. Data from this report were included in the 2008 book titled *Kids Having Kids*, which coordinated seven studies on the consequences of teen childbearing utilizing data from the National Longitudinal Survey of Youth. Only 40% of mothers who gave birth before age 17 graduated from high school. Additionally, fewer than 2% of pregnant teens who graduated completed college by the age of 30 years. More recently, Perper, Peterson, and Manlove (2010) utilized data from the National Longitudinal Survey of Youth to conduct a study to determine trends in teen pregnancy and the impact of pregnancy on academic success. A sample of 8,984 youth participated in annual follow-up surveys. Only 38% of adolescent mothers who became parents before the age of 18 graduated from high school or earned a GED by age 22, which means that more teen mothers dropped out than those who graduated.

Children born to teen mothers often experience their own academic struggles (National Campaign to Prevent Teen and Unplanned Pregnancy, 2016). These children are more likely to be part of an unsupportive and less stimulating environment, as well as
possess lower cognitive development and experience more behavioral issues (Boustani et al., 2015; McCave, 2007). Hoffman (2006) reviewed data from the National Longitudinal Survey of Youth and found that children born to teen mothers are more likely to drop out of school themselves when compared to children whose mothers delayed childbearing. In a 2012 study reviewing the results of math and reading readiness tests, children of mothers who gave birth before the age of 18 had scores significantly lower than those born to older parents (National Campaign to Prevent Teen and Unplanned Pregnancy, 2016).

Theoretical Framework

Individual, peer, family, community, and societal factors are all influential on teen sexual development and behaviors (Wright, Duffy, Kershner, Flynn, & Lamont, 2015). Adolescents transition daily through a number of contexts that can be influential. A conceptual framework that considers both individual behavior and environmental determinants is the Bioecological Theory of Human Development, more commonly known as Ecological Systems Theory (EST), originally proposed by Bronfenbrenner to explain how human development occurs (George et al., 2013; McLeroy, Bibeau, Steckler, & Glanz, 1988; Neal & Neal, 2013; Rosa & Tudge, 2013). EST posits that behavior is affected by and affects the interaction of multiple levels of social and environmental contexts (George et al., 2013; McLeroy et al., 1988).

EST is one of the most widely used theoretical frameworks for investigating individuals in ecological contexts (Neal & Neal, 2013). EST considers the direct and indirect impact of an individual’s environment on influencing and reinforcing behaviors
and aspects of personal growth. The bioecological theory provides a relevant framework for studying adolescent development by assessing the settings where a developing individual has continuous interaction over an extended period of time (Bronfenbrenner, 1986; Duerden & Witt, 2010; Griese, Kenyon, & McMahon, 2016; Rosa & Tudge, 2013; Van Horne, Wiemann, Berenson, Horwitz, & Volk, 2009). This theory draws from Piaget and the concept that an individual’s phenomenological world is not simply a representation of the reality of his/her world, but of the individual’s “construction of reality” (Bronfenbrenner, 1979, p. 10). The emphasis of EST is on the individual’s perception of his/her ecological environment and what an individual perceives, desires, and thinks about as knowledge and how the nature of these elements change based on a person’s exposure to his/her environment. EST posits that the most immediate environmental activities that happen to an individual or in an individual’s presence are most impactful and can inspire an individual to engage in similar activities. What an individual perceives has more importance than what is actual, and external activities and other individuals influence the motivation for behavior (Bronfenbrenner, 1979). EST highlights the importance of observation within interpersonal relationships where an individual closely observes the behaviors of another, which motivates the observed party to continue that behavior (Bronfenbrenner, 1979).

EST outlines four levels of interpersonal and intrapersonal environmental influences where changes in one level impact other levels. These levels are the microsystem, mesosystem, exosystem, and macrosystem (Clemons, Wetta-Hall, Jacobson, Chesser, & Moss; Duerden & Witt, 2010; McLeroy et al., 1988). The
microsystem represents interactions and personal relationships within the immediate setting (e.g., unique physical and personal characteristics and experiences, significant others such as peers, family, neighbors). The nature of interpersonal connections changes as an individual develops. For adolescents, the microsystem expands to include more involvement with peers and members of extracurricular activities (Bronfenbrenner, 1979; Duerden & Witt, 2010; Griese et al., 2016; McLeary et al., 1988; Rink, 2006; Steinberg, 2001). During the period of adolescence, peers are more influential on decisions such as engagement in risky behaviors (Steinberg, 2001).

The mesosystem involves the linkages between two or more microsystems and includes other various settings that the individual frequents and actively participates in, such as school and church (Bronfenbrenner, 1979; Duerden & Witt, 2010; Griese et al., 2016; McLeary et al., 1988; Rink, 2006). The exosystem includes external interactions within the larger social systems connecting microsystems to the larger social context (e.g., activities performed by the local school board, a mother and father’s peer group, government institutions, the teacher-parent relationship, unemployment rates, parent’s work environment). General patterns (micro-, meso-, and exosystem) tend to be common within certain cultures or subcultures. These generalized patterns constitute the macrosystem (Bronfenbrenner, 1979), which includes the larger cultural world and refers to the cultural values, norms, and laws in the world that surrounds youth. Examples of macrosystem include public perceptions of youth, media, and the current youth policy climate (Clemons et al., 2011; Duerden & Witt, 2010; McLeary et al., 1988). Individuals who operate within a healthy ecology have the fundamental resources and support to
elicit appropriate responses to social norms and expectations beyond their community (Bronfenbrenner, 1986). For example, if the cultural values and norms support abstinence from risky behaviors, the developing adolescent is provided with a healthy “blue-print” (Clemons et al., 2011, p. 48). *Figure 1* displays the levels of Bronfenbrenner’s Ecological Systems Theory.

*Figure 1.* Levels of influence in Bronfenbrenner’s Ecological Systems Theory. This figure derives from a compilation of information from multiple sources, including the work of Bronfenbrenner (1979, 1986), Duerden & Witt (2010), Meade (2008), Neal & Neal (2013), Rosa & Tudge (2013), and Rink (2006).
To determine whether the ecological factors from the microsystem to the exosystem can predict adolescent sexual behavior, Wright et al. (2015) surveyed three groups: (a) teens who reported currently abstaining from sex; (b) teens who reported engaging in sexual intercourse and using contraceptives at last engagement; and (c) teens who reported engaging in sexual intercourse and not using contraceptives at last engagement in sexual intercourse. Wright et al. (2015) recruited adolescents between the ages of 15 and 21 to participate in training on informed consent, protecting confidentiality, and asking survey questions. The trained youth later read the questions aloud while 744 youth participants recorded their answers to the paper-based survey. Participants answered three questions about their perceptions on what their peers think about engaging in sexual intercourse, using contraceptives, and becoming a teen parent.

Wright et al. (2015) implemented four types of analyses: Cronbach’s alpha to analyze scale reliability; Pearson’s correlations to examine the relationships between the variables of interest; demographic categories to distinguish levels of risk; and logistic regression models to examine individual and social environmental factors and determine whether factors in different levels of the ecological model can predict the group in which youth belong. Of the variables assessed, Wright et al. (2015) found peer norms to be the only true protective factor, which demonstrates the powerful and motivational force that peers have during adolescence. Peer norms were a significant predictor of reported use of birth control at last engagement in sexual intercourse. Peer norms were influential in condom use, supporting the previous research on the powerful influence of peers during
the period of adolescence. Wright et al. (2015) did not find the number of perceived accessible resources for contraceptives to impact sexual behavior.

Wright et al. (2015) also found that African-American male adolescents were more likely to report engaging in sex than males of other racial and ethnic groups. African-American youth reported social issues within their communities more often than youth of other groups. As for parent communication, youth who reported having sex were more likely to have talked to a parent about sex. The study did not account for the content and quality of communication between youth and their parents and if the discussions occurred after the youth became sexually active (Wright et al., 2015). The results of the study demonstrated an interconnectedness of all environmental levels. The recommendation of the researchers was to offer a network of evidenced-based interventions to understand and address needs based on the specific profile of youth in their own communities (Wright et al., 2015).

To explore the role of social networks in providing sexual health information to African-American adolescents, George et al. (2013) utilized the Ecological Systems Theory by focusing on the broader range of individuals who influence adolescents, rather than exploring proximal social networks. George et al. (2013) conducted focus groups and administered a sociodemographic questionnaire to determine the range of social networks where adolescents receive education about sex and the adolescent and parent perspectives on the roles of the different social networks. Mothers and fathers with children between the ages of 15 and 17 years and male and female adolescents participated in separate focus groups.
Most of the adolescent participants reported having previously engaged in sexual activity (George et al., 2013). Both adolescent and parent participants described African-American social networks as complex and influential in providing sexual health education for adolescents. Grandmothers were often mentioned as a key source for sexual health information. Siblings and members of the extended family had more influence than that of other adults. Participants reported schools as a source of limited and basic information about sex that potentially sparked information later clarified by parents or other individuals within the social networks. The respondents reported healthcare providers as emphasizing abstinence and sexually transmitted infections, but not providing information to help with sexual decision-making skills. Participants descriptions of religious institutions as being limited in their effect, as they promoted abstinence and specific values and not decision-making. The results of this study suggested that a variety of African-American individuals play important roles in providing sexuality education for adolescents. Program developers and researchers can acknowledge and support the various social networks of African-American adolescents to help reduce adverse sexual health outcomes (George et al., 2013).

Van Horne and colleagues (2009) applied the Ecological Systems Theory to explore the multiple levels of influence that predict condom use 12 months postdelivery by a multiethnic group of adolescent mothers. In the postpartum hospital unit, 932 adolescent mothers completed the baseline interview within 48 hours after delivery. Both six-month and twelve-month follow-up interviews were completed by 636 participants. Van Horne et al. (2009) found each level of the EST model to be significantly associated
with condom use among participants. Race/ethnicity was an important predictor in condom use behavior among participants.

To gain an understanding of the intergenerational cycle of teen pregnancy discussed in the literature, Meade, Kershaw, and Ickovics (2008) examined risk factors of adolescent childbearing. The researchers hypothesized that environmental factors would significantly impact teen childbearing among offspring. The quantitative study utilized a national sample of 1,430 adolescent females between the ages of 13 and 16 from the National Longitudinal Survey of Youth 1997, which provides data on a sample of U.S. adolescents born in the early to mid-1980s. After accounting for other risks, Meade et al. (2008) found that the offspring of teenage mothers were 66% more likely to become adolescent mothers themselves.

Meade et al. (2008) also discovered a number of risk factors for adolescent childbearing in common for those born to teen moms and those born to older moms. These included poor school performance, lower maternal education, unmarried parents when the child was age two, a high number of other children living in the household, early dating, of African-American race, and living in a less enriching environment. Poor school performance during the early adolescent years may indicate lower intellectual abilities, educational goals, or parental support of education, which may decrease an adolescent’s motivation to delay motherhood. Poor school performance was also associated with delinquency and substance abuse (Meade et al., 2008).

Aronowitz, Rennells, and Todd (2006) conducted focus groups in inner-city community centers with 28 African-American mother-daughter dyads to explore
Bronfenbrenner’s ecological factors influencing the sexual risk behaviors of African-American adolescents. The home, school, and community centers were the three venues identified as sources of formal sex education. Daughters reported school and community centers as primary sources for information about puberty and STDs. Mothers and daughters reported media as a source of exposure.

In addition, Aronowitz et al. (2006) identified community, the macrosystem, as a source of formal and informal sexual content and sexual communication. The exposure to community influences was found to impact their acceptance of societal norms around sexuality. The parents described monitoring of their daughters’ friends and activities and social support as ways to control exposure at the familial and extrafamilial levels of the ecological framework. All ecological categories shaped the attitudes and values of the adolescent participants on sex, relationships, and sexuality (Aronowitz et al., 2006).

Rink (2006) stated that within the mesosystem, the connection to parents, peers, and school serves as familial and social factors that impact an adolescent female’s perceptions of sex. Rink (2006) applied the Ecological Systems Theory in the Add Health Study to examine the forming of perceptions of sex during the adolescent period and the motivation for sexual behavior among adolescent females. The Add Health Study was a longitudinal study that examined adolescent health behaviors, environments, and transitions into young adulthood by including measures of ecological factors. Adolescents of 132 schools were eligible to participate in a series of four surveys. In 1995, approximately 18,924 participated in Wave I, and 13,570 participated in Wave II in
1996. This study compared the responses of adolescent females who reported being depressed and those who did not report depression.

Rink (2006) found that personal devotion or connection with God had a potential protective effect against risky health behaviors. In addition, the respondents of both groups reported feeling strongly connected to their parents and supported the inclusion of parent-daughter relationships when designing programs that address the sexual attitudes and behaviors of adolescent females. The majority of respondents reported a strong connection to peers, who played an important role in either protecting them or putting them at risk for engaging in risky sexual behaviors. Both depressed and nondepressed respondents reported ambivalent perceptions of sex. The study demonstrated that less favorable perceptions have an influence on an adolescent female’s decision to delay sexual debut. Interventions that combine parental involvement, peer involvement, school activities, and spiritual beliefs may be more effective in shaping adolescent females’ perceptions of sex in an effort to delay initiation of sexual intercourse (Rink, 2006).

In an effort to provide information for designing a culturally specific positive youth development curriculum for Northern Plains American Indian youth, Griese and colleagues (2016) used the bioecological framework to identify participants for focus groups with parenting and nonparenting youth, elders, high school personnel, and healthcare providers. The research questions of this investigation referenced ecological items, such as measures of community attitude toward teen pregnancy, media, cultural and social norms, accessibility of reproductive health services, and history of sexual behaviors and contraceptive use of teens.
Griese et al. (2016) conducted multiple focus groups of 5 to 11 participants each with 185 community members. Protective factors found to be most common among American Indian youth included (a) family, describing parenting types, warmth and openness of communication, and appropriate discipline that demanded respect and included consequences for behavior; (b) school, including relationships formed, appropriate sexual education, engagement in extracurricular activities; and (c) enculturation, including involvement in cultural activities and spiritual traditions (Griese et al., 2016).

MacDonald et al. (2011) also used focus groups to explore the individual and contextual factors that influence youth sexual behaviors. Youth contributed to the first phase by informing the process of curriculum design. During the second phase, youth confirmed that the analysis of their input was accurate. Participants reported no support of healthy sexuality from members of the community. Participants also reported mixed feelings about their interactions with friends, parents, teachers, and school counselors, stating that a lack of trust was the main concern. The youth stated that they felt there was a lack of value for them as young men and women in society. MacDonald et al. (2011) concluded that, while youth attempt to take control of their sexual behavior, they face messages that may make it difficult for them. When they receive respect for their views on sexual health, they may feel empowered to make healthier sexual decisions.

Adolescent Voice

Because various perspectives and influential factors influence adolescent behavior, it is imperative to provide the opportunity for the voices of young people to be
heard (Walker, Thomson, & Mearns, 2011). Eisenberg, Wagenaar, and Neumark-Sztainer (1997) investigated student opinions on school sexuality education by conducting focus groups with 29 high school students from five public high schools in Minnesota. Students expressed a desire for a greater variety of material to address their many questions on sexuality, pregnancy, and STD prevention. Students recognized abstinence as an option for prevention, but all participants felt the need to learn more about contraception, including available options, instructions on use, and access to contraceptives. Participants believed that sexuality education should be required for all students and teachers should be more prepared to teach it. Teens also wanted nonjudgmental, nonpersuasive discussions on abortion, information on sexual violence, and tips for talking about sexuality with their parents. The most significant message that the students expressed was the need for sexuality education teachers to create an environment of openness and honesty. Input from the adolescents who can provide insight on current programs is necessary to develop and deliver more efficacious sexuality education (Eisenberg et al., 1997).

