NYC Sex Education Pilot Program:
Process Evaluation Results

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Executive Summary and Recommendations

In the spring of 2008, the New York City Departments of Education (DOE) and Health and Mental Hygiene (DOHMH) implemented a pilot program of evidence-based sex education in seven South Bronx public middle schools and high schools. The South Bronx was chosen due to its high teen pregnancy rate (nearly 16% of girls aged 15-19 became pregnant in 2006) and level of sexual activity (one in five South Bronx high school students report having had four or more sex partners in their lifetime).

All South Bronx middle and high schools were invited to participate. Following site visits, schools willing to meet the pilot’s inclusion criteria—provide the school infrastructure necessary to support the pilot, implement the selected curricula, allow teachers to attend a three-day professional development training, and collect and provide evaluation data—were invited to participate. Of ten schools initially selected, seven completed the pilot. The other three schools ultimately could not incorporate the pilot into their schedules because of other teaching requirements.

Participating teachers received materials, professional development, and ongoing technical assistance. A comprehensive process evaluation of the pilot was designed to assess the feasibility of implementing sex education in New York City public schools. The evaluation consisted of teacher focus groups, interviews with principals, qualitative data recorded by technical assistance liaisons, weekly teacher logs, and instructor assessment of the professional development.

Based on this evaluation we found the following:

1. **The Professional Development (PD) significantly increased teacher knowledge and self-confidence.** Teachers also reported their efforts were enhanced by on-going support and technical assistance (TA). TA Liaisons found that site visits and phone calls helped to keep schools motivated and to foster buy-in.

**Recommendations:**
- PD should be offered on an ongoing basis to accommodate the needs of school schedules and budgets. Each segment should last no longer than two consecutive days. Middle and high school teachers may benefit from training tailored to their students’ grade level.
- For at least their first two years as instructors, sex education teachers should have the opportunity for ongoing professional development and technical support, including materials, trainings, and regular meetings where they can share their experiences and learn from each others’ feedback.
2. By the semester's end, initially skeptical instructors were excited about teaching sex education the following year. Principals and teachers alike reported strong-to-moderate support from parents, school administrators, and other school officials.

Recommendations:
- DOE and DOHMH should find opportunities to educate parents and community members about the proven benefits of comprehensive sex education (increased contraceptive use, delay of sexual debut), and to dispel common myths about sex education (e.g. comprehensive sex education leads to an increase in sexual activity).
- A New York City-specific student outcome evaluation of the sex education curricula should be undertaken to assure that the recommended curricula are effective in the New York City context. Locally based, rigorous evaluation can help to ensure continued support and sustainability.

3. Of the 18 teachers that participated in the pilot, none of the teachers were able to complete the curriculum in the time scheduled by their respective schools.

Recommendations:
- Comprehensive health/sex education should be formally incorporated into school schedules to allow for sufficient instructional time, and to reflect the commitment of school leaders for student health and achievement.
- The principal evaluation process should include assuring that Comprehensive Health Education time meets NYSED instructional mandates.
- The central DOE Office of Fitness and Health Education should continue to provide additional training and technical assistance around scheduling and curriculum fidelity. (Evaluation of this and other similar curricula has shown that the effectiveness of the curricula in influencing teen behavior is correlated with delivery of the entire curriculum.)
**Background**

New York State Education Department Commissioner’s regulations mandate one semester of Health Education during middle school and an additional semester during high school.¹ This mandate is separate from the New York State-mandated HIV/AIDS curriculum and carries the expectation that classes will convene five days a week, be taught by certified health educators, and cover “…alcohol, tobacco, and other drugs, safety, mental health, nutrition, dental health, sensory perception, disease prevention and control, environmental and public health, consumer health, first aid, and other health-related areas.” NYC schools also have the option of providing the health education course over a span of one school year, where classes convene two days per week in one semester, and three days per week in the other semester. While sex education is an integral component of any comprehensive health education curriculum, it is not mandated explicitly.

Youth Risk Behavior Survey (YRBS) and DOHMH Office of Vital Statistics data offer compelling evidence that sex education instruction is needed in all of our public schools. In 2006, 10% of all 15-19 year old girls in New York City became pregnant² and 2007 YRBS data reveal that 46% of high school students have had sexual intercourse. Additionally, 16% of high school students have had sex with more than four people during their lifetimes and 9% first had sex before age 13. While 72% of sexually active teens report having used a condom the last time they had sex, only 6% report using birth control pills.³

In the South Bronx, these statistics are even more startling: 53% of public high school students have had sex, 19% have had sex with more than four partners and 12% first had sex before age 13. The 2006 teen pregnancy rate among girls age 15-19 years was almost 16%, with only 5% reporting using birth control pills the last time they had sex.⁴ Because of the elevated teen pregnancy rate and level of sexual activity in this community, DOE and DOHMH selected the South Bronx as the target area to pilot test evidence-based, DOE-recommended sex education curricula in middle and high schools.

**DOHMH & DOE Curriculum Selection Process**

**Department of Health and Mental Hygiene**

The NYC DOHMH Office of School Health (OSH) and Bureau of Maternal, Infant, and Reproductive Health (MIRH) formed a workgroup to review the literature on the effectiveness of sex education curricula in order to make recommendations to the DOE. The workgroup

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¹ NYCRR §§135.3(c).
³ Division of Epidemiological Services. 2007 Youth Risk Behavior Survey Results: Details Tables – Weighted Data. New York City Department of Health and Mental Hygiene, 2008.
⁴ Ibid.
reviewed five promising curricula, which were individually scored using ten characteristics of effective sex and HIV education curricula developed by Douglas Kirby.5

The scoring methodology placed emphasis on curricula that: (1) focused on reducing one or more sexual behaviors leading to unintended pregnancy or sexually transmitted infections (STI)/HIV infection; (2) included a clear, consistent message about sexual activity and condom or contraceptive use; and (3) provided basic, accurate information about sexual risks and methods of avoiding intercourse or using protection against pregnancy and STIs. The workgroup also gave weight to curricula that: (1) provided basic reproductive health information as well as information about contraceptives and STIs; (2) were appropriate for middle school and high school students; (3) could be fit into school schedules; and (4) were found to be effective at delaying sexual activity or increasing condom and/or contraceptive use.

Based on the above scoring system, the workgroup recommended the evidence-based Reducing the Risk curriculum and three lessons from the “Abstinence and Sexual Health” component of HealthSmart curriculum for 9th grade students in high schools. It recommended the science-based HealthSmart to be delivered to 6th grade students in middle schools. The workgroup also recommended these curricula be supplemented with a message of dual protection, as well as additional information on relationship violence, Lesbian, Gay, Bisexual, Transgender, and Questioning (LGBTQ) issues, and information about substance abuse and other risky behaviors.

Department of Education
Schools may choose when students receive the one required credit of health education in both middle and high school, and which health education curricula to use. The New York City Department of Education’s Office of Fitness and Health Education (formerly known as the Office of Health Education and Family Living) conducted a review of comprehensive health education curricula for middle and high schools during the 2006-07 school year. This review was conducted in partnership the New York State Student Support Services Center (NYS SSSC), an organization funded by the State Education Department to support health education instruction statewide, to plan and implement all curriculum review steps. The goal was to review health education curricula to determine how well each one aligned with New York State standards.6

The review committee reviewed curricula recommended by Advocates for Youth, Blueprints for Violence, Collaborative for Academic, Social and Emotional Learning (CASEL), Sexuality Information and Education Council of the United States (SIECUS), and Substance Abuse and Mental Health Services Administration (SAMHSA). To be included in the review, curricula had to be: (1) evidence-based in that it was effective at delaying sexual activity or increasing condom and/or contraceptive use; (2) classroom-based; (3) geared to co-educational classrooms; and (4) recently published. The review committee excluded curricula that: (1) exclusively covered

HIV/AIDS (since New York City already has a HIV/AIDS curriculum); (2) were abstinence-only; (3) targeted subpopulations (e.g., girls only); (4) required significant ongoing external resources (e.g., a full-time health care provider); and (5) were not designed for urban settings. Two comprehensive health education curricula that met all but one of the inclusion criteria and none of the exclusion criteria were reviewed because they had been reviewed and recommended by the DOHMH review team.