To understand students’ perceptions of effective sexuality education, Allen (2005) distributed a survey that solicited suggestions for improving high school sexuality programs to 1180 senior high school students. In terms of classroom structure, participants expressed a desire for opportunities for active participation and a role in making decisions in topics of discussion. Respondents requested to be treated as sexual beings and wished for their sexuality to not be viewed as a problem that needs management and an impediment to the goals of school. Teacher comfort was the final
area identified by respondents, who shared a number of suggested recommendations on improving teachers’ pedagogic approaches. Reflecting on young people’s criteria for effective sexuality education may result in programming that both youth and adults deem as successful (Allen, 2005).

In order to explore the opinions of adolescents’ who participated in a sex education course, Barker (2005) utilized journals and focus groups to review the reflections of 25 adolescents on their experiences throughout the implementation of the course. Respondents listed a variety of sources available for them to receive basic information on sexuality, but expressed an eagerness to learn more about their own sexuality. After participating in the course, students reported an increase in knowledge about the topics discussed. Students felt validated and supported, and they responded that they understood more reasons to delay sexual activity (Barker, 2005).

In response to the disproportionately high rates of pregnancy and births among adolescents of color who reside in low-income urban areas, Tanner et al. (2013) utilized focus groups to examine youths’ perspectives of adolescent pregnancy and parenting in Baltimore, Maryland. Participants included youth from different areas in Baltimore who were in school or out of school. Participants discussed individual, peer, family, and community influences consistent with the social ecological model. Findings suggest that utilizing a socioecological framework for prevention efforts is essential to address the complex set of factors that influence adolescent sexual behavior (Tanner et al., 2013).

Through individual, semistructured interviews, Secor-Turner and colleagues (2011) explored the social messages about childbearing and timing of pregnancy of 18
young, African-American women between the ages of 18 and 22 years who resided in a low-income urban community received. Participants explained that they believed that having sex during the adolescent years was inevitable for the individuals in their community. This belief had a greater influence than their personal values on their decision to engage in intercourse for the first time. Participants also believed that their social environments had the expectations for African-American females to be impoverished, school dropouts, sexually promiscuous, and young unmarried mothers of multiple children. Additionally, participants who were teen parents reported feelings of personal disappointment and embarrassment, as well as a shift in their expectations for their future (Secor-Turner et al., 2011). Although prior research has explored contextual factors, this study captured the perspectives of young women from a community where multiple social contexts shaped their sexuality beliefs and behaviors.

Harper and Carver (1999) described a collaborative effort between a university and a community-based organization where youth were hired as collaborators to help explore HIV-related risk behaviors of suburban street youth. Through interviews, focus groups, and informal discussions, the youth collaborators provided input on the design and recruitment efforts of a youth program that would be relevant for a target population of youth who were not attending school regularly and residing with someone other than a parent or legal guardian. Harper and Carver (1999) administered an anonymous survey that assessed the life experiences and risk behaviors to 677 youths. Additionally, 277 youths participated in an HIV prevention workshop in which the researchers administered a baseline survey and follow-up surveys every three months for a period of one year. The
youth collaborators reported that their involvement throughout the various phases of the project made them feel empowered and valued. Additionally, survey participants reported feeling empowered (Harper & Carver, 1999).

Kimmel et al. (2013) stated that having an understanding of the perspectives of youth on sexuality education is essential. Utilizing a community-based participatory research approach, Kimmel et al. (2013) conducted six single-gendered focus groups with 48 adolescent males and females where they discussed healthy sexuality in their community. The overall youth responses to school-based sexuality education were unfavorable, with a number of complaints about the discomfort of the teachers, the restricted content, and the lack of engaging activities. Participants reported that they reached beyond schools to other sources for sexuality education information including peers, parents, health professionals, and community-based organizations. Despite these complaints, some youth felt that the school was an appropriate environment for the delivery of sexuality education. Kimmel et al. (2013) cited this study as one of few to ask urban African-American youth about their experiences with sexuality education from schools and other sources. Additionally, this study is one of few where input from youth was solicited for the improvement of future experiences with sexuality education. Participant responses suggested that, in addition to schools, the community-at-large, to include peers, parents and other significant adults, and health educators, should also provide education on sexuality (Kimmel et al., 2013).

Selwyn and Powell (2007) used anonymous questionnaires combined with focus groups to explore the influence of advice seeking from school-based sources of sex and
relationship education. Participants were 401 youths between the ages of 12 and 19 years participated in the study. Fifty-seven youths participated in the follow-up focus groups.

Selwyn and Powell (2007) found school instruction was used more frequently as a source of information; however, participants were highly critical of school lessons. Participants reported dissatisfaction in school sex education that had a primary focus on biological aspects of sex and relationships (Selwyn & Powell, 2007).

The contentious history of school-based sexuality education, current state of sexual health of teens in the United States, and the evaluations of current sexuality education efforts present compelling reasons to address further the significant areas in need of improvement to maximize the effectiveness of implementation and provide students with the best sexuality education for supporting and enhancing their sexual health (Elia & Tokunaga, 2015; Suleiman & Brindis, 2014). To maximize the benefits of sexual health education, researchers should focus on determining if the curriculum addresses perceived needs of students (Byers, Sears, Voyer, & Thurlow, 2003). Effective programs consider adolescent needs by understanding adolescents’ views about sexuality education (Kimmel et al., 2013; Walker et al., 2003). Sexual health curriculum should be flexible and relevant to youth and take into account the information that youth want and need to receive (Stevens et al., 2013). Young people should be afforded the opportunity to be actively involved in meeting their own health needs (Kim & Free, 2008).

Summary

The focus of this literature review was to explore the history and the influences on adolescent sexual health. Sexuality education is currently being implemented in some
form in the majority of public middle and high schools in the United States. However, there is a great variation in the quantity and quality of school-based sexuality education programs throughout the United States. The two main forms of sexuality education are (a) comprehensive sexuality education, which encourages abstinence while providing information about contraceptive options, and (b) abstinence-only sexuality education, which stresses abstinence with little or no information about contraceptives. Historically, adolescents have received limited opportunities to contribute to decisions on the preferred approach and list of discussion items for the sexuality education that they receive. This study fills the information gap by examining the perspective of low-income, urban, African-American youth on sexuality education, for this group is disproportionately impacted by adverse consequences of early and risky sexual behaviors. Through solicitation of the opinions of these youth on their experiences with the sexuality education that they have received in public schools and what they believe should be included in such lessons, this study sought to provide insight for curriculum developers and school administrators on modifications that may contribute to the delivery of more relevant and culturally-appropriate interventions.
CHAPTER 3

METHODOLOGY

This quantitative study focused on the impact of social and environmental factors associated with preferences of sexual health information of youth in the low-income areas of Upper County, Georgia (pseudonym). The primary purpose of this study was to explore adolescent opinions on what should be included in family life and sex education courses offered in public schools. The views of youth on what topics are most important in school-based sexual health discussions were compared to what is currently expected of teachers, as demonstrated by the Health Education Performance Standards for the state of Georgia. Additionally, this study sought to determine if there is a correlation between perceived peer engagement in sexual behaviors and endorsement of controversial topics in school-based sexuality education discussions. By comparing the level of perceived peer engagement in sexual behaviors, this study examined whether perceived peer sexual experience norms are related to adolescents’ perceptions of sexual health education needs.

This study utilized the Family Life Sex Education Goal Questionnaire (FLSE-GQ II), which is a cross-sectional survey instrument (see Appendix D). Study participants included African-American adolescents between the ages of 12 and 21 years who resided in the low socioeconomic target communities of Upper County, Georgia. This age range captured those who were current or recent middle and high school students. Through
utilization of the FLSE-GQ II and application of the Ecological Systems Theory (EST) framework, findings provided relevant information for curriculum developers and school administrators to gain a better understanding of what sexuality education information youth wanted. Specifically, this study focused on the microsystem variable of the ecological systems theory (Bronfenbrenner, 1979).

This chapter reviews the methodology that the current study utilized to address the research questions and hypotheses, restated in the following section. This chapter also describes the participant sample and recruitment strategies. There is also an overview of the measures used to assess the demographic characteristics, perceived peer sexual experience norms, and the goals that adolescent participants feel are most important for family life and sexuality education. Further, this chapter offers information on the data analysis procedures and researcher bias of this study.

Research Questions Reiterated

The research questions guiding this study are:

1. What content do low-income, urban African-American youth consider to be most important for family life sexuality education course(s) delivered in public schools?
   
   \( H_a1: \) All participants will support a comprehensive approach to sexuality education including the support of both noncontroversial and controversial topics in family life and sexuality education course delivered in public schools.
2. To what extent does the level of perceived peer history of engagement in sexual activity influence the support of content to be included in public school family life sexuality education courses?

Hₐ₂: Adolescents who perceive their friends as having a higher level of engagement in sexual behaviors will be more likely to endorse a wider range of content.

Research Design

The descriptive method of research is appropriate since the purpose of this study was to investigate the topic areas that urban African-American youth believe are important for public school sexuality education and further explore the influences of friends on the attitudes of adolescents. This cross-sectional quantitative study utilized a voluntary, self-report survey methodology, requesting information about individuals’ opinions on what should be included in public school sexuality education discussions. According to Creswell (2011), quantitative research is used in situations where the researcher identifies a problem based on trends or the need to explain why a situation occurs. Quantitative studies can determine the tendency and variance of responses from individuals. Results can inform how individuals within a population view an issue and the diversity of their opinions.

Creswell (2011) described survey research as a popular design in the field of education. In quantitative research, the survey research designs involve procedures where investigators gather information about a population’s attitudes, behaviors, opinions, or characteristics by administering a survey instrument to participants.
(Creswell, 2011). Isaac and Michael (1997) believed that surveys provide an efficient way to gather data about the characteristics of a group and their current practices, conditions, and needs. Additionally, anonymous surveys can be an appropriate method to capture data on sensitive topics, such as sexual health. In-person, group administration of surveys provides an opportunity for the survey administrator to answer the questions of the survey respondents while they complete surveys (Trochim & Donnelly, 2007). The cross-sectional survey design involves researchers collecting data at one point in time to measure current attitudes, opinions, or practices. An advantage of a cross-sectional study is that data generate at one time, which means gathering of data can occur in a short period (Creswell, 2011).

Research Setting

Upper County, Georgia (pseudonym) encompasses the city of UR as well as several other smaller cities (U.S. Census Bureau, 2010). Importantly, the highest income inequality ratio in the United States is in the city of UR (pseudonym) (Berube & Holmens, 2015). The less affluent southern areas of the city of UR have more adverse health, social, educational, and economic outcomes than other sections of the city and county (U.S. Census Bureau, 2010). Consequently, the highest teen birth rates for teens aged 15-19 years are in the southwest sections (U.S. Census Bureau, 2010).

In 2013, the national average teen birth rate was 26.2 per 1,000 adolescent females aged 15-19. During that same year, the teen birth in Georgia was 30.5 births per 1,000 (higher than the national average). For Upper County, the birth rate for teens of all races was even higher at 32.8 for every 1,000 for that same age group. Disturbingly, the
average teen birth rate among Black teens aged 15 to 19 years in Upper County Black
during this period was 49.6 per 1,000, as compared to only 3.2 per 1,000 for White teens
during the same period (U.S. Census Bureau, 2010).

Although the rate of new HIV infections is decreasing in communities across the
country, Upper County does not reflect this trend. Racial disparities in HIV infections
are also present in Upper County. Seventy percent of new HIV diagnoses in 2014 were
among Blacks (Georgia Department of Public Health, 2016). Of the 200 AIDS-related
deaths in Georgia in 2014, 75% were Black (Health, 2016). The areas with the highest
prevalence of HIV are also the areas of greatest inequalities, including poverty, unstable
housing, high levels of unemployment and crime, and low levels of educational
achievement (Fonner, Armstrong, Kennedy, O’Reilly, & Sweat, 2016).

Research Participants

The sample for this study included youth from low-income communities of Upper
County who have participated in one or more event or activity hosted by either the Care
Point nonprofit organization (pseudonym) or the City of UR Seekers community-based
programs (pseudonym). These participants were representative of not only youth who
historically have limited voice in sexuality education, but also low-income African-
American youth, a population with disproportionately higher rates of sexually transmitted
infections and teen pregnancies than that of other youth populations. At the time of the
study, 100% of the participants of the Adolescent Health & Youth Development program
of Care Point organization were considered low-income, as demonstrated by their
residing in subsidized housing and their eligibility for government assistance, such as
free- or reduced-lunch. Activities planned by Care Point for youth in the community also targeted low-income youth. Over 90% of participants of the Seekers program were considered low-income as demonstrated by their eligibility for government assistance, such as free- or reduced-lunch. Inclusion criteria for this study were: (a) self-identified African-American or Black, (b) residing in UR, Georgia within the limits of Upper County, (c) between the ages of 12 and 21 years, and (d) participation in programs or activities hosted by the Care Point or Seekers organization.

The researcher administered surveys to 100 adolescents between the ages of 12 and 21 years from the target population. This age group was inclusive of current middle and high school students and those who had been out of school or outside of the age group for high school within the last five years. The researcher estimated that statistical power would be sufficient for the proposed analyses. A priori power analysis was conducted in G-POWER to determine a sufficient sample size using an alpha of 0.05, a power of 0.80, and a medium effect size ($f^2 = 0.15$) (Faul, Erdfelder, Buchner, & Lang, 2008). Based on the assumptions, the proposed sample size of 84 was considered adequate for the desired analysis.

Data Collection

Prior to collecting data, the researcher obtained permission from both research sites and the Institutional Review Board of Mercer University (see Appendix A). After obtaining IRB and site approval, the researcher obtained signed consent from a parent or legal guardian of each youth participant under the age of 18 years (see Appendix B) and directly from youth aged 18 years and older. Those under the age of 18 years also signed
an assent form to indicate voluntary participation (see Appendix C). Employees of each respective site provided youth with a letter to send home for parental signature. The letter included a description of the purpose of the evaluation and the types of data to be collected. After obtaining consent from parents and assent from adolescents, those who agreed to participate received an opportunity to ask the researcher questions about the study.

Prior to administering the survey, the researcher addressed the participants and explained that they would be giving their opinions on what they believe should be included in sexuality education discussions. The researcher took precautions to assure the rights of participants and minimize the risk for participants and any other parties involved. Procedures designed to ensure confidentiality included assigning identification numbers to each completed survey instrument and keeping the identity of participants private by not requesting identifying information. All consent forms, survey tools, and demographic information pages were stored separately under lock and key. Data were not shared with other participants or individuals not related to the project.

Participation in the study was voluntary. To assist with reading comprehension, when possible, the researcher read questionnaires aloud as each participant or group of participants completed the survey. Light refreshments were provided during data collection, and a gift card incentive at the value of $5 to $50 was raffled during group settings upon completion of the survey.