More than 30 stakeholders first attended a two-day training prior to reviewing six comprehensive health education curricula for middle school and six comprehensive health education curricula for high school, including school administrators, teachers, parents, DOHMH staff, and representatives from community-based organizations. Each curriculum was reviewed by at least two stakeholders using an assessment tool developed by the NYS SSSC in concert with DOE.

Each comprehensive health education curriculum that met the minimum requirements subsequently was reviewed by NYS SSSC staff to ensure scores were supported by evidence in the curriculum, determine its applicability to a New York City audience, and to gauge its ease of use for teachers. Based on the scoring methodology, consideration of stakeholders’ notes and comments, and a process of elimination of “unqualified” curricula, the HealthSmart and Reducing the Risk curricula were chosen for high school. HealthSmart was selected as the middle school curriculum because its continued use from middle through high schools offered continuity for students. The Chancellor of the NYC DOE announced the rollout of the new curricula in October 2007. More than 500 teachers from 324 middle and high schools have participated in the Comprehensive Health Education professional development sessions from October 2007 through March 2010, and additional trainings will be held during the spring and summer 2010.
Sex Education Pilot – Process Evaluation Components

The evaluation component of the Sex Education Pilot Project aimed to strengthen the case for sex education to principals in terms of the curriculum’s ease of use for teachers and its ability to be integrated into schools’ existing frameworks. To achieve this purpose, the evaluation: (1) assessed the extent to which the PD prepared instructors to teach the lessons; (2) determined the amount of time teachers felt they needed to adequately prepare for and teach each lesson; and (3) identified what ongoing support was required by teachers to maximize the effectiveness of the sex education curricula. The evaluation also (4) gauged principals’ commitment to sex education and whether they felt inclusion of the curricula helped or hindered other academic goals.

The evaluation consisted of the following components:

1. **Needs Assessment**
   DOE and DOHMH staff interviewed each teacher initially assigned to participate in the sex education pilot. The teachers answered questions about their experiences teaching sex education and the PD and support they thought a teacher would need to teach the current HIV/AIDS curriculum. The results of the survey informed the DOE’s and DOHMH’s development of the PD, specifically to ensure the PD would be an adequate length and would be relevant to the teachers’ needs.

2. **Pre-/Post-test Evaluation of the PD**
   At the beginning of the three-day PD, instructors selected to teach sex education completed a 3-page pre-test covering sexual and reproductive anatomy, NYC/NYS policies regarding sexual health and minors’ rights, and teachers’ perceived self-confidence in their ability to teach the material. At the close of the PD, the same test was given again in order to assess changes in knowledge and attitudes resulting from the training.

3. **Teacher Lesson Logs**
   A one-page, four-question teacher log was developed to determine teacher time spent preparing for each class, identify changes to the curriculum made by teachers, and gauge whether instructors felt the PD adequately prepared them to teach the material covered in each lesson. The logs included a space for open-ended comments/impressions. Teachers were asked to complete the log following each class.

4. **Site Visit Data collected by Technical Assistance Liaisons**
   Each teacher participating in the pilot was assigned one of three Technical Assistance Liaisons (TALs) from DOE and DOHMH to provide ongoing assistance as the semester progressed. TALs maintained detailed logs of their interactions with instructors, the type of assistance needed, frequency of interactions, and general impressions of the delivery of the curricula. TALs also attempted to visit at least one class taught by the teachers to whom they were assigned in order to assess teachers’ fidelity to the curricula and comfort level with the material, as well as to observe the students’ level of involvement and interest.
5. **End-of-semester Teacher Focus Groups**
Two focus groups with sex education instructors were conducted in June 2008. The focus groups covered a wide array of topics including the PD, time needed to complete lessons, interactions and relationships with TALs, impressions of the curricula and student reactions, and perceived support from principals, school administrators, and parents.

6. **End-of-semester Principal Interviews**
Semi-structured, one-on-one interviews with pilot school principals were conducted after the close of the 2007-2008 academic year. Interviews focused on principals’ perceived need for sex education, challenges in providing sex education along with other school priorities, and support for the curricula from parents, school officials, and students. Principals also were asked whether they would implement the curricula in future years.

Results from each of these evaluation components follow and all instruments are available in the Appendix.
Results – Needs Assessment

Three DOE and DOHMH staff members interviewed 25 teachers assigned to participate in the sex education pilot. The interviewers, who also were responsible for designing the PD, summarized the interviews from each school and subsequently analyzed summaries to identify common themes.

In these face-to-face interviews most teachers revealed they had been asked by their principals to participate in the sex education pilot. Almost all had little or no experience teaching sex education, but a few had taught the lessons from the HIV/AIDS curriculum. During the interviews, they identified needing support with feeling more comfortable with the material, identifying the key points students needed to learn, and on how best to respond to students’ questions and parents’ concerns. Teachers also were concerned with how to find the time to teach the lessons, given all their other teaching assignments and responsibilities. The majority of the teachers were not health educators.

This information was used to design a three-day PD that created a foundation for teachers, providing information about puberty and relationships, establishing ground rules in classrooms, building students’ skills using role plays, and strategies for answering students’ and parents’ challenging questions.

25 teachers from 7 schools were initially assessed, only 11 of whom (44%) actually taught sex ed during the pilot program. Since 18 teachers ultimately sat through the PD and subsequently taught sex ed, it follows that just over 60% were represented in the needs assessment. This was a result of (a) principals assuming that the PD was a “turn-key” model and that participating teachers could, in turn, pass relevant information onto other sex ed teachers (this was, in fact, not the case) and (b) scheduling conflicts that arose during the 6 to 8 week interval between the assessment and the PD resulting in teachers being (un)assigned sex ed teaching duties according to the school’s/principal’s needs.
Results – Professional Development

Teachers attended a three-day PD for the sex education pilot. A pre/post-test survey was developed to assess whether the training increased instructor knowledge of and perceived comfort with material in the curricula.

Twenty-four questions inquired about knowledge related to anatomy/physiology, pedagogical tools for teaching sex education, minors’ rights under NYS law, STI/HIV prevention, and DOHMH sexual health recommendations (such as recommendations around condom use). An additional nine self-efficacy questions gauged teachers’ confidence in their abilities to talk about sexual health, sexual orientation, and anatomy. Finally, four questions inquired about years spent teaching, health education certifications, and previous experience teaching sex education.

Linear regression reveals significant increases both in overall knowledge and perceived self-confidence from pre-test to post-test. Results are presented in Table 1.

After adjusting for number of years spent teaching, health education certifications, and previous experience teaching sex education, average scores on the 24 knowledge questions increased an average of four points (p < .001) from the pre-test to the post-test (56% correct versus 73% correct). Similarly, when the 9 self-efficacy questions were combined to form a scale (range 9-36), there was a significant (p < .01) increase of nearly 6 points from pre- to post-test.

Table 1: Knowledge and Confidence both Improved from Pre- to Post-Test

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<thead>
<tr>
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<th>Before PD</th>
<th>After PD</th>
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<tr>
<td>Sex-Ed Related Knowledge (average score out of 24)</td>
<td>13.5</td>
<td>17.6</td>
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<tr>
<td>Self-Confidence (average score out of 36)</td>
<td>26.3</td>
<td>32.1</td>
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Results – Teacher Logs

Forty unique classrooms took part in the sex education pilot and both the middle and high school curricula each contained 24 lessons. If teachers had remitted one log per lesson as instructed, a total of 960 logs would have been returned. The evaluator only received 75 logs (8% return rate) from eight of the 18 teachers/teams participating in the pilot. Instructors teaching multiple classes were told they could return one log per lesson as opposed to one log per class. The return rate was 20% with this more relaxed denominator.

97% of the logs received indicated that the instructor felt the PD adequately prepared him/her to teach the lesson. Table 2 compared data on actual time spent preparing for lessons and the amount of time teachers, having taught the lessons, would recommend others spend preparing.

![Table 2: Actual and Recommended Teacher Preparation Times](image)

82% of responding instructors suggested spending between 16 and 45 minutes of preparation time. When individual teacher responses are compared across the two items presented in Table 2, 16% of the time teachers recommended spending 15-30 minutes more than they themselves had prepared. Only 3% of teachers suggested less preparation.

25% of responding teachers indicated that they added supplemental material to the lessons including PowerPoint presentations, transparencies, videos, and role-play. Some instructors found students to be “bored and inattentive” at first; but as the semester progressed, the logs reflected that students were increasingly “engaged,” “interested,” and “interactive.”

Half of the teachers commented on the difficulty of covering one lesson in a single class period (“We were only half done...”, “The time (one period) was not enough because [the students] all wanted to present...”, “It took me two days for this lesson”). This theme was particularly salient for instructors teaching younger high school students.
The divide between 9th and 10th graders versus 12th graders also was a recurring theme. For some lessons, older students “...were slightly more engaged” and “...asked a lot of questions” while younger students “...needed more probing” and benefited from additional activities. This dichotomy was starker for teachers instructing mixed classrooms. “Immaturity” was often cited as a barrier to the timely and organized delivery of lessons.

Regarding specific content areas, three teachers wrote that most students “...were unfamiliar with reproductive systems” and that because of the lack of prior exposure they “...had to review for two days on structures in both males/females”. Indeed, other teacher comments make it clear that students were “very interested” in anatomy but had had little to no previous instruction in it.

While some instructors found that “students were not surprised about the same sex relationships,” others noted that lessons regarding homosexuality led to some “heated” and “polarized” classes. One teacher mentioned that the PD never addressed how to handle these lessons when a LGBTQ student is in the classroom.
Results – Technical Assistance Liaison Reports

TALs established contact with all principals and the majority of teachers. Interactions with principals, teachers, and other school contacts took place in the form of email (n = 80) and phone conversations (n = 12), individual and group on-site visits (n = 20), and classroom observations (n = 6). TALs initiated the majority of contacts; however, teachers also initiated contact with TALs in order to discuss challenges and identify solutions. Most issues were discussed and resolved via phone and/or email. Of the 20 total visits that took place, three were prompted by school request. These findings are consistent with what teachers reported in the focus groups that were conducted with the teachers at the end of the semester.

TALs established contact and set up initial meetings with principals, contacts, and teachers to discuss implementation, initial questions, and information about materials and the curriculum. Throughout the pilot, TALs reminded teachers to send logs, answered questions, helped with troubleshooting, linked teachers to additional resources, and brainstormed with teachers on how to improve lessons.

In general, teachers expressed positive feedback about the lessons and student responses. However, teachers of older students (12th grade) reported that the information was not age-appropriate. Many teachers requested materials (e.g., transparencies) and supporting materials (e.g., videos, websites, workbooks, anatomical models, and statistical information). TALs referred teachers to websites—such as ETR and DOHMH Youth Risk Behavior Survey—in response to these requests.

Multiple schools experienced difficulty with the coordination and receipt of materials. Materials were delivered to schools, but some teachers were not made aware of deliveries. One principal did not want to distribute materials until the TAL visited on-site. In this case, the TALs responded by visiting the school. Teachers also reported that the lessons took more than one class period to complete. One teacher reported the lessons were especially challenging to teach during advisory period. In response, TALs encouraged teachers to do their best, as finishing was essential to the pilot evaluation.

TALs observed a total of six lessons in different classrooms. In general, teachers were comfortable teaching the lessons. Teachers established ground rules and utilized several behavior management strategies. Most students appeared to be engaged and participated in discussions.

The TALs provided various forms of contact and support to both administrators and teachers during the pilot, and generally addressed urgent issues effectively. Most challenges appeared to be the result of scheduling issues and implementation of the curricula in the middle of the school year. The frequency of TAL contact depended on both schools’ needs and TALs’ diligence level. Some schools expressed needing more support than was provided. Consistent with what teachers reported during the focus groups, TALs were competent, important points of contact and support; however, teachers were more likely to reach out to internal contacts before TALs.
Results – Focus Group Report Summary

Two focus groups were conducted with eleven of the eighteen teachers that participated in the pilot. Only one of the teachers participating in the focus groups previously had taught sex education. Feedback was generally positive and teachers expressed that they enjoyed the lessons. Students were generally eager to learn and requested more information and activities. Little feedback was received from parents, with only a few parents opting for their children not to participate. We recognize responses may have been biased by the timing of the focus groups, which took place two days before the end of the school year.

Teachers used various approaches to assess lesson effectiveness. Some teachers assigned homework lessons and incorporated lessons into final projects, while others gauged effectiveness by classroom participation or participation in role play activities. Most students appeared interested, engaged, and comfortable with the curricula; however, some students occasionally expressed discomfort or embarrassment and older students generally were less interested. Some students approached teachers regarding personal questions or referrals. Many of the teachers questioned by the students did not have school-based health services at their schools or information on external referrals.

Training
Most teachers found the PD adequately prepared them for the pilot, but, as one participant said, “You are not a teacher until you teach.” Most participants found the role plays and modeling activities in the training to be especially helpful. Some teachers did not like having the middle- and high school-level trainings together, while others found this helpful since students in each grade have varying ages and developmental stages. Some teachers thought the three-day training was too long and they would have benefited from the sessions being spread out over a semester, especially since this would allow teachers to report back to one another with experiences. Several teachers thought the training was too long and could have been completed in two days.

Materials
Teachers recommended that books and resources be sent further in advance than they were for the pilot. Some instructors found repetition between the two books and recommended the books be combined. Other teachers felt burdened by making copies for the lessons. They added that students did not take worksheets seriously and would benefit greatly from having formal student workbooks.
Results – Principal End-of-Pilot Interview

Brief post-pilot interviews were conducted in July 2008 with six principals from the seven schools (three from middle schools, three from high schools) participating in the pilot. DOHMH interviewed principals regarding their attitudes about the need for sex education, experiences with implementing the pilot, and lessons learned.

In general, principals had much to say and provided mostly positive feedback about the pilot. All principals reported there is a great need for sex education in their communities. Many principals explained their students are from high risk populations with above average teen pregnancy and STI rates, and discussed misconceptions among students about sex and sexuality.

Implementation
Prior to implementation, comfort with and attitudes about sex education at the schools varied. For some schools, open discussions about sexuality and/or school-based or school-linked health care were already part of the school’s culture. However, some schools – especially the middle schools - experienced more discomfort among teachers and principals, although most expressed overall support for the curricula. Only one principal described an instance of internal conflict; the principal responded by establishing support from the school’s leadership team, which included parents. Principals received between zero and three opt-out letters from parents. In one case, the principal spoke directly with the parent and the parent rescinded the opt-out after receiving more information. The other parents opted out due to religious reasons. No other feedback was received directly from parents during the course of the pilot, but half (three) of the principals reported strong parental support in general. The three other principals reported moderate or slight parental support or were not aware of the level of parental support.

Most principals (four) reported being involved in the implementation somewhat closely with the rest reporting very close involvement. Most principals described their involvement as adjusting schedules to accommodate teachers’ needs vis-à-vis professional development training and teaching. Many principals reported that teachers should have been given more time to plan their lessons and schedules, and that materials should have been sent sooner. The January start date was challenging for many schools.

Curriculum
All principals reported strong support of the HealthSmart and Reducing the Risk curricula and believed teachers liked using them. Principals reported that the curricula were user-friendly and well-organized. Many reported that the curricula provided skills for teachers about discussing sexuality and increasing comfort levels. Most principals had little negative feedback; however, two of the middle school principals explained frustration about the limits of the abstinence curriculum. Teachers reacted negatively to being told not to discuss contraceptives. They felt they could not answer fully many students’ questions. Reflecting this feedback, one principal found that the middle school curriculum was “too simple.” Alternately, one middle school principal thought the curriculum was “too much,” and one high school principal thought that the birth control discussions were a “bit much.”
Impact on Principal Priorities
Principals were asked about whether the curricula affected any of their core priorities and, if so, to what extent. In general, principals reported the pilot had no impact on test scores (five) and graduation rates (four). Principals reported the pilot was helpful regarding attendance (four), grades (four), disciplinary incidents (four), and fostering school pride and/or connectedness (five). Of all priorities, none of the principals reported the pilot had any negative impact on their goals.