To serve as an introduction to the Family Life Sexuality Education Goal Questionnaire (FLSE-GQ II), the researcher constructed sociodemographic questions
derived from validated instruments (Card, Peterson, Niego, & Brindis, 1998). The purpose of the introductory questions was to obtain information to address all areas of the Ecological Systems Theory and help determine specific demographic differences of youth participants. Specifically, the questions requested information on the gender, age, ethnicity, zip code, receipt of government assistance, amount of school-based sexuality education received, and perceptions of the sexual behaviors of friends. Two items included in the introductory questionnaire measured the extent to which respondents perceived their friends engage in sexual behaviors (see Appendix E).

The researcher utilized the sociodemographic questions and the Family Life and Sex Education Goal Questionnaire (FLSE-GQ II) to solicit input from youth participants. Designed by Godin, Frank, and Jacobson (1984), the Family Life Sex Education Goal Questionnaire (FLSE-GQ II) is a comprehensive sexuality tool designed to measure the attitudes of school personnel and community members toward the goals of family life and sex education delivered in a public school setting. The initial FLSE-GQ was updated to form the FLSE-GQ II, which includes additional items that are more relevant to current family life sexuality education needs. The FLSE-GQ II used in this study addresses a broad set of topics through 60 items designed in a 5-point Likert-type response format. The original factor analysis identified the following five goal dimensions: (a) facilitating sexual decision-making, (b) teaching about the physical development of males and females, (c) encouraging respect for diversity, (d) providing secondary prevention, and (e) teaching about the family and integrating sexuality in personal growth (Godin, Frank, & Jacobson, 1998; Kazukauskas & Lam, 2009). The FLSE-GQ II has been administered
to various adult populations. To the knowledge of the researcher, to date, the FLSE-GQ II has not been used to gather opinions of adolescents.

The researcher utilized Creswell’s (2011) recommendations for finding a valid survey instrument. As recommended, the researcher selected the most recent version of an instrument proven reliable and valid, and widely cited by other researchers. Additionally, the instrument gave participants the opportunity to record data that fit the hypotheses in this study, and the instrument uses a Likert-type scale, which is an accepted scale of measurement (Creswell, 2011).

Data Analysis

The researcher assigned numeric scores to each survey question and developed a codebook to assist with data entry and analysis. The researcher utilized the SAS software to enter and analyze the data to address the research questions. The study analyses explored if higher perceptions of peer engagement in sexual activity predicted higher levels of support for the inclusion of more controversial topics in family life and sex education courses. Differences in support of topics between youth who more frequently report a perception that their friends have engaged in sexual intercourse, as evidenced by a rating of 4 (Somewhat Agree) or 5 (Definitely Agree) on the questions related to perceptions of friends compared to participants with a rating of 1 (Definitely Disagree) or 2 (Somewhat Agree) were assessed. This analysis was conducted by utilizing a Chi-square test to examine the relationship between perceived peer sexual history and the response to each of the questions considered controversial. Pearson’s chi-square test is appropriate for determining if there is a relationship between two variables (Field, 2013).
Youth responses were then compared to current expectations for sexuality education as listed in Georgia Board of Education Rule 160-4-2-.12 (see Appendix F.)

Researcher Bias

This researcher discloses her own situated position as an African-American female who has worked in the XY community in various capacities for more than 18 years. However, the researcher is not a full member of the group based on her background. The researcher acknowledges the power dynamics between the participants and the researcher as the former nonprofit professional in a leadership role, as well as any perceived power imbalance that may result from social position or age.

Regardless of the research approach, researchers must consider ethical issues, including protecting participants by exercising nonmaleficence and emphasizing the goal of beneficence (Orb, Eisenhauer, & Wynaden, 2000). This researcher acknowledges her dual role as a leader in her place of employment, Care Point, and a researcher working with participants who engage in activities with Care Point and the partnering agency of Seekers summer program. Because of her commitment to social justice, she encouraged and demonstrated open and transparent participation, respect for the experience and knowledge shared, respect for the research site, and nonhierarchical practices. The ultimate goal of the study was to raise awareness among youth participants and other stakeholders of the social influences in order to enhance the forms of family life and sexuality education interventions that schools and community-based program implement with populations similar to the participants in this study.
Summary

This quantitative study utilized the FLSE-GQ II to examine the opinions of Upper County youth participating in Care Point and Seekers organization activities. The one-time administration of the survey was used to gather opinions on public school sexuality education previously received and opinions about what is most important for such programming. Participants included current or recent middle or high school students between the ages of 12 and 21 years. Responses were examined to determine correlations between those who more frequently report perceptions that their friends are involved in sexual activity. Youth responses were compared to current practices of school-based sexuality education as demonstrated in the Georgia Board of Education Rule 160-4-2-.12 to determine what modifications may be necessary to best meet the unique needs of youth from various environments. Chapter 4 presents the results of the survey.
CHAPTER 4
RESULTS

As stated in Chapters 1 and 3, the study reported here examined the attitudes of youth participants on potential topics to be included in school-based discussions of sexuality education. The study also explored correlations between these attitudes and participants’ perception of their friends’ sexual history. This chapter includes a review of the research questions guiding this study, as well as a description of the research sample, survey instrument, data collection procedures, and data analysis.

The following research questions guided this study:

1. What content do low-income, urban African-American youth consider to be most important for family life sexuality education course(s) delivered in public schools?

   \( \text{H}_a 1: \) All participants will support a comprehensive approach to sexuality education including the support of both noncontroversial and controversial topics in family life and sexuality education course delivered in public schools.

2. To what extent does the level of perceived peer history of engagement in sexual activity influence the support of content to be included in public school family life sexuality education courses?
H$_a$2: Adolescents who perceive their friends as having a higher level of engagement in sexual behaviors will be more likely to endorse a wider range of content.

**Description of the Adolescent Participants**

Data were collected in community-based settings within Upper County, Georgia during the months of July to December 2017. The primary setting was the office of the Care Point nonprofit organization. Data were collected during activities organized by the Care Point organization where groups of interested youth were asked to report to a designated area for survey completion. Members of the Care Point organization assisted in ensuring that consent forms were signed and collected prior to entry into the designated area. One hundred and eighteen youths completed the Family Life Goal Sexuality Education Questionnaire. Two of the surveys were not included in the data analysis because the participants joined the data collection process after the group of youth started taking the survey and did not go back to fill in responses to the initial set of questions. The remaining 16 surveys were not included because these participants did not meet the eligibility criteria since they resided outside of the target community. The statistical software SAS Studio was used for analysis of the 100 surveys.

The study sample included 100 adolescents between the ages of 12 to 21 years. The majority (79%) of participants were between the ages of 12 and 16, with the remaining 21% between the ages of 17 and 21 years. Sixty-one percent of participants identified as female, and 39% identified as male. Table 1 presents a summary of the characteristics of the adolescent participants.
Table 1

Age of Participants by Gender (N=100)

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</tbody>
</table>

Respondents received seven racial/ethnic categories from which to choose (White/Caucasian, Black or African-American, Multiethnic/Multiracial, American Indian or Alaska Native, Asian American or Pacific Islander, Latino/Mexican/Hispanic, and Other) and instructions to select all that applied. One respondent did not select an option, leaving a total of 99 responses. The majority (94.95%) identified as African-American, with both White/Caucasian and Latino/Mexican/Hispanic recorded by 2.02%, and Multiethnic/Multiracial recorded by 1.01% of participants.

Because income is a determinant of risky sexual involvement, the target audience for this study was low-income youth, since they are the group with a history of the highest rates of reported negative impacts of risky sexual involvement (i.e., unintended pregnancy and sexually transmitted infections). The areas within Upper County with the highest prevalence of HIV are the areas of greatest inequalities, including poverty (Georgia Department of Public Health, 2016). Of the 100 respondents, 82% selected at
least one form of government assistance that they believe to be benefiting their household (i.e. food stamps, SSI), and 18% recorded the response “to my knowledge my family has not gotten money from such programs.”

Participants in this study were asked about the amount of sexuality education previously received in school. Of the 100 respondents, 29% reported receiving no previous in-school sexuality education. Forty-eight percent reported receiving sexuality education in one class, while 23% reported having more than one class where sexuality education was included. Table 2 presents this information.

Table 2

*Participant Reported History of In-School Sexuality Education*

<table>
<thead>
<tr>
<th>Response Prompt</th>
<th>Percentage of Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>I have not received sexuality education in school.</td>
<td>29%</td>
</tr>
<tr>
<td>I have received sexuality education in school.</td>
<td>48%</td>
</tr>
<tr>
<td>I have received sexuality education in more than one class.</td>
<td>23%</td>
</tr>
</tbody>
</table>

The 29% of participants reporting a history of receiving no school-based sexuality education demonstrates disparities throughout the United States in the delivery of sexual health information. Although in-school sexuality education receives wide support and the expectation throughout the United States is for teachers to cover sexuality education at some level, the lack of adequate preservice preparation in sexuality education results in inadequate knowledge, reduced comfort level, diminished perceived importance, and
lowered self-efficacy for many teachers (Eisenberg, Madsen, Oliphant, & Seiving, 2013; Eisenberg, Madsen, Oliphant, Seiving, & Resnick, 2010). Figure 2 represents the ages of the respondents reporting that they did not receive in-school sexuality education.

![Reported History of No In-School Sexuality Education by Participant Age](chart.png)

*Figure 2. Reported history of no in-school sexuality education by participant age*

As seen above in *Figure 2*, the 29% who reported not receiving sexuality education is distributed among most of the various ages of participants. Only one (.034%) of the 13 participants between the ages of 18 to 21 years reported receiving no sexuality education, while 24% of those aged 12 years and 15 years and 14% of participants aged 13 years and 16 years reported no in-school sexuality education.
Perceived Peer Sexual History

One purpose of this research was to determine if there was a correlation between adolescent participants’ perception of their friends’ sexual history and their support for the inclusion of controversial topics in family life and sexuality education discussions within schools. To understand the survey participants’ perception of their friends’ history of sexual involvement, the demographic survey included the question: “How many of your friends do you think are or have been sexually active (have had sexual intercourse)?” As demonstrated in Table 3, 26% of respondents reported they thought that none of their friends are, or have been, sexually active, and 41% of participants responded “some.” The response of “most” was selected by 18% of the participants; 15% of survey participants reported they believed “all” their peers are, or have been, sexually active.

Table 3

Reported Perceptions of the Number of Friends Who Are or Have Been Sexually Active by Participant Age

<table>
<thead>
<tr>
<th>Age</th>
<th>None</th>
<th>Some</th>
<th>Most</th>
<th>All</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>12</td>
<td>11</td>
<td>3</td>
<td>2</td>
<td>0</td>
<td>16</td>
</tr>
<tr>
<td>13</td>
<td>7</td>
<td>5</td>
<td>1</td>
<td>0</td>
<td>13</td>
</tr>
<tr>
<td>14</td>
<td>5</td>
<td>6</td>
<td>3</td>
<td>3</td>
<td>17</td>
</tr>
<tr>
<td>15</td>
<td>2</td>
<td>11</td>
<td>3</td>
<td>1</td>
<td>17</td>
</tr>
<tr>
<td>16</td>
<td>0</td>
<td>11</td>
<td>3</td>
<td>2</td>
<td>16</td>
</tr>
<tr>
<td>17</td>
<td>1</td>
<td>2</td>
<td>4</td>
<td>1</td>
<td>8</td>
</tr>
<tr>
<td>18</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>19</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>20</td>
<td>0</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>21</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>26</td>
<td>41</td>
<td>18</td>
<td>15</td>
<td>100</td>
</tr>
</tbody>
</table>
Of the 15% (15 respondents) who reported they believed all their friends have a history of being sexually active, 53% (8 survey participants) were between the ages of 18 and 21 years. The remaining seven were between the ages of 14 and 17 years, with no participants aged 12 and 13 years reporting a belief that all their friends have a history of sexual activity. This suggests that, although signs of early sexual activity such as teen pregnancy and sexually transmitted infections are more prevalent among this community than other surrounding areas, the youngest survey participants did not believe that their interpersonal environment represents those statistics.

As individuals advance through the stages of adolescence, the likelihood of engaging in sexual intercourse increases. As demonstrated in Figure 3, the percentage of youth participants in this study who reported that none of their friends have engaged in sexual intercourse decreased by age, demonstrating that older participants believe that more of their friends are or have engaged in sexual intercourse.
Figure 3. Percentage of participants who reported they perceived that “none” of their friends have a history of sexual activity

As displayed in Figure 3, 69% of 12 years olds, 54% of 13 years olds, 29% of 14 years olds, 12% of 15 years olds, 0% of 16 years olds, 13% of 17 years olds, and 0% of 18 to 21 years olds reported that none of their friends had a sexual history. To gather additional information about the survey respondents’ perception of their friends’ history of sexual involvement, participants were asked, “How many of your friends do you think are or have been pregnant or have gotten someone pregnant?” Table 4 and in Figure 4 present the results of the participant responses to this question.
Table 4

*Reported Perceptions of the Number of Friends Who Have Been Pregnant or Gotten Someone Pregnant by Participant Age*

<table>
<thead>
<tr>
<th>Age</th>
<th>None</th>
<th>Some</th>
<th>Most</th>
<th>All</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>12</td>
<td>13</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>16</td>
</tr>
<tr>
<td>13</td>
<td>11</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>13</td>
</tr>
<tr>
<td>14</td>
<td>10</td>
<td>4</td>
<td>0</td>
<td>3</td>
<td>17</td>
</tr>
<tr>
<td>15</td>
<td>8</td>
<td>8</td>
<td>1</td>
<td>0</td>
<td>17</td>
</tr>
<tr>
<td>16</td>
<td>5</td>
<td>9</td>
<td>2</td>
<td>0</td>
<td>16</td>
</tr>
<tr>
<td>17</td>
<td>2</td>
<td>5</td>
<td>1</td>
<td>0</td>
<td>8</td>
</tr>
<tr>
<td>18</td>
<td>1</td>
<td>5</td>
<td>0</td>
<td>0</td>
<td>6</td>
</tr>
<tr>
<td>19</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>20</td>
<td>0</td>
<td>3</td>
<td>2</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>21</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>50</td>
<td>38</td>
<td>8</td>
<td>4</td>
<td>100</td>
</tr>
</tbody>
</table>

Fifty percent of the survey participants recorded the response “none”, 38% selected the response “some”, 8% selected the response “most”, and 4% of participants recorded the response “all”, as displayed in *Figure 4*. 
Figure 4. Percentage of participants who reported they believed that “none” of their friends have been pregnant or gotten someone pregnant

The response “none” was selected by 81% of respondents aged 12 years, 85% of those aged 13 years, 47% of respondents aged 15 years, 31% of respondents aged 16 years, and 16% of respondents aged 17 years. None (0%) of the participants between the ages of 19 to 21 years reported that none of their friends had been pregnant or gotten someone pregnant. These results suggest that the widest gap in reported perceptions is among those aged 13 and 14 years. They are the only age group with respondents who reported they believed that all of their friends had been pregnant or gotten someone pregnant, while over half reported they believed that none of their friends had been pregnant or gotten someone pregnant.

Additionally, of the 4% of survey participants who recorded the response “all”, one participant (25%) was 13 years of age, and the remaining 75% of the four
participants were aged 14 years. It is important to note that the friends that these participants believed to have a history of pregnancy may not be the same age as the participants. The participants may be referring to individuals in an older age bracket who they consider as friends. In contrast, 85% of respondents aged 13 years and 59% of those aged 14 years selected the response “none.”

Content Most Supported by Youth Participants

Previous use of the Family Life Sex Education Goal Questionnaire (FLSEGQ) was with adult populations, and the survey was primarily used to determine the topics that school administrators, teachers, parents, and other members of the community from various communities believed to be important for school-based discussions on family life and sexuality education. The first research question of the study was to determine the content that urban African-American youth find most important for family life sexuality education courses. To analyze the survey responses to address the first research question, the researcher utilized the SAS statistical software to determine the frequency distribution of the responses to each survey goal statement. Appendix G displays a complete list of the participant rankings for all 60 Family Life Sexuality Education Goal Questionnaire (FLSEGQ) goal statements demonstrating participants’ support for the various topics.

Topics Rating of High Importance to Youth

As hypothesized, participants reported support of a wide range of topics with high levels of support for the majority of the 60 survey questions. For additional insight on participant support of sexual health issues, each item in the FLSE-GQ II was reviewed individually to determine the items found most important to address based on a response
of “very important” at a rate of 50% or greater. Participant responses may be found in Table 5. Topics are arranged in order with the topics with the highest overall rating on top to exhibit the topics that the participants believe are most important.

Table 5

*Goals that 50% or More of Participants Rated “Very Important” or “Somewhat Important”*

<table>
<thead>
<tr>
<th>Topic</th>
<th>Goal on Family Life Sex Education Goal Questionnaire</th>
<th>% Rated “Very Important” or 5 on Likert Scale</th>
<th>% Rated “Somewhat Important” or 4 on Likert Scale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sexually Transmitted Infections/HIV</td>
<td>25. To provide information about sexually transmitted infections including HIV and AIDS.</td>
<td>85%</td>
<td>3%</td>
</tr>
<tr>
<td></td>
<td>50. To teach students about the ways in which HIV is transmitted</td>
<td>82%</td>
<td>5%</td>
</tr>
<tr>
<td></td>
<td>56. To teach students about ways to have safer sex to reduce the risk of HIV infection</td>
<td>81%</td>
<td>10%</td>
</tr>
<tr>
<td></td>
<td>48. To teach about the different types of sexually transmitted infections or diseases</td>
<td>71%</td>
<td>17%</td>
</tr>
<tr>
<td>Expectant Teen Parents</td>
<td>60. To encourage pregnant girls to stay in school and to provide special classes for them in prenatal care</td>
<td>76%</td>
<td>13%</td>
</tr>
<tr>
<td></td>
<td>39. To counsel girls who are pregnant</td>
<td>65%</td>
<td>18%</td>
</tr>
<tr>
<td></td>
<td>10. To discuss ways of coping with an unexpected pregnancy</td>
<td>64%</td>
<td>15%</td>
</tr>
<tr>
<td></td>
<td>12. To provide information about how to be good parents</td>
<td>63%</td>
<td>19%</td>
</tr>
<tr>
<td></td>
<td>31. To counsel boys who are expectant fathers.</td>
<td>62%</td>
<td>18%</td>
</tr>
<tr>
<td></td>
<td>43. To provide information about good prenatal care</td>
<td>60%</td>
<td>21%</td>
</tr>
<tr>
<td>Hygiene</td>
<td>59. To encourage personal hygiene</td>
<td>75%</td>
<td>14%</td>
</tr>
<tr>
<td>Reproductive Health &amp; Birthing</td>
<td>9. To provide information about the biology of human reproduction and birth</td>
<td>72%</td>
<td>17%</td>
</tr>
<tr>
<td>Goal Setting &amp; Planning</td>
<td>54. To help adolescents plan for and start working toward future goals</td>
<td>70%</td>
<td>14%</td>
</tr>
<tr>
<td>Self-Esteem</td>
<td>46. To provide individual counseling to students with low self-esteem or those who feel embarrassed about their bodies</td>
<td>67%</td>
<td>14%</td>
</tr>
</tbody>
</table>
Table 5 (continued)

<table>
<thead>
<tr>
<th>Topic</th>
<th>Goal on Family Life Sex Education Goal Questionnaire</th>
<th>% Rated “Very Important” or 5 on Likert Scale</th>
<th>% Rated “Somewhat Important” or 4 on Likert Scale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical Development</td>
<td>45. To teach about biological changes during puberty</td>
<td>66%</td>
<td>17%</td>
</tr>
<tr>
<td></td>
<td>33. To help adolescents to view the growth changes in their bodies as normal and healthy</td>
<td>56%</td>
<td>25%</td>
</tr>
<tr>
<td></td>
<td>32. To correct myths and misinformation about the body</td>
<td>55%</td>
<td>29%</td>
</tr>
<tr>
<td></td>
<td>5. To help adolescents understand how sexual development affects other aspects of personal growth and development</td>
<td>51%</td>
<td>25%</td>
</tr>
<tr>
<td></td>
<td>4. To provide information about abnormal sexual development and behavior</td>
<td>50%</td>
<td>20%</td>
</tr>
<tr>
<td>Responsibilities</td>
<td>55. To provide information about the roles and challenges that go along with reaching different ages in life</td>
<td>64%</td>
<td>23%</td>
</tr>
<tr>
<td></td>
<td>16. To help adolescents understand their responsibilities to self, family, and friends as they grow up</td>
<td>60%</td>
<td>23%</td>
</tr>
<tr>
<td>Abortion</td>
<td>8. To provide information about abortion and its effects on the body</td>
<td>63%</td>
<td>18%</td>
</tr>
<tr>
<td>Reproductive Health</td>
<td>6. To provide complete information about male and female genitalia (sex organs) and other physical differences between men and women</td>
<td>61%</td>
<td>17%</td>
</tr>
<tr>
<td>Peer Pressure</td>
<td>24. To educate adolescents about peer pressure and how to deal with it</td>
<td>61%</td>
<td>23%</td>
</tr>
<tr>
<td>Parent Communication</td>
<td>19. To encourage adolescents to talk more openly with their parents about sexuality</td>
<td>60%</td>
<td>20%</td>
</tr>
<tr>
<td>Contraceptives</td>
<td>44. To provide information about contraceptives and how they work, and describe their effects on the body. To demonstrate how to put on a condom using a plastic teaching model or banana</td>
<td>59%</td>
<td>21%</td>
</tr>
<tr>
<td></td>
<td>17. To inform youth of community services related to birth control and sexual decision-making</td>
<td>56%</td>
<td>17%</td>
</tr>
<tr>
<td></td>
<td>21. To encourage adolescents to use contraceptives if they decide to have sexual intercourse</td>
<td>55%</td>
<td>22%</td>
</tr>
<tr>
<td></td>
<td>23. To help adolescents understand people’s feelings and points of view</td>
<td>53%</td>
<td>22%</td>
</tr>
<tr>
<td>Adolescence</td>
<td>53. To help adolescents to see that most young people are going through many of the same things as they grow toward maturity</td>
<td>58%</td>
<td>18%</td>
</tr>
<tr>
<td>Family Life &amp; Personal Growth</td>
<td>16. To help adolescents understand their responsibilities to self, family, and friends as they grow up</td>
<td>60%</td>
<td>23%</td>
</tr>
<tr>
<td></td>
<td>13. To help adolescents learn to understand and communicate with each other better</td>
<td>57%</td>
<td>26%</td>
</tr>
<tr>
<td></td>
<td>11. To help adolescents develop skills in getting along with members of the opposite sex</td>
<td>56%</td>
<td>19%</td>
</tr>
<tr>
<td></td>
<td>23. To help adolescents understand people’s feelings and points of view</td>
<td>56%</td>
<td>19%</td>
</tr>
</tbody>
</table>
Table 5 (continued)

<table>
<thead>
<tr>
<th>Topic</th>
<th>Goal on Family Life Sex Education Goal Questionnaire</th>
<th>% Rated “Very Important” or 5 on Likert Scale</th>
<th>% Rated “Somewhat Important” or 4 on Likert Scale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parent Communication</td>
<td>57. To discuss ways to help families talk more openly and improve family communication</td>
<td>55%</td>
<td>27%</td>
</tr>
<tr>
<td>Respect for Diversity</td>
<td>47. To meet with parents about a child who is having difficulties with sexual issues and stresses.</td>
<td>58%</td>
<td>17%</td>
</tr>
<tr>
<td></td>
<td>49. To teach about how families may differ in how they make rules and decisions</td>
<td>51%</td>
<td>20%</td>
</tr>
</tbody>
</table>

The three items rated the highest at 81% or more of participants rating it “very important” were all related to HIV and other sexually transmitted infections (STIs).

Information for expectant teen parents was the second category with the highest ratings. Hygiene, reproductive health and birthing, and goal setting were also among the highest rated topics by survey participants. In contrast, items with the lowest ratings included goal items related to involving parents in selecting family life sex education curricula, emphasizing the importance of family, using a plastic teaching model or banana for condom demonstrations, discussing personal family experiences in the classroom, and referring students with special needs to social services for support.

Controversial Versus Noncontroversial Topics

In a previous study conducted by the survey developers, Godin, Frank, and Jacobson (1998), the 60 Likert-type goal statements were divided into five factor dimensions (topics). Of the five dimensions, two were considered controversial: 1) Sexual Decision-Making; and 2) Secondary Prevention. Topics addressed by these goal dimensions include counseling expectant fathers; pregnant females; referring students to
community agencies; discussing family issues and growth and development; and meeting
parents with children who are having difficulties. The noncontroversial factor
dimensions were Physical Development, Respect for Diversity, and Family Life and
Personal Growth. These goal dimensions address several topics, including having a
healthy view and correct information about growth and development; differences of
family expectations; family roles and conflict resolution; and sexually transmitted
infections. To further demonstrate the range of support among participants Tables 7-11
are arranged by the five factor dimensions to present the variety of controversial and
noncontroversial topics that received the most support, as demonstrated by having the
largest percentage of respondents rating it as “very important.” Table 6 lists the goals
that at least 50% of the participants considered “very important” in the controversial
factor dimension Sexual Decision-Making.

Table 6

*Sexual Decision-Making: Controversial Factor Dimension*

<table>
<thead>
<tr>
<th>Goal Number</th>
<th>Goal Statement</th>
<th>Percentage Rated Very Important</th>
</tr>
</thead>
<tbody>
<tr>
<td>8</td>
<td>To provide information about abortion and its effects on the body</td>
<td>63%</td>
</tr>
<tr>
<td>10</td>
<td>To discuss ways of coping with an unexpected pregnancy</td>
<td>64%</td>
</tr>
<tr>
<td>17</td>
<td>To inform youth of community services related to birth control and sexual decision-making</td>
<td>55%</td>
</tr>
<tr>
<td>21</td>
<td>To encourage adolescents to use contraceptives if they decide to have sexual intercourse</td>
<td>53%</td>
</tr>
<tr>
<td>43</td>
<td>To provide information on good prenatal care</td>
<td>60%</td>
</tr>
</tbody>
</table>
The controversial factor dimension Secondary Prevention includes three goals. Table 7 lists the goals that had responses of “very important” from at least 50% of participants. Of the three goals under the controversial factor dimension Secondary Prevention, two received the response “very important” by the majority of participants.

Table 7

*Secondary Prevention: Controversial Factor Dimension*

<table>
<thead>
<tr>
<th>Goal Number</th>
<th>Goal Statement</th>
<th>Percentage Rated Very Important</th>
</tr>
</thead>
<tbody>
<tr>
<td>39</td>
<td>To counsel girls who are pregnant</td>
<td>65%</td>
</tr>
<tr>
<td>45</td>
<td>To teach about biological changes during puberty</td>
<td>66%</td>
</tr>
</tbody>
</table>

Table 8 presents the percentage of participants who responded “very important” to each goal under the Physical Development noncontroversial dimension. Two of the nine goals related to Physical Development received majority support, with over 50% of participants rating it “very important.”

Table 8

*Physical Development: Noncontroversial Factor Dimension*

<table>
<thead>
<tr>
<th>Goal Number</th>
<th>Goal Statement</th>
<th>Percentage Rated Very Important</th>
</tr>
</thead>
<tbody>
<tr>
<td>32</td>
<td>To correct myths and misinformation about the body</td>
<td>55%</td>
</tr>
<tr>
<td>33</td>
<td>To help adolescents to view the growth changes in their bodies as normal and healthy</td>
<td>56%</td>
</tr>
</tbody>
</table>
Table 9 lists the three goals under the *respect for diversity* noncontroversial factor dimension. All three goals in the respect for diversity category received majority support, with over 50% of participants rating them as “very important.”

**Table 9**

*Respect for Diversity: Noncontroversial Factor Dimension*

<table>
<thead>
<tr>
<th>Goal Number</th>
<th>Goal Statement</th>
<th>Percentage Rated Very Important</th>
</tr>
</thead>
<tbody>
<tr>
<td>47</td>
<td>To meet with parents about a child who is having difficulties with sexual issues and stresses.</td>
<td>58%</td>
</tr>
<tr>
<td>48</td>
<td>To teach about the different types of sexually transmitted infections or diseases</td>
<td>71%</td>
</tr>
<tr>
<td>49</td>
<td>To teach about how families may differ in how they make rules and decisions</td>
<td>51%</td>
</tr>
</tbody>
</table>

Table 10 lists two goals under the Family Life and Personal Growth noncontroversial factor dimension that received a response of “very important’ by more than 50% of participants.

**Table 10**

*Family Life and Personal Growth: Noncontroversial Factor Dimension*

<table>
<thead>
<tr>
<th>Goal Number</th>
<th>Goal Statement</th>
<th>Percentage Rated Very Important</th>
</tr>
</thead>
<tbody>
<tr>
<td>16</td>
<td>To help adolescents understand their responsibilities to self, family, and friends as they grow up</td>
<td>60%</td>
</tr>
<tr>
<td>23</td>
<td>To help adolescents understand people’s feelings and points of view</td>
<td>56%</td>
</tr>
</tbody>
</table>
As seen in Tables 6 through 11, participants reported support of both controversial and noncontroversial topics. The first hypothesis of this study was that all participants would support a comprehensive approach to sexuality education, including the support of both noncontroversial and controversial topics. Of the nine goals identified as controversial, seven received majority support from participants with the response “very important” at a rate of 50% or more. Of the 11 goals in the noncontroversial category, seven had support with the response “very important” at a rate of 50% or more.

Responses by Perceived Sexual History of Friends

Another purpose of this study was to determine if there was a relationship between perceived peer sexual history and participants’ level of support for controversial topics in school-based sexuality education. Specifically, responses to the following controversial goal statements were reviewed for the second research question: 8, 10, 17, 18, 21, 39, 43, 45, and 57. As presented in Tables 7 and 8, 50% or more of survey participants rated goal statements 8, 10, 17, 21, 39, 43, and 45 as “very important”, demonstrating an overall high level of support for controversial topics.

A chi-square test was performed to examine the relationship between perceived peer sexual history and the response to each of the goal statements considered controversial. Pearson’s chi-square test is appropriate for determining if there is a relationship between two variables. The proportional odds assumption states that regardless of the ordering of categories a predictor variable has the same effect on moving up to the next higher category (Field, 2013). For several of the goals, very few
participants selected the options “very unimportant”, “somewhat unimportant”, and “neutral.” To avoid violation of proportional odds, some groups were collapsed based on similarities. For example, the Likert rating of 1 to 5 was collapsed so that the responses Neutral, Somewhat Unimportant, and Very Unimportant were grouped together, instead of being in their original three separate groups. Additionally, youth who reported either “most” or “all” of their friends as being sexually active were collapsed into one group. The same procedure for collapsing responses was utilized for all controversial goals. Despite these efforts, proportional odds were violated for the following goals: 10, 17, 43, and 45.