Next Steps
Post-pilot, five of the six principals continue to strongly support the curricula; one principal reported moderate support. Principals reiterated that sex education is needed and three mentioned the need for a mandate. One principal said, “Sex ed. is needed throughout the city—not just in the South Bronx. It should be mandatory.”

All principals said they want to continue using the curricula. Principals discussed various ways in which they will tailor the curricula to better meet their schools’ needs in terms of teacher/classroom types, schedules, and lessons learned from the pilot. All six reported they would recommend *Reducing the Risk* and *HealthSmart* to other principals. One principal said, “Today’s principal needs to address today’s needs.” In providing lessons to other principals, participating principals cited many reasons for why they recommend the curricula, including their clear and balanced messages, medical accuracy, ability to empower students and staff, and the tools provided to teachers.

With regards to lessons learned, principals at both middle and high schools expressed the need for principals to respond to the issues of teen pregnancy and STIs. All but one principal mentioned that sex education needs to be scheduled into the school day and cannot just be and add-on to the current health curriculum. Principals from both middle and high schools also emphasized the importance of ongoing professional development for teachers, as well as a venue where they can support one another, and the value added by supplementing the curricula with speakers and presenters from outside.

Middle school principals also noted that there are many ways to integrate the curricula into schools’ schedules and models. In addition to needing scheduled time to teach lessons, these principals also expressed a need for guidance on lesson planning and pacing among teachers. Another lesson learned is that there always will be parents that choose to opt-out their children. Principals need to be comfortable with this.
Summary of Findings

Support for Sex Education and the Curricula
There was strong support for sex education among teachers and principals. Both groups recognized the need for comprehensive health education that includes sex education, and pilot participants were enthusiastic about continuing their roles as sex education instructors and champions.

However, both groups discussed the difficulty of delivering the curricula in full given the late implementation start date and time constraints, particularly among those instructors teaching during advisory periods. Principals and teachers expressed their support for health/sex education, beginning instruction earlier in the academic year, and integrating the curricula more formally into school schedules and other academic classes. Additionally, pilot participants indicated that DOE should provide a flexible scope and sequence schools can adapt to meet their needs.

Importantly, support for sex education extended beyond pilot participants: principals and teachers alike reported very little—if any—resistance from parents, students, and other members of the school community. In fact, half of the pilot school principals reported strong parental support for the curricula.

Sex Education and Other Academic Priorities
According to principals, implementing sex education did not negatively affect their school priorities. To the contrary, they felt that sex education actually helped to improve attendance, school pride/connectedness, and grades, and to decrease disciplinary incidents. Similarly, teachers expressed that sex education did not interfere with the time needed to prepare their other academic classes; 41% said 15 to 30 minutes of preparation per lesson was sufficient with an equal percentage reporting that 31 to 45 minutes would suffice. No teachers complained that adding sex education to their workload negatively impacted his/her ability to teach other courses.

Professional Development, Materials and On-Teacher Support
Surveys revealed that the three-day professional development was successful at increasing teachers’ knowledge and self-confidence and both teachers and principals recognized the need and benefits of on-going instructor support and training.

However, focus group data showed that three consecutive days is not ideal and that the training should take place over the course of the semester and offer opportunities for teachers to share and learn from each other. Several teachers thought the training was too long and could have been completed in two days. In addition, teachers were divided as to whether the PD should be separate for middle and high school teachers—some teachers did not like having the middle- and high school-level trainings together, while others found this helpful since students in each grade have varying ages and developmental stages.

Improvements to the coordination and delivery of materials were a high priority for both teachers and principals. It was suggested that materials be delivered further in advance to allow teachers more time to plan and prepare their lessons. However, TAL notes show that some principals
were either unaware that materials had been delivered or waited until the liaison visit to distribute them to teachers. Better methods of communication between teachers, principals, and TALs should be fostered to assure the timely delivery and subsequent distribution of materials.

Finally, middle school teachers noted that there was significant overlap between lessons in HealthSmart and those in Reducing the Risk and recommended that the books be combined to reduce redundancy. In order to save preparation time, teachers also suggested creating a student workbook, thereby eliminating the need to photocopy assignments.

Other Issues and Next Steps
The process evaluation of the sex education pilot is an important step in showing that not only is implementing comprehensive sex education possible in New York City public schools, but that it had strong support from teachers and principals alike and dovetailed with other DOE priorities such as reducing attrition and improving grades. Given New York City’s teen pregnancy rate and high incidence of STDs among adolescents, providing middle and high school students the tools and knowledge they need to make healthy sexual choices should be a top priority for both DOE and DOHMH officials.

However, a process evaluation speaks only to the feasibility of implementation and not to student outcomes: that is, do curricula actually impact student knowledge, attitudes, and behaviors? Will sex education delay sexual debut or increase contraceptive use and ultimately impact teen pregnancy and HIV/STI rates?

While evidence exists that the chosen curricula do indeed confer these benefits, no such evaluation has been conducted with a population comparable to that in New York City. In order to engender even more support from school staff, parents and elected officials, DOE and DOHMH should undertake a formal evaluation of these student outcomes. Such evidence may enable sex education champions to make the inroads necessary to expand sex education to all New York City middle and high schools.

Additionally, an important goal of comprehensive sex education curricula is to link students to necessary sexual and reproductive health care and educate them about the services available to them. While school-based health centers exist only in a small percentage of New York City public schools, DOHMH is working to actively link students to medical practices in the Bronx and Brooklyn through its School Linked Health Services and Adolescents Health Initiative programs. However, as focus group data revealed, teachers often are unaware of the services available to students. Some teachers also were unaware their schools maintained Health Resource Rooms where students can receive free condoms and health information.

Given this gap in knowledge of services available to teens, we recommend that future sex education PD include an up-to-date section on resources available to teens in need of sexual and reproductive health services. Furthermore, all teachers—not just those teaching sex education—should receive this information. Increasing teachers’ access to this vital information will ensure educators can provide students with both the knowledge and the awareness of services needed to make healthy choices, and achieve and maintain sexual and reproductive health.
Appendices


B. Regents Policy Statement on HIV/AIDS Instruction

C. Professional Development Pre-/Post Test

D. Teacher Log Form

E. Teacher Focus Group Script

F. Focus Group Report

G. Principal Interview Form

H. Recruitment PowerPoint Presentation
Appendix A

NEW YORK STATE COMMISSIONER’S REGULATIONS
SUBCHAPTER G, Part 135:
HEALTH, PHYSICAL EDUCATION, AND RECREATION

Section 135.1 Definitions

(j) Health education means instruction in understandings, attitudes, and behavior in regard to
the several dimensions of health. This instruction relates to alcohol, tobacco, and other drugs,
safety, 
mental health, nutrition, dental health, sensory perception, disease prevention and control,
environmental and public health, consumer health, first aid, and other health-related areas.

Section 135.3 Health Education

(a) Provision for health education. It shall be the duty of the trustees and boards of education
to provide a satisfactory program in health education in accordance with the needs of pupils in
all grades. This program shall include, but shall not be limited to, instruction concerning the
misuse of alcohol, tobacco, and other drugs.

(b) Health education in the elementary schools.

1. The elementary school curriculum shall include a sequential health education program for all
pupils, Grades K-6. In the kindergarten and primary grades, the teacher shall provide for pupil
participation in planned activities for developing attitudes, knowledge and behavior that
contribute to their own sense of self-worth, respect for their bodies and ability to make
constructive decisions regarding their social and emotional, as well as physical, health.
Personal health guidance shall also be provided according to the individual needs of pupils.
This guidance shall include the development of specific habits necessary to maintain good
individual and community health. In addition to continued health guidance, provision shall be
made in the school program of Grades 4-6 for planned units of teaching, which shall include
health instruction through which pupils may become increasingly self-reliant in solving their
own health problems and those of the group. Health education in the elementary school grade
shall be taught by the regular classroom teachers.