A chi-square test was performed to examine the relationship between the responses to the controversial survey goal statements (8, 18, 21, 39, and 57) and participants’ reported perception of their friends’ sexual history. For goal statement 8, “To provide information about abortion and its effects on the body”, the relationship between these variables was significant: $X^2 (2, N = 100) = 7.5816, p = .023$. As demonstrated in Table 11, there was no detectable significant difference between responses by participants’ perceptions of peer sexual history for the remaining controversial goals (18: “To counsel girls who are pregnant”, $X^2 (3, N = 100) = .5890, p = .897$; goal 21: “To encourage adolescents to use contraceptives if they decide to have sexual intercourse”, $X^2 (2, N = 100) = 4.9898, p = .083$; goal 39: “To counsel girls who are pregnant”, $X^2 (3, N = 100) = 5.6542, p > .129$; and 57: “To discuss ways to help families talk more openly and improve family communication”, $X^2 (2, N = 100) = , p > .568$).
Table 11

Results for Controversial Goals

<table>
<thead>
<tr>
<th>Goal Number</th>
<th>Goal Statement</th>
<th>$p$</th>
</tr>
</thead>
<tbody>
<tr>
<td>8</td>
<td>To provide information about abortion and its effects on the body</td>
<td>.023</td>
</tr>
<tr>
<td>18</td>
<td>To counsel adolescents to make their own decisions about how far to go in their sexual activities</td>
<td>.897</td>
</tr>
<tr>
<td>21</td>
<td>To encourage adolescents to use contraceptives if they decide to have sexual intercourse</td>
<td>.083</td>
</tr>
<tr>
<td>39</td>
<td>To counsel girls who are pregnant</td>
<td>.129</td>
</tr>
<tr>
<td>57</td>
<td>To discuss ways to help families talk more openly and improve family communication</td>
<td>.568</td>
</tr>
</tbody>
</table>

While this study demonstrates some evidence that friends influence perceptions of sexual health needs, this study provided only minor insight into the ecological influence of friends on adolescent perceptions of their need for information on controversial issues. As seen in Table 11, the finding of peer influence was observed with statistical significance in goal 8, but not observed in other goals within the controversial factor dimension.

Summary

This study employed a quantitative methodology to examine the range of topics that disadvantaged, African-American youth find most important for inclusion in school-based family life and sexuality education discussions, as well as determine if the perception of their peer’s sexual behavior impact the level of support for controversial topics. The Family Life Sexuality Education Goal Questionnaire, previously utilized
with adult participants, was the survey instrument used by the researcher to obtain information on participants’ support for different topics. Adolescent participants included individuals between the ages of 12 to 21 years who were part of community-based initiatives of two youth-serving organizations located in Metro-UR, Georgia. All survey goals were assessed to address the first hypothesis. The focus of the first hypothesis was on the range of sexual health topics supported by youth participants. As hypothesized, there was strong support from participants on a wide array of topics with HIV-related issues garnering the most support.

The focus of the second hypothesis was on participant responses to the goals within the two controversial factor dimensions, predicting that those who perceive their friends as having a history of sexual activity will report a higher need for the inclusion of controversial topics in sexuality education as demonstrated by their support of the topics within the controversial factor dimensions. The finding of peer influence was observed with statistical significance in participants’ responses to goal statement 8, but not observed in responses to other goals within the controversial factor dimensions.
CHAPTER 5
DISCUSSION

In this chapter, I first review the purpose of the study and the research method utilized. I then discuss the survey findings in relation to previous research and the Ecological Systems Theory. The limitations of my research are also addressed, as well as recommended future research directions.

The following research questions guided this investigation:

1. What content do low-income, urban African-American youth consider to be most important for family life sexuality education course(s) delivered in public schools?
   
   $H_a1$: All participants will support a comprehensive approach to sexuality education including the support of both noncontroversial and controversial topics in family life and sexuality education course delivered in public schools.

2. To what extent does the level of perceived peer history of engagement in sexual activity influence the support of content to be included in public school family life sexuality education courses?
   
   $H_a2$: Adolescents who perceive their friends as having a higher level of engagement in sexual behaviors will be more likely to endorse a wider range of content.
The purpose of this investigation was to extend the limited existing knowledge of adolescents’ perceived sexual health education needs, as well as explore the impact of perceptions of friends’ sexual history on stated needs by drawing upon the Ecological Systems Theory (EST). The EST considers the direct and indirect impact of an individual’s interactions between multiple factors within their environment on influencing and reinforcing behaviors and aspects of personal growth. This theory provides a relevant framework for studying adolescents by assessing the settings where a developing individual has continuous interaction over an extended period (Bronfenbrenner, 1979, 1986; Duerden & Witt, 2010; Griese, Kenyon, & McMahon, 2016; Van Horne, Wiemann, Berenson, Horwitz, & Volk, 2009; Rosa & Tudge, 2013). According to the EST, an adolescents’ behavior is not only influenced by their progression of maturation, but also by their interactions between multiple factors within their environment, which affect their perceptions of a behavior (Bronfenbrenner, 1979). The EST draws from Piaget and the concept that an individual’s phenomenological world is not simply a representation of the reality of their world, but of the individual’s “construction of reality” (Bronfenbrenner, 1979, p. 10). The emphasis of the EST is on the individual’s perception of his or her ecological environment, as these perceptions have more influence than what is actual (Bronfenbrenner, 1979).

The key findings from the analysis of the data are listed below and then described in detail:

- Though sexuality education is mandated in the state of Georgia 29% of study participants reported no history of in-school sexuality education. Most of
these youth were aged 12 and 13 years and may not have yet received in-school sexuality education.

• Twenty-six percent of respondents reported that they thought that “none” of their friends were or had been sexually active, and 15% of survey participants reported that they believe that “all” friends were or had been sexually active.

• Fifty percent of the survey participants responded that they believe that “none” of their friends have been pregnant of have gotten someone pregnant, and 4% of participants recorded the response “all.”

• Participants demonstrated support for the inclusion of a wide array of both controversial and noncontroversial sexual health topics in school-based sexual health discussions.

• The three survey questions found most important by participants as demonstrated by them being given the highest ratings are all HIV-related questions. Support for information for expectant teen parents was the next category that received the highest participant ratings. Hygiene, reproductive health and birthing, and goal setting were also among the highest rated topics by survey participants.

• A correlation was identified between perceptions of peer sexual history and the endorsement of question #8: “To provide information about abortion and its effects on the body.”

• Participants expressed support for many of the topics listed in the Georgia guidelines for sex and HIV education (i.e. peer pressure, local community
values); however, these topics were not among the issues that received the highest participant ratings.

Range of Topics Supported

The first hypothesis of this study suggested that, based on Bronfenbrenner’s ecological systems theory, the community where study participants reside impacts their perception of their need for sexual health information. The Ecological Systems Theory posits that individuals are influenced by the interaction of multiple levels of social and environmental contexts (George et al., 2013; McLeroy, Bibeau, Steckler, & Glanz, 1988). EST outlines four levels of interpersonal and intrapersonal environmental influences where changes in one level impact other levels. These levels are the microsystem, mesosystem, exosystem, and macrosystem (Bronfenbrenner, 1979; Clemons, Wetta-Hall, Jacobson, Chesser, & Moss; Duerden & Witt, 2010; McLeroy et al., 1988). The microsystem represents interactions and personal relationships within the immediate setting (e.g., unique physical and personal characteristics and experiences, significant others such as peers, family, neighbors).

The mesosystem involves the linkages between two or more microsystems and includes other various settings that the individual frequents and actively participates in, such as school and church (Bronfenbrenner, 1979; Duerden & Witt, 2010; Griese et al., 2016; McLeroy et al., 1988; Rink, 2006). The exosystem includes external interactions within the larger social systems connecting microsystems to the larger social context (e.g., activities performed by the local school board, a mother and father’s peer group, government institutions, the teacher-parent relationship, unemployment rates, parent’s
work environment). General patterns (micro-, meso-, and exosystem) tend to be common within certain cultures or subcultures. These generalized patterns constitute the macrosystem (Bronfenbrenner, 1979), which includes the larger cultural world and refers to the cultural values, norms, and laws in the world that surrounds youth (Clemons et al., 2011; Duerden & Witt, 2010; McLeroy et al., 1988).

Because the rates of teen pregnancy and sexually transmitted diseases within the Upper County community are higher than national and state averages, the researcher predicted that there would be widespread support among all participants for a variety of sexual health topics. Each item in the Family Life Sex Education Goal Questionnaire (FLSE-GQ II) was reviewed individually to determine the items found most important to address based on a response of “very important” at a rate of 50% or greater. The participants responded as predicted with an endorsement of all topics within the survey. It is possible that the myriad of ecological influences contributed to the high level of support for a wide array of topics. For example, the macrosystem influence of the high rates of adolescent pregnancies in the community may indicate hypersexual cultural norms.

Of the nine survey goals identified as controversial, seven had majority support with the response of “very important” at a rate of 50% or more. Of the 11 questions in the noncontroversial category, seven had support with the response “very important” at a rate of 50% or more. These results indicate that youth participants were highly supportive of controversial topics, and they also endorsed the inclusion of
noncontroversial topics, demonstrating support of a comprehensive approach to school-based sexuality education.

Topics with Highest Ratings

Of all 60 survey items, the three items rated the highest (81% or more of participants rated it “very important”) are all related to HIV. Considering that the Ecological Systems Theory focuses on individuals’ perception of their ecological environment, it is likely that the high level of support by youth participants for the inclusion of HIV-related information is reflective of the prevalence of HIV among African Americans in Upper County. Although the rate of new HIV infections is decreasing in communities across the country, this trend is not reflected in Upper County. Racial disparities in HIV infections are also present in Upper County, for 70% of new HIV diagnoses in 2014 were among Blacks (Georgia Department of Public Health, 2016). Of the 200 AIDS-related deaths in Georgia in 2014, 75% were among Blacks (Georgia Department of Public Health, 2016). Awareness of higher than average HIV rates within the community may have influenced the participants’ high level of support for the information on HIV-related material.

Additionally, sexually transmitted infections (STIs) are disproportionate among African-American teens. One in four sexually active adolescent females between the ages of 14 and 19 years is infected with at least one of the most common sexually transmitted infections. The impact is even greater for African-American females as one in two African-American females among the same age group acquire a common STI (Forhan et al., 2009; Sales et al., 2014). Study participants appeared to understand that
based on the high rates, there is also a great need for HIV/STI education in the community.

Information for expectant teen parents was the second category with the highest ratings. This is also reflective of the community. In 2013, the national average teen birth rate was 26.2 per 1,000 adolescent females aged 15-19 years. During that same year, the teen birth in Georgia was 30.5 births per 1,000. For Upper County, the birth rate for teens of all races was even higher at 32.8 for every 1,000 for that same age group. Disturbingly, the average teen birth rate among Black teens aged 15 to 19 years in Upper County during this period was 49.6 per 1,000, as compared to only 3.2 per 1,000 for White teens during the same period (U.S. Census Bureau, 2010).

In contrast, many of the goal items with the lowest ratings were questions involving families, including the following: involving parents in selecting family life sex education curricula, emphasizing the importance of family, personal family experiences in the classroom. Other questions with the lowest ratings included using a plastic teaching model or banana for condom demonstrations and discussing and referring students with special needs to social services for support.

School-Based Sexuality Education to Address Teen Pregnancy and STIs

The longstanding trend of higher rates of pregnancy and sexually transmitted diseases within this population continues to be addressed by schools who provide the main source of formal sex education to help youth avoid early and risky sexual behaviors. Consistent with previous research on the inconsistencies with the delivery of sexuality education among and within various communities 48% of participants reported receiving
sexuality education in one previous class, 23% reported receiving such information in more than one class. The remaining 29% reported receiving no previous in-school sexuality education, demonstrating that either those youth received limited information that did not resonate or that they received no formal in-school sexuality education despite the expectations in Georgia for this information to be included in the curriculum. The 29% of participants reporting a history of receiving no school-based sexuality education demonstrates disparities throughout the United States in the delivery of sexual health information. Despite the support and the expectation of in-school sexuality education, many teachers lack adequate preservice preparation, which consequently has a negative effect on their knowledge, self-efficacy, and comfort level (Eisenberg, Madsen, Oliphant, & Seiving, 2013; Eisenberg, Madsen, Oliphant, Seiving, & Resnick, 2010). Because control over content is localized, there is not only wide variation in the sexuality education curriculum from state to state, but also between districts and schools, and in some cases, between classrooms within the same building (Eisenberg et al., 2010; Elia & Tokunaga, 2015). Only one of the 13 participants between the ages of 18 to 21 years reported receiving no sexuality education. The lower levels of reported history of sexuality education among the younger participants reveal that the lack of sexuality education may be partially based on trends in the delivery of sex education throughout the years in addition to the varying levels of sex education offered in different schools and classrooms. Because in-school sex and HIV education in Georgia is typically offered to youth aged 14 and older, these youth may not have yet had the opportunity to receive this information. More importantly, the response of receiving no previous sexuality
education could be a result of the views of the limited information provided, since some participants may not consider the instruction they received to be formal sex education.

In Georgia, sex and HIV education is mandated, but the information is not required to be medically accurate, age-appropriate, or culturally appropriate and unbiased. Georgia sex and HIV education programs stress and discuss the negative outcomes of teen sex. However, the programs are not required to include information on contraception, sexual orientation, avoidance of coercion, healthy decision-making, and family communication (Guttmacher Institute, 2016). The Georgia State Board of Education determines minimum guidelines for sexuality education. These guidelines, found in Georgia Board of Education Rule 160-4-2-.12 (see Appendix F), state that the following topics should be included in sexuality education: peer pressure, self-esteem, community values, abstinence as prevention of HIV and the only guaranteed method of preventing STIs and pregnancy, emphasis on abstinence until marriage, and fidelity in marriage (Georgia Department of Education, 2015). While study participants recorded support for these topics, many of the issues were not among the highest rated. For example, the top 10 issues supported by participants include information on different types of sexually transmitted infections; information on how HIV is transmitted and ways to reduce rates of HIV through safer sex; support and special courses for pregnant girls to encourage them to stay in school and get prenatal care; personal hygiene; self-esteem; reproductive health; goal setting; and puberty. Table 12 presents these findings, which indicate a potential disconnect between the information that students are expected to receive and the topics that youth reported wanting to know more about.
Table 12

**Comparison of Georgia Sexual Health Standards and Participants’ Perceived Sexual Health Needs**

<table>
<thead>
<tr>
<th>Topics Included in GA Department of Education Guidelines for Sexuality Education</th>
<th>Related Topics Included in Participants’ Top 10 Perceived Sexual Health Needs</th>
<th>Articulating the Gap</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abstinence as prevention of AIDS</td>
<td>• Information on HIV/AIDS • Information on transmission of HIV • Ways to reduce rates of HIV through safer sex • Information on different types of sexually transmitted infections (STIs)</td>
<td>The GA Standards call for HIV-related discussions/sexually transmitted infections information to be centered around abstinence as the means for prevention while the youth in this study support a broader discussion on HIV and other sexually transmitted infections.</td>
</tr>
<tr>
<td>Handling peer pressure</td>
<td>Not included in the top 10 issues supported by youth participants</td>
<td>While youth participants support the inclusion of discussions on peer pressure, this issue is not among the 10 top items that youth support.</td>
</tr>
<tr>
<td>Promotion of high self-esteem</td>
<td>Counseling to youth with low self-esteem and embarrassment about body</td>
<td>The youth participants in this study are in support of counseling to support those with low self-esteem. The GA Standards provide a related plan of action to address the issue of low self-esteem through the promotion of high self-esteem</td>
</tr>
<tr>
<td>Local community values</td>
<td>Not included in the top 10 issues supported by youth participants</td>
<td>Youth did not include local community values among the top 10 issues to address.</td>
</tr>
<tr>
<td>• Abstinence as the only guaranteed method of preventing STIs and pregnancy • Emphasize abstinence from sexual activity until marriage and fidelity in marriage as important personal goals</td>
<td>Not included in the top 10 issues supported by youth participants</td>
<td>Youth did not include abstinence-related discussions among the top 10 issues to address.</td>
</tr>
<tr>
<td>Topics Included in GA Department of Education Guidelines for Sexuality Education</td>
<td>Related Topics Included in Participants’ Top 10 Perceived Sexual Health Needs</td>
<td>Articulating the Gap</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Not included in the GA Health Education Standards for Sexual Health</td>
<td>Encouragement and special courses for pregnant girls to help them stay in school and get prenatal care</td>
<td>Although the majority of teen mothers in the U.S. drop out of school before earning a high school diploma and this issue is rated highly important by youth participants, the GA Standards do not call for addressing the needs of pregnant girls to assist with lowering the rate of drop out</td>
</tr>
<tr>
<td>Not included in the GA Health Education Standards for Sex Education/HIV Education</td>
<td>Encourage personal hygiene</td>
<td>Personal hygiene is not included in the GA Sexual Health Education standards</td>
</tr>
<tr>
<td>Not included in the GA Health Education Standards for Sex Education/HIV Education</td>
<td>Human reproduction and birth</td>
<td>Reproduction and Birthing is not included in the GA Sexual Health Education standards; however, this subject may be covered in Science courses</td>
</tr>
<tr>
<td>Not included in the GA Health Education Standards for Sex Education/HIV Education</td>
<td>Planning and pursuing goals</td>
<td>Goal setting and planning is not included in the GA Sexual Health Education standards</td>
</tr>
<tr>
<td>Not included in the GA Health Education Standards for Sex Education/HIV Education</td>
<td>Changes during puberty</td>
<td>Puberty is not included in the GA Sexual Health Education standards</td>
</tr>
</tbody>
</table>

Previous use of the Family Life Sex Education Goal Questionnaire (FLSEGQ) was with adult populations. The first use of the FLSEGQ by Godin, Frank, and Jacobson (1998) revealed a significant difference in support among parent participants (31% variance) for goals related to sexual decision-making and life skills. The largest factors among teachers from that study were “family life” and “personal growth” (Godin et al.,
1998) with 30% variance. Razzano (2005) compared the results of the responses on the FLSEGQ from middle and high school teachers and parents in support of controversial versus noncontroversial topics among public school teachers; parents of children enrolled in public schools; private religious school teachers; and parents of children enrolled in a private religious school. All four samples reported support for the inclusion of discussions on HIV and other sexually transmitted infections. Compared to teachers, parents were more in support of controversial issues, such as counseling expectant fathers, pregnant females, referring students to community agencies, discussing family issues and growth and development, and meeting parents with children who are having difficulties. Compared to teachers in religious schools both parents and public school teachers were more in support of accessing information about planned parenthood, contraception, homosexuality, abortion, and how far to go in sexual behaviors (Razzano, 2005). Compared to previous use of the Family Life Sexuality Education Goal Questionnaire with adult populations that revealed a clear difference among different groups of adults in support of some categories, in this study, adolescents completed the survey and reported support for a wide array of topics with no significant differences in levels of support based on perceptions of friends’ sexual history. The issue with the second highest rating among participants in this study was providing information to expectant teen mothers. In previous studies, the parents felt that this goal item was more important that the teachers. Importantly, the participants of this study rated the topics of HIV and sexually transmitted infections as most important of all FLGSEQ items. Similarly, in Razzano (2005), all four samples of participants (public school teachers,
parents of children enrolled in public schools, private religious school teachers, and parents of children enrolled in a private religious school) reported support for the inclusion of discussions on HIV and other sexually transmitted infections. All groups supported discussions on not just abstinence as prevention, but also safer sex and modes of transmission.

Relationship between Participant Attitudes and Perception of Friends

The microsystem of the Ecological Systems Theory (EST) represents interactions and personal relationships within the immediate setting (e.g., unique physical and personal characteristics and experiences, significant others such as peers, family, neighbors). The emphasis of EST is on the individual’s perception of his/her ecological environment and what an individual perceives, desires, and thinks about as knowledge and how the nature of these elements change based on a person’s exposure to his/her environment. What an individual perceives has more importance than what is actual, and external activities and other individuals influence the motivation for behavior. During the period of adolescence, peers become more influential on decisions such as engagement in risky behaviors (Steinberg, 2001).

With peers being a very influential part of an adolescent’s immediate (interpersonal) environment, the Ecological Systems Theory (EST) was applied in the second hypothesis of this study to assess the extent to which perceived sexual behaviors of friends influence adolescents’ support of sexuality education content. To understand the participants’ perception of their friends’ history of sexual involvement, the demographic portion of the survey included the following question “How many of your
friends do you think are or have been sexually active (have had sexual intercourse)?”

Twenty-six percent of respondents reported that they thought that none of their friends were or had been sexually active; 41% of participants responded “some.” The response of “most” was selected by 18% of participants, and 15% of survey participants reported that they believe that all friends were or had been sexually active. Of the 15% (15 respondents) who reported that they believed that all their friends have a history of being sexual active, 53% (eight survey participants) were between the ages of 18 and 21 years. The remaining seven were between the ages of 14 and 17 years, with no participants aged 12 and 13 years reporting a belief that all their friends have a history of sexual activity.

These findings suggest that, although signs of early sexual activity such as teen pregnancy and sexually transmitted infections are more prevalent among this community than other surrounding areas, the youngest survey participants did not believe that their interpersonal environment represents those statistics. As individuals progress through the stages of adolescence, the likelihood of engaging in sexual intercourse increases. The percentage of youth participants in this study who reported that none of their friends have engaged in sexual intercourse decreased by age, demonstrating that older participants believe that more of their friends are or have engaged in sexual intercourse.

The focus of previous research has been on the influence of friends on adolescents’ sexual behavior and not on their perceived sexual health needs. Kirby (2002) stated that the ecological factors in the immediate environment, such as connection with peers, parents, and school, have the greatest effect on an adolescent’s perceptions of sex and sexual behavior. Rink (2006) applied the Ecological Systems Theory to examine the
forming of perceptions of sex during the adolescent period and the motivation for sexual behavior among adolescent females. The majority of respondents reported a strong connection to peers, who played an important role in either protecting them or putting them at risk for engaging in risky sexual behaviors. To determine whether the ecological factors from the ESTs microsystem to the exosystem can predict adolescent sexual behavior, Wright, Duffy, Kershner, Flynn, and Lamont (2015) later surveyed 744 teen participants. Of the variables assessed, Wright et al. (2015) found peer norms to be the only true protective factor influencing healthier sexual practices, which demonstrates the powerful and motivational force that peers have during adolescence. The majority of respondents reported a strong connection to peers, who played an important role in either protecting them or putting them at risk for engaging in risky sexual behaviors.

With previous research demonstrating that engagement in sexual behaviors during adolescence is influenced by the sexual behaviors of peers the researcher predicted that perceived sexual behaviors of friends would also influence adolescents’ perceived need for information on different sexual health topics. In analyzing the correlations between perceptions of peer sexual history and endorsement of controversial topics in this study apart from one survey goal (#8: To provide information about abortion and its effects on the body), results of the analyses indicated no significant differences in this study between participants who believe that all or most of their friends have a history of sexual behaviors and participants who believe that none or some of their friends have a sexual history. With respect to furthering our understanding of the extent to which perceptions of friends influence adolescent perceptions of their sexuality education needs, this study
demonstrates that perceptions of the sexual history of friends may not have substantial influence on support of sexual health content. While this study demonstrates some evidence that friends influence perceptions of sexual health needs, this study provided only minor insight into the ecological influence of friends on adolescent perceptions of their sexuality education needs, since the findings of peer influence were not consistently observed in the results. Adolescents transition daily through several contexts that can be influential. The Ecological Systems Theory (EST) posits that the interaction of multiple levels of social and environmental contexts influence individuals (George et al., 2013; McLeroy et al., 1988). It is possible that other factors in both the mesosystem and other levels of the EST impact adolescents’ perceived sexuality education needs (i.e. family, school environment, media influence, cultural norms). Table 13 provides a detailed response to the connection with the Ecological Systems Theory.
Table 13

*Connection to Ecological Influences*

<table>
<thead>
<tr>
<th>System</th>
<th>Connection</th>
</tr>
</thead>
<tbody>
<tr>
<td>Macrosystem</td>
<td>Seventy percent of new cases of HIV infection in the target community are among Blacks, yet their remains an insufficient level of HIV prevention interventions targeted to the Black community. This represents a potential macrosystem influence. Years ago, HIV was deemed as more of a universal threat that received greater attention from various avenues. The diminished levels of attention provides an example of how society may respond differently when issues are more of a threat to minority populations. The macrosystem influence of the rates of adolescent pregnancies in the community that have been higher than national and state averages for several decades may indicate cultural norms that are more accepting to adolescent pregnancies.</td>
</tr>
<tr>
<td>Exosystem</td>
<td>With 29% of participants reporting no previous in-school sex education there appears to be more room for support among this area of the exosystem. Youth ages 12 to 13 years were more likely to report that they do not believe that their friends are sexually active. This group was also less likely to report a history of receiving in-school sex education. Because those ages 14 and older were more likely to report a belief that their peers are sexually active and in-school sex education is likely to be provided to youth ages 14 and older this highlights a potential missed opportunity of positive exosystem influence of providing in-school prevention efforts to a younger age group of youth who are less likely to have initiated sexual behaviors. The three highest rated survey goal items being HIV-related represents a potential exosystem influence of recognition of participants of the high rates throughout the community and related perceived need for HIV prevention education.</td>
</tr>
<tr>
<td>Mesosystem</td>
<td>Through community-wide collaborative efforts there is an opportunity to strengthen a more supportive mesosystem influence through a greater level of prevention efforts by the school, church and other areas of the mesosystem.</td>
</tr>
<tr>
<td>Microsystem</td>
<td>While this study demonstrates some evidence that friends influence perceptions of sexual health needs, this study provided only minor insight into the ecological influence of friends on adolescent perceptions of their need for information on controversial issues. As seen in Table 11, the finding of peer influence was observed with statistical significance in goal 8, but not observed in other goals within the controversial factor dimension.</td>
</tr>
</tbody>
</table>
Limitations

The results of this research will not necessarily generalize to all urban, African-American youth. Isaac and Michael (1997) stated that individuals who are accessible and cooperative are included in the survey data collection process, which may produce biased results. Because of the small sample size (100) of youth who participated in the study, results cannot be generalized to the population as a whole. Additionally, the FLSEGQ includes 60 goal statements. It is likely that some participants experienced fatigue while completing the survey, which may have impacted their responses. Lastly, the older participants were more likely to report a belief that their friends were engaging in sexual behaviors; however, 79% of participants in this study were between the ages of 12 to 16 years. If the study included more participants in the older age groups, the results would have likely been different and evinced statistically significant correlations for additional goal items. An additional consequence of having younger participants, particularly those aged 12 and 13 years who may not have yet had the opportunity to participate in school-based sexuality education discussions and who may have limited personal experiences and experiences of their friends to reflect on, is that they may not fully understand the ramifications of risky sexual behaviors. Individuals within this age range may best offer input on the delivery approach of sexual health discussions but may have a limited perspective on their sexual health education needs.

Implications for Practice and Research

To get the most out of sexual health education research should be conducted to determine if the curriculum being delivered is addressing perceived needs of students
(Byers, Sears, Voyer, & Thurlow, 2003). A World Health Organization representative stated, “The first principle of successful health promotion is the involvement of young people themselves” (Friedman, 1992, p. 349). This study answers the call for more input from U.S. adolescents on what information they want from school-based sexuality education. The recommended approach from the researcher for the improvement of in-school sexuality education is a collaborative approach with continued research that provide youth with opportunities to voice their opinions on not just the best content to be included in discussions, but also on the best approaches for teachers to deliver the material. Additionally, these qualitative discussions could provide a better understanding of the ecological influences on the ratings of the survey goal items.

It is clear from the literature that sexual risk behaviors can adversely impact a number of areas in the life of an adolescent. It is also clear that comprehensive, school-based prevention efforts can reduce the likelihood of a teen engaging in such behaviors. In recent years, there has been a significant decline in teen pregnancy rates in the United States, but the decline is substantial among ethnicities other than African Americans, suggesting a need for better understanding of the needs specific to African-American youth.

Whether a sexuality education program actually addresses the needs of young people is a key criterion for quality programming (Walker, Green, & Tilford, 2003). The review and analysis of current school-based sexuality education efforts in the United States indicates significant areas in need of improvement (Elia & Tokunaga, 2015). Researchers, providers, and advocates have criticized some formal sexuality education
programs in the United States for insensitivity to the changing needs of adolescents (Peter, Tasker, & Horn, 2015). Sexuality health curricula can be more flexible and relevant by understanding adolescents’ perspectives about sexuality education to better match the content of programs to young peoples’ expressed needs (Kimmel et al., 2013; Stevens et al., 2013). Young people should be provided the opportunity to be actively involved in meeting their own health needs by investing in the programs designed for them (Kim & Free, 2008; MacDonald et al., 2011). Failing to consider youth input in educational approaches can lead to serious undermining of curricula and subsequent failure (MacDonald et al., 2011). Other countries have been more intentional about documenting adolescents’ attitudes towards sexuality education (Byers et al. 2003; Kimmel et al., 2012). However, it is rare that U.S. youth have the opportunity to provide input to inform the design of sexual health curriculum, and limited literature describes how adolescents feel about current sexuality education and what they want from school and community-based programs (Kimmel et al., 2012; MacDonald et al., 2011).

Because of the emotional and social consequences of risky sexual behaviors, such as the increased likelihood of school dropout resulting from teenage pregnancies, school administrators, teachers, parents, and community stakeholders should continue to invest in seeking the most effective prevention efforts. This study contributes to the limited literature on what U.S. teens want from school-based sexuality education. Identifying issues thought most important by youth residing in a community with a great need for prevention information and acknowledging these issues are not among the topics listed in the Georgia mandates reveals an area of disconnection between youths’ perceived needs
and potential missed opportunities for how the needs are currently being addressed. The findings can contribute to the design of more relevant material by curriculum developers and the selection of more suitable material for educators and community stakeholders working with a large percentage of low-income African-American students.