2. All elementary schools shall provide appropriate instruction concerning the Acquired
Immune
Deficiency Syndrome (AIDS) as part of the sequential health education program for all pupils,
Grades K-6. Such instruction shall be designed to provide accurate information to pupils
concerning the nature of the disease, methods of transmission, and methods of prevention; shall
stress abstinence as the most appropriate and effective premarital protection against AIDS; and
shall be age appropriate and consistent with community values. No pupil shall be required to
receive instruction concerning the methods of prevention of AIDS if the parent or legal
guardian of such pupil has filed with the principal of the school which the pupil attends a
written request that the pupil not participate in such instruction, with an assurance that the
pupil will receive such instruction at home. In public schools, such instruction shall be given during an existing class period using existing instructional personnel, and the board of education or trustees shall provide appropriate training and curriculum materials for the instructional staff who provide such instruction and instructional materials to the parents who request such materials. In public schools, the board of education or trustees shall establish an advisory council which shall be responsible for making recommendations concerning the content, implementation, and evaluation of an AIDS instruction program. The advisory council shall consist of parents, school board members, appropriate school personnel, and community representatives, including representatives from religious organizations. Each board of education or trustees shall determine the content of the curriculum and approve its implementation, and shall be responsible for the evaluation of the district’s AIDS instruction program.

(c) Health education in the secondary schools.

1. The secondary school curriculum shall include health education as a constant for all pupils. In addition to continued health guidance in the junior high school grades, provision shall also be made for a separate one-half year course. In addition to continued health guidance in the senior high school, provision shall also be made for an approved one-half unit course. Health education shall be required for all pupils in the junior and senior high school grades and shall be taught by teachers holding a certificate to teach health. A member of each faculty with approved preparation shall be designated as health coordinator, in order that the entire faculty may cooperate in realizing the potential health-teaching values of the school programs. The health coordinator shall insure that related school courses are conducted in a manner supportive of health education, and provide for cooperation with community agencies and use of community resources necessary for achieving a complete school-community health education program.

2. (i) All secondary schools shall provide appropriate instruction concerning the Acquired Immune Deficiency Syndrome (AIDS) as part of required health education courses in Grades 7-8 and in Grades 9-12. Such instruction shall be designed to provide accurate information to pupils concerning the nature of the disease, methods of transmission, and methods of prevention; shall stress abstinence as the most appropriate and effective premarital protection against AIDS; and shall be age appropriate and consistent with community values. No pupil shall be required to receive instruction concerning the methods of prevention of AIDS if the parent or legal guardian of such pupil has filed with the principal of the school which the pupil attends a written request that the pupil will receive such instruction at home. In public schools, such instruction shall be given during an existing class period using existing instructional personnel, and the board of education or trustees shall provide appropriate training and curriculum materials for the instructional staff who provide such instruction and instructional materials to the parents who request such materials. In public schools, the board of education or trustees shall establish an advisory council which shall be responsible for making recommendations concerning the content, implementation, and evaluation of an AIDS instruction program. The advisory council shall consist of parents, school board members, appropriate school personnel, and community representatives, including representatives from religious organizations. Each
board of education or trustees shall determine the content of the curriculum and approve its implementation, and shall be responsible for the evaluation of the district’s AIDS instruction program.

(ii) Boards of education or trustees that make condoms available to students as part of the district’s AIDS instruction program shall:

a. submit a condom distribution policy to the advisory council for consideration;

b. make condoms available only to students who participate in an appropriate AIDS instruction program as defined in this section;

c. provide each student receiving condoms with accurate and complete health guidance as to the risks of disease that may result from the student’s use or misuse of such product, which appropriately takes into account the child’s age;

d. assure that such personal health guidance is provided by health service personnel or school personnel trained and supervised by competent health professionals or health educators; and

e. submit for approval by the commissioner a plan for the training of health service personnel, as defined in subdivision (c) of section 136.1 of this Part, or school personnel who will provide such personal health guidance. Such plan shall be approved upon a finding of the commissioner that the training is adequate to prepare such personnel or school personnel to provide the required personal health guidance in an effective manner.
Appendix B

REGENTS POLICY STATEMENT ON HIV/AIDS INSTRUCTION

At its July 25, 1991, meeting, the Board of Regents adopted the following explanation of the Commissioner’s Regulation (8 NYCRR 135.3 (C)(2)).

1. The requirement that HIV/AIDS instruction must “stress abstinence as the most appropriate and effective premarital protection against AIDS” means that written and oral instruction on AIDS prevention must devote substantially more time and attention to abstinence than to other means of avoiding HIV infection. It also means that such instruction must always make it clear that no other method of prevention can provide the same 100 percent protection against infection as abstinence can.

2. Among other things, the requirement that HIV/AIDS instruction must “provide accurate information...concerning... methods of prevention” means that any written or oral instruction relating to condoms must fully and clearly disclose the various risks and consequences of condom failure.
Appendix C

Please Circle the Correct Answer

1. The average number of sperm cells in an ejaculation is:
   A. 50-100
   B. 50 thousand - 100 thousand
   C. 500 thousand - 1 million
   D. 200 million to 600 million

2. The anatomical feature(s) in males that is/are analogous to fallopian tubes in females is/are the:
   A. Testicles
   B. Vas Deferens
   C. Limbic System
   D. Urethra

3. The male condom is an effective method of preventing STIs if
   A. a latex condom is used with petroleum jelly lubricant
   B. a natural skin condom is used
   C. a latex or polyurethane condom is used from start to finish
   D. All of the above.

4. The New York City Department of Education and Department of Health and Mental Hygiene recommend a condom lubricant containing:
   A. Peanut Oil
   B. Mineral Oil
   C. Nonoxynol-9
   D. None of the above

5. Ground rules for setting up sex education role plays should include:
   A. You may spell s-e-x, but you may not say it.
   B. Respect the contributions of others.
   C. No physical contact
   D. All of the above.
   E. B and C but not A

6. In New York State, a minor can consent to reproductive health services at this age:
   A. 10
   B. 12
   C. 16
   D. no minimum age

7. The physical changes of puberty for a boy usually start with:
   A. enlargement of the testicles
   B. sprouting of pubic hair
   C. A and B
   D. neither A nor B

8. During puberty, the penis and scrotum begin to grow because of rising levels of:
   A. Testosterone
   B. Estrogen
   C. Progesterone
   D. Albumin
9. How many orifices do females have below the waist?
   A. 1       B. 2
   C. 3       D. 4

10. Fertilization occurs in the:
   A. Vagina    B. Fallopian tubes
   C. Uterus    D. Clitoris

11. The onset of menstruation is called:
   A. Amenorrhea  B. The curse
   C. Menarche   D. Dysmenorrhea

12. The only 100% effective method of preventing pregnancy is:
   A. Abstaining from vaginal intercourse
   B. Depo-Provera
   C. Latex Condoms
   D. All of the above

13. An indicator of an assertive response is:
   A. The use of "I" messages
   B. Shouting
   C. Initiating confrontation
   D. None of the above.

14. A type of surgery in which the foreskin of the penis is removed is called:
   A. Circumnavigation
   B. Circumcision
   C. Circumlocution
   D. Neutering
   E. None of the above

15. Which one of these is NOT a hormonal method of contraception?
   A. Diaphragm      B. Vaginal ring
   C. Patch          D. Depo-Provera

16. New York City Department of Health and Mental Hygiene recommends that sexually active adolescents use effective dual protection for STI and pregnancy prevention. Dual protections means, for example:
   A. Using a male latex condom and female condom together
   B. Using a latex condom and birth control pills
   C. Using withdrawal and Depo-Provera
   D. Using a condom and Fertility Awareness Method
   E. Using an IUD and male latex condom

Please Check True or False
17. It is the policy of the New York City Department of Education to teach that abstaining from sexual intercourse is the only 100% effective way to prevent pregnancy and STIs and is the most appropriate way for students to behave.
   True___  False___.