To advance the capacity of prevention efforts to address the disproportionate rates of teen pregnancy and sexually transmitted infections among African-American youth, a collaborative approach affording youth with the opportunities to voice their opinions on the best content to be included in discussions and the best approaches for delivery of sexuality education could benefit future school-based sexual health interventions. This can be achieved by first replicating studies such as the current study where youth provide opinions on content using selected questions of the FLSEGQ or similar instrument. To understand the ecological influences on perceived sexuality education needs more clearly, future research can compare the responses of groups of youth from various communities and include additional survey questions that address not just perceptions of friends’ sexual behaviors, but also areas within other levels of the Ecological Systems Theory. A larger sample size with participants from different cities may lead to greater generalizability. The quantitative data collection can be followed by a series of qualitative approaches gathering more detailed input from youth on desired content and delivery to inform later collaborative efforts.

Final Thoughts

Great strides in reducing national teen pregnancy and teen birth rates have been made in the United States. Continuous efforts through school-based sexuality education
will result in reaching large groups of youth in a trusted setting. Careful attention to understanding the unique sexuality education needs of the most vulnerable populations to risky sexual behaviors is necessary in order to learn more about the best approaches to attend to those needs. This study provides much needed information for stakeholders to take advantage of local control of sexuality education and implement more tailored approaches that deliver accurate information, as well as skills building in the most culturally-relevant format, to help youth focus on their future goals with an understanding of how risky sexual behaviors may impact those goals, recognize the benefits of delaying sexual involvement, and develop a clear understanding of the characteristics of healthy relationships and how to advocate for themselves.
REFERENCES


APPENDICES
Monday, July 24, 2017

Ms. Kerri McDonald
Mercer University
TFT College of Education - Atlanta
3001 Mercer University Dr
Atlanta, GA 30341

RE: An Ecological Exploration Of Youth Perceptions of Sexuality Education Needs and Sexual Behaviors of Peers [H1706191]

Dear Ms. McDonald:

On behalf of Mercer University's Institutional Review Board for Human Subjects Research, your application submitted on 11-Jul-2017 for the above referenced protocol was reviewed in accordance with Federal Regulations 21 CFR 56.115(b) and 45 CFR 46.110(b)(3) (for expedited review) and was approved under category(ies) 7 per 63 FR 60364.

Your application was approved for one year of study on 22-Jul-2017. The protocol expires on 22-Jul-2018. If the study continues beyond one year, it must be re-evaluated by the IRB Committee.

Item(s) Approved:
Initial Application: Study will disseminate the Family Life and Sex Education Goal Questionnaire II (FLSE-GQ II) to individuals between the ages of 12 to 21 years from low-income communities through a summer and after-school program. This study will explore participants' views on what topics adolescents from the target community feel are most important for school-based sexual health discussions.

NOTE: Please report to the committee when the protocol is initiated. Report to the Committee immediately any changes in the protocol or consent form and ALL accidents, injuries, and serious or unexpected adverse events that occur to your subjects as a result of this study.

We at the IRB and the Office of Research Compliance are dedicated to providing the best service to our research community. As one of our investigators, we value your feedback and ask that you please take a moment to complete our Satisfaction Survey and help us to improve the quality of our service.

It has been a pleasure working with you and we wish you much success with your project! If you need any further assistance, please feel free to contact our office.

Respectfully,

[Signature]

Ann Chambers-Richardson, Ph.D., CCP, CHRA
Associate Director of Human Research Protection Programs (HCPP)
Member
Institutional Review Board

"Mercer University has adopted and agrees to conduct its clinical research studies in accordance with the International Conference on Harmonization's (ICH) Guidelines for Good Clinical Practice."
APPENDIX B

PARENTAL PERMISSION FORM
AN ECOLOGICAL EXPLORATION OF YOUTH PERCEPTIONS OF SEXUALITY EDUCATION NEEDS AND SEXUAL BEHAVIORS OF PEERS

Parent or Guardian Informed Consent Form

Your child is being asked to participate in a research study entitled, AN ECOLOGICAL EXPLORATION OF YOUTH PERCEPTIONS OF SEXUALITY EDUCATION NEEDS AND SEXUAL BEHAVIORS OF PEERS. The study is being conducted by Keri McDonald, Keri.McDonald@live.mercer.edu, and Dr. Karen Swanson at swanson ks@mercer.edu, 678-547-6398. The results will be used to further the researcher’s understanding of what topics youth think are most important for family life and sexuality education. Your child’s participation is voluntary. A decision to participate in the research will not affect his/her relationship with the relationship with other teachers, or his/her academic standing.

I. The purpose of my study is to explore:

This research study is designed to get the opinions of teens in order to better understand the best information for our teens to receive to help them make the best decisions for their sexual health.

The data from this research will be used to compare what youth want to hear and what schools are being asked to provide in family life and sexuality education discussion. Gathering this information is part of a requirement for the researcher’s graduation from the Tift College of Education.

II. Procedures

If you allow your child to volunteer for this study, your child will be asked to take one survey that will ask them to rate different items that may be discussed in their classrooms. Your child’s participation will take approximately 40 minutes.

Your child will be asked to assent to participate in this research (Assent means that your child will be asked to voluntarily participate in this research). Your child will tell the teacher they want to participate by answering YES or NO after the teacher verbally reads to your child what the research is about and what he or she will be asked to do. If you and your child decide to participate she/he will be handed a survey. The person conducting the study will read the instructions and each question out loud. Snacks will be provided and your child will have an opportunity to enter into a raffle to win a gift card after he/she submits their completed survey.

Parent/Guardians who allow students to participate must:

Please read and complete the consent form granting permission for your child to take the survey that should take approximately 40 minutes.

III. Potential Benefits to Students and/or Society

Some potential benefits for students and society are that your child may win a gift card as the survey administrator will raffle several gift cards. Another benefit is that your child will
understand that their opinions are valuable and they can impact the information that other teens receive in school. With the high rates of teen pregnancy and sexually transmitted diseases your child can help to make sure that teens get the information that they need.

IV. Potential Risk and Discomforts

There are no foreseeable risks associated with this study. Your child will not have any more risks than they would have in their normal day of life. Your child has the right to discontinue participation either temporarily or permanently at any time.

V. Withdrawal of Participation

Your child’s participation is voluntary. Your child will not be penalized or lose any benefits that he/she is otherwise entitled to if you decide that your child will not participate in this research project.

If your child decides to participate in this project, he/she may discontinue participation at any time without penalty or loss of benefits. You have the right to inspect any instrument or materials related to the proposal. Your request will be honored within a reasonable period after the request is received.

VI. Payment for Participation

Students will not be paid for their participation. There is no financial obligation for participants.

VII. Confidentiality and Data Storage

The only people that will have access to your child’s answers are the people working on the research project. Procedures designed to ensure confidentiality include assigning identification numbers to each survey participant, assigning numbers to completed survey instruments and keeping the identity of participants private by not requesting identifying information.

All consent forms and survey tools will be stored separately under lock and key at the office of the Center for Black Women’s Wellness. Data will not be shared with other participants or individuals not related to the project.

The researchers will ensure that your child’s information remains confidential. Your child’s name will not be associated with his or her individual responses and will be identified only by an assigned coded number. At no time will your child’s name be associated with the results of the research or shared with parents or others. Any identifying information provided by your child will never be used as part of the research or associated with the results of the study.

Your child’s responses will be stored in a locked location and will only be used for research purposes by Mercer University School. A number will identify the information that will be collected from the Family Life Sexuality Education Goal Questionnaire II surveys from your child. The list connecting participant numbers and names will also be kept in separate locked cabinets.

Questions about the Research
If you have any questions about the research, please speak with Keri McDonald at Keri.McDonald.Pridgeon@live.mercer.edu. If you have questions later, you may contact Dr. Karen Swanson at swanson ks@mercer.edu. 678-547-6398.

You have been given the opportunity to ask questions and these have been answered to your satisfaction. If you agree to allow your child to participate in this research, please complete the information below:

I, ________________________________, grant my child, ________________________________, permission to participate in this research study.

Name of Parent or Legal Guardian  Name of Child Participating in Study

Parent/Guardian Name (Print)  Name of Person Obtaining Consent (Print)

Parent/Guardian Signature  Person Obtaining Consent Signature

Date  Date

Please return to Keri McDonald as soon as possible.

In order to conduct this research, this project has been reviewed and approved by Mercer University’s Institutional Review Board (IRB). If you believe there is any infringement upon your child’s rights as a research subject, please contact the IRB Chair at (478) 301-4101. The IRBs are the governing bodies that are set in place to ensure responsible and safe conduct of research investigations.
APPENDIX C

STUDENT INFORMED ASSENT
Informed Assent for Children Ages 12-14

Investigators at Mercer University are doing a research study where we are trying to learn more about what teens want from family life and sexuality education courses in their schools.

The purpose of this study is to determine your wants and needs for family life and sexuality education.

You are being asked to participate in this study because you can provide valuable input to help us provide the most meaningful information in your classes.

The people in charge of this study are Keri McDonald who is a student at Mercer University and an employee at the Center for Black Women’s Wellness.

This study will take place at the recreation center that you regularly attend.

If you decide to be in this study you will take one survey. The survey will last about 40 minutes. The survey will ask questions about what topics you think are most important for discussions that you have in class.

You will be asked to complete the Family Life Sexuality Education Goal Questionnaire II (FLSE-GQ II). Your parents will not know what you say on the FLSE-GQ. We will save some of these surveys in a locked cabinet to do our research. Your name will not be on the forms. Your information will be kept private.

The only people that will know your answers are the people working on the research project.

Your parent(s) have said that it is okay for you to be in this research study. You do not have to be in this study if you do not want to be. You can change your mind at any time by telling your mom, your dad, your teacher, or the person conducting this study.

______ NO, I do not want to be in this study. ______ YES, I want to be in this study.

_________________________  __________________________
Signature of Participant Date

_________________________  __________________________
Signature of Person Obtaining Assent Date

Mercer University Office of Research Compliance
1501 Mercer University Drive, Macon, Georgia, 31207
Phone: 478-301-4101  Email: ORC_Research@Mercer.Edu  Fax: 478-301-2329
You are being asked to participate in a research study. Before you give your consent to volunteer, it is important that you read the following information and ask as many questions as necessary to be sure you understand what you will be asked to do.

Investigators at Mercer University are doing a research study where we are trying to learn more about what teens want from family life and sexuality education courses in their schools.

The purpose of this study is to determine your wants and needs for family life and sexuality education.

**Procedures**

You will be asked to take one survey. The survey will ask questions about what topics you think are most important for discussions that you have in class. You have the right to refuse to have your information included in the research. Refusing to include your information will not jeopardize you receiving any services related to your summer and afterschool program at your recreation center.

**Questionnaires**

You will be asked to complete the Family Life Sexuality Education Goal Questionnaire II (FLSE-GQ II) at the recreation center that you regularly attend. The survey will last about 40 minutes.

**Videotaping**

There will be no videotaping related to this project.

**Potential Risk and Discomforts**

In this study, you will not have any more risks than you would in a normal day of life.

**Potential Benefits of the Research**

The benefits of participation in the research may not directly assist you. Overall, we hope to gain information that may impact the way that family life and sexuality education information is delivered in the future. Refreshments and a raffle for gift cards will be provided.

**Confidentiality and Data Storage**

Mercer University Office of Research Compliance
1501 Mercer University Drive, Macon, Georgia, 31207
Phone: 478-301-4101 Email: ORC_Research@Mercer.Edu Fax: 478-301-2329
The person conducting this study will keep your records private to the extent allowed by law. Your name will not be associated with your responses and will be identified only by an assigned coded number. At no time will your name be associated with the results of the research.

Your responses will be stored in a locked location and will only be used for research purposes by Mercer University School.

Your parent(s) have said that it is okay for you to be in this research study. You do not have to be in this study if you do not want to be. You can change your mind at any time by telling your mom, your dad, or your therapist.

_____ NO, I do not want to be in this study.  _____ YES, I want to be in this study.

_________________________  ______________________
Signature of Participant     Date

_________________________  ______________________
Signature of Person Obtaining Assent  Date
APPENDIX D

FAMILY LIFE SEXUALITY EDUCATION GOAL QUESTIONNAIRE
Exhibit

Family Life and Sex Education Goal Questionnaire

This questionnaire lists goals which some people have described as important for a family life sex education program. Some goals may be of lesser importance than others. For each of the goals listed, we would like you to indicate (on the 5-point scale provided) whether or not you view the goal as important for a family life sex education program in the ____ (specify program, school, grade level, etc).

Instructions: In the column to the right of the goals listed on the pages which follow, indicate the importance of each goal by using the following scale:

<table>
<thead>
<tr>
<th>Very Important</th>
<th>1</th>
<th>Very Unimportant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Somewhat Important</td>
<td>2</td>
<td>Somewhat Unimportant</td>
</tr>
<tr>
<td>Neutral Importance</td>
<td>3</td>
<td>Neutral Unimportance</td>
</tr>
<tr>
<td>Important</td>
<td>4</td>
<td>Important</td>
</tr>
<tr>
<td>Very Important</td>
<td>5</td>
<td>Very Unimportant</td>
</tr>
</tbody>
</table>

Here is an example of how to use the scale:

Example Items

A. To teach children about how to stay physically healthy as they grow. 1 2 3 4 5
B. To teach children how to play a musical instrument. 1 2 3 4 5

If in your opinion, the first goal (“To teach children about how to stay physically healthy as they grow”) is somewhat important (number “4” on the scale) for a family life sex education program, you would circle “4” next to the goal statement in the column on the right. If, in your opinion, the second goal (“to teach children how to play a musical instrument”) is very unimportant for a family life sex education program, you would circle the number “1” in the column to the right.

Remember, you may see some goals as more important than others. Please circle your opinion by circling the number that best represents your views beside each goal statement.

Exhibit

Family Life and Sex Education Goal Questionnaire

This questionnaire lists goals which some people have described as important for a family life sex education program. Some goals may be of lesser importance than others. For each of the goals listed, we would like you to indicate (on the 5-point scale provided) whether or not you view the goal as important for a family life sex education program in the ____ (specify program, school, grade level, etc).
Instructions: In the column to the right of the goals listed on the pages which follow, indicate the importance of each goal by using the following scale:

1  2  3  4  5
Very Unimportant Somewhat Unimportant Neutral Important Somewhat Important Very Important

Here is an example of how to use the scale:

Example Items

A. To teach children about how to stay physically healthy as they grow.  1  2  3  4  5
B. To teach children how to play a musical instrument.  1  2  3  4  5

If in your opinion, the first goal (“To teach children about how to stay physically healthy as they grow”) is somewhat important (number “4” on the scale) for a family life sex education program, you would circle “4” next to the goal statement in the column on the right. If, in your opinion, the second goal (“to teach children how to play a musical instrument”) is very unimportant for a family life sex education program, you would circle the number “1” in the column to the right.

Remember, you may see some goals as more important than others. Please circle your opinion by circling the number that best represents your views beside each goal statement.

1. To help adolescents feel good about their physical appearance.  1  2  3  4  5
16. To help adolescents to appreciate their special qualities and personality as well as that of other boys and girls.  1  2  3  4  5
3. To reduce guilt and fear about sexuality.  1  2  3  4  5
4. To provide information about abnormal sexual development and behavior.  1  2  3  4  5
5. To help adolescents understand how sexual development affects other aspects of personal growth and development.  1  2  3  4  5
6. To provide complete information about male and female genitalia (sex organs) and other physical differences between men and women.  1  2  3  4  5
7. To involve parents in selecting instruction materials and planning the curriculum of the family life sex education program.

8. To provide information about abortion and its effects on the body.

9. To provide information about the biology of human reproduction and birth.

10. To discuss ways of coping with an unexpected pregnancy.

11. To help adolescents develop skills in getting along with members of the opposite sex.

12. To provide information about how to be good parents.

13. To help adolescents learn to understand and communicate with each other better.

14. To make youth aware of community services related to health and prenatal care.

15. To emphasize the importance of the family as the keystone of American life.

18. To help adolescents understand their responsibilities to self, family, and friends as they grow up.

17. To inform youth of community services related to birth control and sexual decision-making.

35. To counsel adolescents to make their own decisions about how far to go in their sexual activities.

19. To encourage adolescents to talk more openly with their parents about sexuality.

20. To discuss the role of the family in personal growth and development.

21. To encourage adolescents to use contraceptives if they decide to have sexual intercourse.

22. To discuss ways in which families work out conflicts and solve problems.
23. To help adolescents understand people’s feelings and points of view.

24. To educate adolescents about peer pressure and how to deal with it.

25. To provide information about sexually transmitted infections including HIV and AIDS.

26. To teach about abstention as a form of contraception.

27. To encourage discussion of personal family experiences in the classroom.

28. To provide special courses about family life and sexuality for disabled students.

29. To encourage adolescents to think about alternatives to abortion.

30. To bring in outside speakers to talk to youth about sexuality.

31. To counsel boys who are expectant fathers.

32. To correct myths and misinformation about the body.

33. To help adolescents to view the growth changes in their bodies as normal and healthy.

34. To discuss how the attitudes toward growth and development may be different for different ethnic groups and cultures in our society.

52. To provide information about alternative sexual behaviors and lifestyles, such as homosexuality.

53. To discuss abortion as a form of contraception.

37. To provide workshops to assist parents in talking more openly with their adolescent children about sexuality.

38. To encourage grooming and thoughtfulness about personal appearance.

39. To counsel girls who are pregnant.

40. To demonstrate how to put on a condom using a plastic teaching model or banana.
41. To refer students with special needs to social service agencies.

42. To make adolescents aware of the negative effects of sex role stereotypes.

43. To provide information about good prenatal care.

44. To provide information about contraceptives and how they work, and describe their effects on the body.

45. To teach about biological changes during puberty.

46. To provide individual counseling to students with low self-esteem or those who feel embarrassed about their bodies.

47. To meet with parents about a child who is having difficulties with sexual issues and stresses.

48. To teach about the different types of sexually transmitted infections or diseases.

49. To teach about how families may differ in how they make rules and decisions.

50. To teach students about the ways in which HIV is transmitted.

51. To provide information about how different ethnic and cultural groups differ in sexual beliefs and behaviors.

52. To work with outside community agencies to provide rap groups about sexuality and sexual decision-making.

53. To help adolescents to see that most young people are going through many of the same things as they grow toward maturity.

54. To help adolescents plan for and start working toward future goals.

55. To provide information about the roles and challenges that go along with reaching different ages in life.

56. To teach students about ways to have safer sex to reduce the risk of HIV infection.
57. To discuss ways to help families talk more openly and improve family communication.

61. To listen and respond to the opinions of the outside community and local interest groups in making family life sex education goals.

59. To encourage personal hygiene.

60. To encourage pregnant girls to stay in school and to provide special classes for them in prenatal care.
APPENDIX E

DEMOGRAPHIC QUESTIONS
FLSEGQ Demographic
Youth Survey

This survey is part of a study on school-based sexuality education. The information you provide will help us gain a better understanding of what teens want in sexuality education courses.

All of your answers are completely private and confidential. No one will be told your answers.

Before you begin answering the questions, we want to say something really important.

Teens have different experiences with sex and opinions about sex. Many teens have not had sex. Other teens have.

Remember the answers you give will help us only if you tell us what you really feel. No one will know how you answer. We hope you will answer truthfully.

If you have any questions during the survey, raise your hand and a survey administrator will come over to help you.

Do you have any questions now?

If so, please raise your hand.
Please Answer All Of The Questions Below As Completely As You Can.

THIS INFORMATION IS CONFIDENTIAL.

1. Are you a female or male?
   1…Female
   2…Male

2. How old are you?
   ______ Years old

3. Which best describes you. I am:
   a. A High school student
   b. A Middle school student
   c. No longer in school

4. What zip code do you live in?
   a. 30312
   b. 30310
   c. 30311
   d. Other: _____________

5. Which one category best describes your racial background? (Choose all that apply)
   1…White/Caucasian
   2…Black or African American
   4…Multi-ethnic/Multi-racial (my parents are from two different groups)
   5…American Indian or Alaska Native
   6…Asian American or Pacific Islander
   7…Latino/Mexican/Hispanic
   8…Other _______________________

6. Select the box that best describes the amount of sexuality education you have previously received in school
   a. I have not received sexuality education at my school
   b. I have received sexuality education in one class at my school
   c. I have received sexuality education in more than one class at my school

7. At this time (right now), what adults do you live with most of the time? (Check All That Apply)
   1…Mother
   2…Stepmother
   3…Father
   4…Stepfather
5…Grandparents
6…Foster Care/DFACS
6…Other adults (*please name: ex. guardian, mother’s boyfriend*)

7…I do not live with any adults

8. In 2017, has anyone in your family or your household received assistance from the following programs (*Click All That Apply*)
a…Medicaid, Peach Care, Amerigroup, PeachState, or Wellcare
b…SSI
c…Food Stamps
d…Other (Please Name) ______________________________
e…To my knowledge my family has not gotten money from such programs.

9. How many of your friends do you think are or have been pregnant or have gotten someone pregnant?
   a. None
   b. Some
   c. Most
   d. All

10. How many of your friends do you think are or have been sexually active (have had sexual intercourse)?
    a. None
    b. Some
    c. Most
    d. All
APPENDIX F

GEORGIA BOARD OF EDUCATION RULE 160-4-2-.12
160-4-2-.12 COMPREHENSIVE HEALTH AND PHYSICAL EDUCATION PROGRAM PLAN.

(1) DEFINITIONS.

(a) Alcohol and other drug use education – a planned program of instruction that provides information about the use, misuse and abuse of alcohol, tobacco, legal and illegal drugs.

(b) Disease prevention education – a planned program of instruction that provides information on how to prevent chronic and infectious diseases, including sexually transmitted diseases.

(c) Psychomotor skills – skills that use hands-on practice to support cognitive learning for cardiopulmonary resuscitation (CPR) and use of an automated external defibrillator (AED).

(d) Sex education/AIDS education – a planned program that shall include instruction relating to the handling of peer pressure, promotion of high self-esteem, local community values, and abstinence from sexual activity as an effective method of preventing acquired immune deficiency syndrome and the only sure method of preventing pregnancy and sexually transmitted diseases. This instruction shall emphasize abstinence from sexual activity until marriage and fidelity in marriage as important personal goals.

(e) Fitness assessment program – annual assessment measuring and reporting health related fitness in the areas of aerobic capacity, body composition, flexibility, muscular strength, and muscular endurance.

(2) REQUIREMENTS.

(a) The local board of education shall develop and implement an accurate, comprehensive health and physical education program that shall include information and concepts in the following areas.

1. Alcohol and other drug use

2. Disease prevention

3. Environmental health

4. Nutrition
5. Personal health

6. Sex education/AIDS education

7. Safety

8. Mental health

9. Growth and development

10. Consumer health

11. Community health

12. Health careers

13. Family living

14. Motor skills

15. Physical fitness

16. Lifetime sports

17. Outdoor education

18. Fitness assessment

(b) Each school containing any grade K-5 shall provide a minimum of 90 contact hours of instruction at each grade level K-5 in health and physical education.

(c) Each school containing any grade 6-12 shall make available instruction in health and physical education.

(d) Each school containing any grade K-12 shall provide alcohol and other drug use education on an annual basis at each grade level.

(e) Each local board of education shall develop procedures to allow parents and legal guardians to exercise the option of excluding their child from sex education and AIDS prevention instructional programs.
1. Sex education and AIDS education shall be a part of a comprehensive health program.

2. Prior to the parent or legal guardian making a choice to allow his or her child or ward to take the specified unit of instruction, he or she shall be told what instruction is to be provided and have the opportunity to review all instructional materials to be used, print and nonprint. Any parent or legal guardian of a child to whom a course of study in sex education is to be taught shall have the right to elect, in writing, that such child not receive such course of study.

(f) Each local board of education shall establish a committee to review periodically sex/AIDS education instructional materials and make recommendations concerning age/grade level use. Recommendations made by the committee shall be approved by the local board of education before implementation. The committee shall be composed primarily of nonteaching parents who have children enrolled in the local public schools and who represent the diversity of the student body augmented by others such as educators, health professionals and other community representatives. The committee shall also include a male and female student currently attending the 11th or 12th grade in the public schools.

(g) Beginning in the 2011-2012 school year, each local school system shall conduct an annual fitness assessment program, as approved and funded by the State Board of Education, one time each school year for students in grades one through 12, to be conducted only during a physical education course that is taught by a certificated physical education teacher in which a student is enrolled. Such assessments shall include methods deemed by the State Board of Education as appropriate to ascertain levels of student physical fitness. Each local school system shall report the individual results of the fitness assessment to the parent or guardian of each student assessed and the aggregate results of the fitness assessments by school to the State Board of Education annually in a format approved and funded by the State Board of Education. The minimum required contents of the report shall be determined by the State Board of Education.

(h) Beginning in the 2013-2014 school year, each local board of education which operates a school with grades nine through 12 shall provide instruction in cardiopulmonary resuscitation and the use of an automated external defibrillator to its students as a requirement within one of the required health or physical education courses (Health (17.011), Health and Personal Fitness (36.051), or Advanced Personal Fitness (36.061)) to satisfy this requirement. Such instruction shall incorporate the psychomotor skills necessary to perform cardiopulmonary resuscitation and to use an automated external defibrillator. Each local board of education shall report adherence to this
requirement as determined by the Georgia Department of Education. The instructional program shall include either of the following:

1. An instructional program developed by the American Heart Association or the American Red Cross, or

2. An instructional program which is nationally recognized and is based on the most current national evidence based emergency cardiovascular care guidelines for cardiopulmonary resuscitation and the use of an automated external defibrillator. Authority O.C.G.A. § 20-2-142 (b), (c); 20-2-143; 20-2-149.1; 20-2-777.

Adopted: August 22, 2013 Effective: September 11, 2013
APPENDIX G

PARTICIPANT RATINGS ON ALL FLSEQQ ITEMS
### Participant Responses to the FLSEGQ

<table>
<thead>
<tr>
<th>Goal Statement</th>
<th>Very Unimportant</th>
<th>Somewhat Important</th>
<th>Neutral Importance</th>
<th>Somewhat Important</th>
<th>Very Important</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. To help adolescents feel good about their physical appearance</td>
<td>1</td>
<td>3</td>
<td>18</td>
<td>29</td>
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<tr>
<td>2. To help adolescents to appreciate their special qualities and personality</td>
<td>3</td>
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<td>18</td>
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<td>as well as that of others boys and girls</td>
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<td>3. To reduce guilt and fear about sexuality</td>
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<td>4. To provide information about abnormal sexual development and behavior</td>
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<td>5. To help adolescents understand how sexual development affects other</td>
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<td>aspects of personal growth and development</td>
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<td>6. To provide complete information about male and female genitalia (sex organs)</td>
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<td>5</td>
<td>12</td>
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<tr>
<td>and other physical differences between men and women</td>
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<td>7. To involve parents in selecting instruction materials and planning the</td>
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<td>8. To provide information about abortion and its effects on the body</td>
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<td>14. To make youth aware of community services related to health and prenatal</td>
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<td>16. To help adolescents understand their responsibilities to self, family, and friends as they grow up</td>
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<td>17. To inform youth of community services related to birth control and sexual decision-making</td>
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<td>18. To counsel adolescents to make their own decisions about how far to go in their sexual activities</td>
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<td>21. To encourage adolescents to use contraceptives if they decide to have sexual intercourse</td>
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<td>23. To help adolescents understand people’s feelings and points of view</td>
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<td>24. To educate adolescents about peer pressure and how to deal with it</td>
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<td>25. To educate adolescents about sexuality transmitted infections including HIV and AIDS</td>
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<td>29. To encourage adolescents to think about alternatives to abortion</td>
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<td>34. To discuss how the attitudes toward growth and development may be different for different ethnic groups and cultures in our society</td>
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<td>35. To provide information about alternate sexual behaviors and lifestyles, such as homosexuality</td>
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<td>36. To discuss abortion as a form of contraception</td>
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<td>39. To counsel girls who are pregnant</td>
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<td>40. To demonstrate how to put on a condom using a plastic teaching model or banana</td>
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<td>42. To make adolescents aware of the negative effects of sex role stereotypes</td>
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<td>43. To provide information about good prenatal care</td>
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<td>44. To provide information about contraceptives and how they work, and describe their effects</td>
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<td>46. To provide individual counseling to students with low self-esteem or those who feel embarrassed by their bodies</td>
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<td>48. To teach about the different types of sexually transmitted infections or diseases</td>
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<td>49. To teach about how families may differ in how they make rules and decisions</td>
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<td>50. To teach students about the ways in which HIV is transmitted</td>
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Table G1 (continued)

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<th>Neutral Importance</th>
<th>Somewhat Important</th>
<th>Very Important</th>
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<td>51. To provide information about how different ethnic and cultural groups differ in sexual beliefs</td>
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<td>52. To work with outside community agencies to provide rap groups about sexuality and sexual decision-making</td>
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<td>53. To help adolescents to see that most young people are going through many of the same things as they grow toward maturity</td>
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<td>54. To help adolescents plan for and start working toward maturity</td>
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<td>55. To provide information about the roles and challenges that go along with reaching different ages in life</td>
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<td>56. To teach students about ways to have safer sex to reduce the risk of HIV infection</td>
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<td>58. To listen and respond to the opinions of the outside community and local interest groups in making family life sex education goals</td>
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<td>60. To encourage pregnant girls to stay in school and to provide special classes for them in prenatal care</td>
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<td>3</td>
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</tbody>
</table>
APPENDIX H

PERMISSION TO USE FLSEQQ
June 9, 2018

To: Keri Mcdonald Pridgeon

From: Steven Godin, Ph.D., MPH, PHI Certificate
      Visiting Professor; Division of Public Health

Re: Permission to Use the FLSE Goal Questionnaire II

As author of the Family Life Sex Education Goal Questionnaire II (FLSE-GQ II), I provided Keri McDonald-Hill, Ph.D. candidate at Mercer University Tift College of Education, permission to use the FLSE-GQ II survey instrument prior to her use in the study entitled 'An Ecological Exploration of Youth Perceptions of Sexuality Education Needs'. I understand that the instrument was photocopied and administered to youth between the ages of 12 to 21 years old.

Steven Godin, Ph.D., MPH, PHI Certificate
Visiting Professor; Division of Public Health
President Emeritus, Association of Accredited Public Health Programs (AAPHP)
Department of Family and Preventive Medicine
University of Utah; School of Medicine
375 Chipeta Way; Suite A
Salt Lake City, UT 84108

Office Phone: 801-585-9365

steven.godin@utah.edu