18. The New York City Department of Education teaches an "abstinence-only" HIV/AIDS curriculum
   True___  False___.

19. The New York City Department of Education has a condom availability program in middle schools.
   True___  False___.

20. Approximately 75% of high school students in New York City have had sexual intercourse.
   True___  False___.

21. Newborn girls are born with all the egg cells (ova) they will ever produce.
   True___  False___.

22. Testicular torsion is when a testicle twists out of its normal position.
   True___  False___.

23. An erection occurs due to muscle contractions acting on the penile erector bone.
   True___  False___.

24. Sexual attitudes, behaviors and beliefs are unaffected by culture and religion.
   True___  False___.

See additional Pre Test questions continued next page
Sex Ed Pilot Pre/Post Training Questions
(continued)

25. Please answer the following by checking a box for each statement:

<table>
<thead>
<tr>
<th></th>
<th>1 Not at all confident</th>
<th>2 Somewhat confident</th>
<th>3 Very Confident</th>
<th>4 Completely confident</th>
</tr>
</thead>
<tbody>
<tr>
<td>A.</td>
<td>I feel confident in my ability to facilitate a role play</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B.</td>
<td>I feel confident in my ability to answer sensitive questions about sex</td>
<td></td>
<td></td>
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<tr>
<td>C.</td>
<td>I feel confident in my ability to discuss male anatomy with students</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>D.</td>
<td>I feel confident in my ability to discuss female anatomy with students</td>
<td></td>
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<tr>
<td>E.</td>
<td>I feel confident in my ability to teach young people how to take care of their sexual health.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F.</td>
<td>I feel confident in my ability to teach young people about methods that will protect them from STI's.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>G.</td>
<td>I feel confident in my ability to teach young people about how to prevent pregnancy.</td>
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</tr>
<tr>
<td>H.</td>
<td>I feel confident in my ability to discuss sexual orientation.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I.</td>
<td>I feel confident in my ability to handle student disclosures about sexual activity.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

26. Please answer the following questions about your teaching experience:

A. I have been teaching for:
   This is my first year ______ 2-3 years ______
   4-6 years ______ 7 or more years ______

B. I am certified in health education  Yes ______ No ______

C. I have been teaching health education for:
   This is my first year ______ 2-3 years ______
   4-6 years ______ 7 or more years ______
D. I have taught sex ed:
   Yes, currently teach ______
   Yes, I have taught sex ed in the past, but am not currently teaching it ______
   I have not taught sex ed ______
Appendix D
Teacher Class Log Form – Sex Education Pilot Evaluation

NAME:

DATE:

Dear Teacher: Thank you for completing this log after each class session. Your candid answers will help us understand how well the sex education curriculum goes from the teacher’s perspective and to improve teacher training as we expand this effort to other schools.

LESSON / TOPIC NAME COVERED PRE-PRINTED ON ALL FORMS FOR SEMESTER

1. I spent this many minutes preparing for today’s lesson:
   
   [ ] 0 – 15 minutes  [ ] 16 – 30 minutes  [ ] 31 – 45 minutes  [ ] 46 – 60 minutes  [ ] 61+ minutes

2. Now that I’ve taught today’s lesson, I would recommend that a teacher allot this much time for preparation:
   
   [ ] 0 – 15 minutes  [ ] 16 – 30 minutes  [ ] 31 – 45 minutes  [ ] 46 – 60 minutes  [ ] 61+ minutes

3. I feel that the 3-day teacher training sufficiently prepared me to teach the topics covered in today’s lesson.
   
   [ ] Yes
   [ ] No (Explain ____________________________)

4. Please select as many as apply:
   
   [ ] I made no changes to today’s lesson plan.
   [ ] I deleted parts of the curriculum for today’s lesson.
      (I deleted ____________________________)
   [ ] I added supplemental written/AV material or activities to today’s lesson.
      (I added ____________________________)

5. Please briefly describe in-class experiences, student reactions and/or your overall impressions or concerns about today’s lesson.
Appendix E

Sex Education Pilot Teacher Focus Group

Thanks for coming today. We are very interested in learning about your experience with the sex education pilot as we prepare to support all NYC middle and high schools in teaching sex education.

Please introduce yourself and let us know one thing you hope students will remember from the sex education lessons you taught.....

Now, about the sex education pilot...
1. How much experience did you have with teaching sex education before this semester?
2. Did you volunteer to participate in the sex education pilot, or did your principal or assistant principal recruit you?

Thoughts about professional development training
We had asked all of the teachers participating in the sex education pilot to attend a three-day workshop. You all attended and we received your evaluation forms. Now that you have taught the lessons, I’d like to ask you to look back at the training and let me know...

1. What were the most valuable parts of the training for you?
2. Were there parts of the training that were not as useful? Why?
3. What changes in content or delivery would you recommend for future trainings?
4. How well did the training prepare you to teach the lessons?
5. What expectations did you have regarding
   a. Time needed to complete the lessons
   b. Content that you needed to cover
   c. Completing all the lessons
   d. Completing and returning the logs
   e. Materials availability
f. Lesson preparation, including photocopying

**Support for Implementation**

Once you completed the training and were at your school ready to teach the sex education pilot,

1. Were you assigned to teach sex education to the number of classes/students that you expected to teach?
2. Why/why not?
3. How did your administrator or others in your school support you in teaching the sex education lessons?
4. What additional support would you have like to receive from administrators or others in your school?
5. Members of NYCDOE and NYCDOHMH staff were assigned to support you in your schools.
   a. What was the relationship like between you and your TA Liaison?
   b. How important was the TA Liaison as a resource for you?

**Teaching**

1. How was the experience of teaching the lessons?
2. How did your students react to the lessons?
3. Did anything in the curriculum surprise you? If so, what?
4. What lessons worked well? Why?
5. Which lessons did NOT work well? Why?
6. How were you able to assess the lessons' effectiveness?
7. Some of you started teaching the lessons later in the semester. How far did you get in teaching the lessons?
8. Re the logs:
   a. If you did not send all the logs, what were the barriers to sending them?
   b. What methods of communicating with the researcher might work better in the future?
Resources
1. How does your school connect with school-based or neighborhood health services?
2. Did students request referrals to health services?
3. Were you able to meet student demand for referrals?
4. As you know, condom demonstrations are not allowed in the classroom, but take place in the resource room upon student request. How were the condom demonstrations in high school handled? What was the demand?

Improvements
1. In order to teach these lessons: What do you think are the absolutely essential
   a. Principal/school support
   b. Parent support
   c. PD
   d. TA
   e. Other support (please specify)
2. Are there topics students need to address that are not covered in the curriculum? Please specify:
3. How else can we at the DOE or NYCDOHMH support schools and teachers in helping students reduce their risk of HIV, STD and pregnancy?
4. Do you think teaching our students sex education is valuable? Why or why not?
5. If sex education were to be mandated, how would you feel about it?
6. Do you want and/or plan to teach the sex education lessons next year?
Appendix F

Highlights from the Meeting with Teachers on the Sex Education Pilot Project
Two one-hour and forty-five minute focus groups were held on Tuesday, June 24, 2008, at the Bronx School of Science, Inquiry, and Investigation (MS 331). A total of eleven Sex Education Pilot Project teachers participated, eight in the first session and three in the second session. A representative from the Department of Education (DOE), Stephanie Caloir, facilitated the group while a representative of the Department of Health and Mental Hygiene (DOHMH), Jessica Silk, took notes. Notes were taken anonymously. Teacher comments are represented by bullets. Stephanie Caloir’s summary/commentary added in italics. (Transcripts of the meetings are available, but participant identifiers have been removed).

A note: the mood in the room was jovial. Teachers were about to complete their work for the year. Some had already finished teaching for the year. Teachers enjoyed coming together to discuss their experiences. Also, the initial training took place in January, so the answers provided now, several months later, may not be reflective of their initial thoughts during the earlier stages of training and implementation.

Experience teaching sex education: All but one of the teachers was teaching sex education for the first time. Some had been science teachers or physical education teachers, but only one had taught sex education. One had been trained on the HIV/AIDS curriculum and had taught it in the past.

Volunteer or assigned by principal? All were assigned. Some with little or no advance notice. One found out the day of the three-day training, one was “blindsided”. Several had to squeeze into other topics they were teaching (during the designated sex education class periods) and could not possibly do both. One brand new teacher attended the three-day training before being put on the payroll.

Thoughts about professional development training

6. What were the most valuable parts of the training for you?
   - Some of the activities. The true/false and agree/disagree. The activities allowed me to see how to use/introduce topics.
   - Role-playing – most participants found role plays very helpful. Learning how to step away, and use the third person getting students to say “he/she”
   - PowerPoint visuals. They built upon materials and were very helpful.
   - Modeling activities (x several) especially group dynamics/discussions. Strategies to get people to open up, feel comfortable.

7. Were there parts of the training that were not as useful? Why?
   - Having the middle school and high school training together. You’re dealing with two totally different spectrums. Different resources.
   - Someone else found combination helpful because of having 15 and 16 year olds in an 8th grade class. Development stages vary between grades.
• Statistical stuff in PowerPoint. Interesting and helpful, but could get in a packet.
• Ground Rules. Congested. Too many concepts. All useful, but overflowed with information.
• Several people thought the training was too long and should have been spread out (e.g. 1x week x 2 weeks)

8. What changes in content or delivery would you recommend for future trainings?
• I would have liked a schedule/timeline.
• Books/resources should be given.
• There should be a pacing schedule and “must haves.” You could tell us what we should teach and the rest could be at the liberty of the teachers. Core subjects weren’t defined well enough. Time ended and I wasn’t able to finish.
• There should be a better transition between books.
• The lessons should be combined into one book.
• A week long training before school starts would be better: this is what you should teach, this is what kids need to know, and then it should add cultural difference, etc.
• There was repetition between the two books/lessons. In the training, one day in groups to discuss STIs did not give enough time. As teachers, we are used to teaching kids but we may be shy in front of other adults. We were only allowed snapshot discussions in our groups. It felt cut off.
• I was responsible for teaching other teachers and making copies for them, I did not have time.
• The Board of Education should make the training mandatory for all instructors teaching sex education.
• More hands-on websites would be useful.
• Information on dealing with LGBTQ youth. A couple of students are finding themselves and looked uncomfortable.

9. How well did the training prepare you to teach the lessons?
• I didn’t feel ready, but I felt comfortable. I didn’t feel like an expert, so I learned on my own time.
• You are not a teacher until you teach. The real experience is in the classroom.
• I felt comfortable with the small group; may not with large group.
• I needed more time to make photocopies.
• You never know what direction the discussion will go in. You can’t put off questions. Makes it hard to cover lessons [in time]. More flexible.
• Several felt prepared because of learning teaching methods such as “how to diffuse situations and deal with dissenting opinion” and language.
• Lesson plans helped a lot.

Time needed to complete the lessons
All said that there wasn’t enough time to teach the lessons.
• Each lesson takes longer than one period – may take 3 days. I taught 1x week so
if we ran out of time, we could not continue conversation until next week
• Didn’t get through. Focused on exit projects, but I tried to incorporate related
topics (i.e. STD research). Mostly did abstinence and puberty.
• Wasn’t able to finish. I integrated lessons into health ed. I had no chance at
starting RTR. Lessons usually lasted 90 minutes. Kids wanted to talk.
• Too long. Unable to finish.
• When the bell rings, kids continued to discuss.
• Didn’t get beyond abstinence and puberty.
• Got to lesson 16, skipped skills, and went to HIV.

Completing and returning the logs
Lots of groans – one person said “Sweet Jesus!”
• I had trouble submitting via fax. The number would be busy.
• The logs were geared to teachers who teach the lessons once per day. Not 5
classes. I had 5 classes with different levels so I could not fill out one log (two
people expressed this). I had to fudge because I did not want to turn in 5 separate
logs.
• It started off well, but then I relaxed/got lazy – I usually had the same comments.
• They were the worst part. It was frustrating. I didn’t get the self-addressed
stamped envelopes until later.
• It was too much

Materials availability
Virtually all teachers said that materials should have been sent sooner and that they would have
preferred workbooks for each student. They felt they wasted a lot of time and paper making
copies.
• The two books were not presented in the same format. The binder was excellent. I
tore out pages of one book and added them to the binder.
• There was no CD for abstinence and puberty. Would have been helpful re: smart
board presentations.
• Some lessons needed to be retyped (page from curriculum was too dark when
printed for students with visual problems). It was frustrating and time consuming.
• I had to make transparencies. It would have been better to be given all soft copies
and hard copies of all forms. Better sooner.
• The wrong copies were sent to us.
• Need to add materials for 12th graders, i.e. CDC stats, current event articles.
• Everything I needed was in the books.

Support for Implementation
Some teachers felt supported by the principal. Most felt left alone by the principal.
• Very supportive; helpful with copies.
• I didn’t have a room for my students. I shared my room with another teacher and ended up teaching 2 classes. Administration never asked about it. They forgot or didn’t care.
• Administration asked how it was going.
• An ELA/DYO writing assessment essay asked students about abstinence and students already had practice and were able to write about information they knew. I was thanked by ELA teachers.
• The principal wanted to observe and visit, but was too busy at the end of the year.
• [Administration] was friendly and would jokingly call us the “sex squad.”
• Felt supported because we were three teachers.
• Needed additional support with conflicts in scheduling. I was told “you’ll make it work.” I had to squeeze [sex ed] in with another long-term project during AP.

Additional support that would be helpful from school administrators/others.

Several teachers suggested that they would need more time to teach the lessons or to have a different schedule in order to teach the lessons. Others requested workbooks.
• The administration did not realize how time intensive the curriculum would be.
• Time away. PD. Summer training? Training for credits?
• Smart boards.

TA Liaisons: What was the relationship like between you and your TA Liaison?
• TA was amazing, very smart; but we gave her a hard time, i.e. avoiding phone calls. We were set after the training. Teachers supported one another. She was there and available. We had good conversations.
• TA was incredibly supportive but difficult to get a hold of. I would call and leave messages (2 emails, 2 voicemails) but the time I heard back it was too late. She helped work through the kinks. We need a constant communication if we need help right away. I had issues with materials. A more efficient contact is needed.
• Good, came twice.
• Was cool. Helped when we were given the wrong materials. Emailed.

How important was the TA Liaison as a resource for you?
• I had an internal HIV curriculum contact who was helpful, more useful.
• Very supportive, kept me on track, got back immediately. It would have been helpful for TAs to contact us when they sent materials. Materials were missing and I accidentally found the binders in the VPs office. Needed better communication.
• Accessibility is important. Point of contact in case something did happen. Didn’t need that much but knew someone was there.
• Follow-up emails are important.

Teaching the lessons
• I had a blast. Could add creativity and additional activities.
• They liked it; asked for more. Packets were good to have in front.
• Students asked for more next year.
• It was fragmented so didn’t work that great. Students ranged from apathetic to really interested. It could have been better.
• Enjoyed it. I received interesting exit slips about what they learned.
• Kids appreciated the break in monotony. Some needed a lot more than 45 minutes.
• I taught all girls. Girls were not interested in sexual stereotyping. They were most interested in relationships, healthy versus non-healthy.
• I teach 8th grade and 11th grade. Teaching experiences differed based on maturity.
• Reproductive health was shocking for 6th graders. They were uncomfortable, but eventually it worked well. They had many questions and sometimes I had to reiterate.
• Boys reacted to their own reproductive sex anatomy. Were embarrassed; there were some “ew” reactions (2 said this).
• Was redundant for 12th graders (two said this).
• Needed to reiterate ground rules.
• They did a birth control project for an exit project and they got into it.
• They taught each other.
• Student surprised that “you don’t urinate out of your clitoris”
• Surprised about the language, re: male breasts.

What lessons worked well? Why?
• Role-playing (a few said this).
• Relationships. Role-playing. Skits—they loved it. It’s amazing what they’ve seen.
• Relationships. They were curious and involved—asking questions. Could be applied to friendships. It was frustrating to those without boyfriends. They asked “When are we going to use it?” Different reactions
• First lessons were very appropriate. Interactive. Lots of things to share. Media pressures. Presentations.

Which lessons did NOT work well? Why?
• “Go to the side of the room.” It was good at first but they got lazy.
• Role-playing for the 12th grade. They got bored with it and did not want to do any more.

Assessing the lessons’ effectiveness
• No written assessment in books. No accountability on worksheets. I treated it like a standard and integrated it in the midterm.
• Weekly quizzes, taken from book.
• Oral presentations, role-plays. I used the rubric to have them grade role-play presentations. I kept their worksheets in a folder for grades.
• They didn’t get back homework.
• Sharing own information, i.e. their mom, friend, cousin, etc. re: teen pregnancy. They really got the message with teen pregnancy. Long impact. They reacted, “We are not having that!” 3 Es: education, excitement, employment. Will stay with them.
• Students began to participate who hadn’t. They came back with questions. They did homework assignments.

Logs: Barriers to sending them
(see previous answers)
• Too many. Overwhelmed as a new teacher. Too much paper.
• No problem. Only one class.
• Not bad.

What methods of communicating with the researcher might work better in the future?
• We are in the digital age. There should be a website or email. My school has one fax machine in the principal’s office.
• Email. Online form/feedback system.
• Online, but in some schools it’s hard to get to a computer.

How does your school connect with school-based or neighborhood health services?
• Various respondents: not available or they don’t.
• The Teen Choice program supplies contraceptives in high school, but we are losing that partnership.

Did students request referrals to health services?
• Yes. Student came to me and told me a personal problem (several said this).
• One [8th grade] student was pregnant and still in school. It affected a lot of students. Real life example.
• I mentioned avenues/referrals. One student approached me about testicular cancer and I asked him if he felt comfortable talking to his family. He said he did. He told his parents and they took him to the doctor and he is fine.
• They have posters with phone numbers by the nurses office, but some are shy. They should leave them out in classrooms, hallways.
• No. Don’t know about clinics, insurance.

Knowledge of health resource room/ demand for referrals for condom demonstrations?
Teachers had little/no information about health resource room/where/how to refer students for condom demonstrations.
• Teen Choice does for high school students in the resource room.
• Kids would play/joke around with the condoms, but playing is part of learning.
• Used the exercise about asking students where health resource room is. But I don’t know when the person is there or what they do.

Improvements- what supports are essential in order to teach the lessons?
Principal/school support
- Money
- Technology, i.e. smart boards, online access (two said this)

Parent support
- There is no connection.
- Principal sent letters to parents, but they don’t go home. A few opted out.
- They need to send the letters in the mail.

PD
- Not 3 consecutive days. Separate.
- Separated weekly would allow teachers to come back and get feedback from one another.
- How to handle issues/discussions/dynamic, re: GLBT and questioning students, students living with HIV, pregnant or parenting teens in classroom

Are there topics students need to address that are not covered in the curriculum? Please specify:
- There is not enough time for more.
- There is enough material.

How else can we at the DOE or NYCDOHMH support schools and teachers in helping students reduce their risk of HIV, STD and pregnancy?
- Current videos at discoveryeducation.com. One month free trial.
- United Streaming Videos
- Brain Pop
- A high school mothers group came to do presentations to students and share experiences. It was powerful and had a greater impact.
- Peer tutoring.

Do you think teaching our students sex education is valuable? Why or why not?
An overwhelming “Yes!” (all agreed)
- Would do again.
- There is no way to keep sex out of the lives of students. They are exposed to sexual material; it’s easily accessible, everywhere. Sex education is invaluable to have in a forum for where they spend most of their time.
- Extremely important.
- Good opportunity to lead the right path and correct misconceptions.

If sex education were to be mandated, how would you feel about it?
Virtually all thought it should be mandated.
- Definitely.
- Parents are not talking about sex.
- A good piece to the curriculum
- Integration of sex education into health
• Should be extended. There are many questions in the beginning because it is about them.

Do you want and/or plan to teach the sex education lessons next year?
Several participants said Yes.
• Some transformation is needed. Really important.
• Would love to. Especially with more experience.
### Appendix G

**Sex Education Pilot**  
**Principal End-of-Pilot Interview**

<table>
<thead>
<tr>
<th>Interviewed by:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Interview:</td>
<td></td>
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<tr>
<td>Principal Name:</td>
<td></td>
</tr>
<tr>
<td>School Name:</td>
<td></td>
</tr>
</tbody>
</table>

**Grade Level(s) participating in pilot**  
(circle all that apply)  

<table>
<thead>
<tr>
<th>6th</th>
<th>7th</th>
<th>8th</th>
<th>9th</th>
<th>10th</th>
<th>11th</th>
<th>12th</th>
</tr>
</thead>
</table>

#### Q1. Before implementation of the sex education curriculum, how much of a need for such a program was there in your school?

1. Great Need  
2. Moderate Need  
3. Slight Need  
4. No Need

#### Q2. Why did you think/not think you needed a sex education curriculum at your school?

#### Q3. Once the curriculum was explained to you, how strong was your personal support for the sex education program being offered?

1. Strong Support  
2. Moderate Support  
3. Slight Support  
4. No Support
<table>
<thead>
<tr>
<th>Q4. Were you aware of any existing support for sex education from parents, students, or other school staff prior to its implementation? If yes, please describe.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q5a. How closely were you involved with the curriculum’s implementation?</td>
</tr>
<tr>
<td>1. Very Closely</td>
</tr>
<tr>
<td>2. Somewhat Closely</td>
</tr>
<tr>
<td>3. Not at all Closely</td>
</tr>
<tr>
<td>Q5b. Please describe your involvement.</td>
</tr>
<tr>
<td>POSITIVE:</td>
</tr>
<tr>
<td>NEGATIVE:</td>
</tr>
<tr>
<td>Q7. Please describe any reactions to the sex education curriculum by the teachers who taught it.</td>
</tr>
<tr>
<td>Q8. Please describe any reactions to the sex education curriculum by other teachers, school counselors, or other staff.</td>
</tr>
<tr>
<td>Q9. Please describe students' reactions to the sex education curriculum.</td>
</tr>
<tr>
<td>Q10. How many opt-out letters did you receive from parents/guardians?</td>
</tr>
<tr>
<td>Q11. Did any parents/guardians contact you with feedback regarding the curriculum? If yes, what was the content of that feedback?</td>
</tr>
</tbody>
</table>
| Q12. In your opinion, how much support for the sex education program was there among parents/guardians? Was there strong, moderate, slight or no support? | 1. Strong Support  
2. Moderate Support  
3. Slight Support  
4. No Support  
5. Not aware of parental opinion |
Q13. I'm going to read a list of priorities that many principals share. For each, please tell me whether you think offering sex education helped, hindered or had no impact on that priority.

<table>
<thead>
<tr>
<th>Priority</th>
<th>Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>13a. Attendance</td>
<td>1. Helped</td>
</tr>
<tr>
<td></td>
<td>2. Hindered</td>
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<tr>
<td></td>
<td>3. No impact</td>
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<tr>
<td></td>
<td>4. Don’t Know</td>
</tr>
<tr>
<td>13b. Test Scores</td>
<td>1. Helped</td>
</tr>
<tr>
<td></td>
<td>2. Hindered</td>
</tr>
<tr>
<td></td>
<td>3. No impact</td>
</tr>
<tr>
<td></td>
<td>4. Don’t Know</td>
</tr>
<tr>
<td>13c. Grades</td>
<td>1. Helped</td>
</tr>
<tr>
<td></td>
<td>2. Hindered</td>
</tr>
<tr>
<td></td>
<td>3. No impact</td>
</tr>
<tr>
<td></td>
<td>4. Don’t Know</td>
</tr>
<tr>
<td>13d. Disciplinary Incidents</td>
<td>1. Helped</td>
</tr>
<tr>
<td></td>
<td>2. Hindered</td>
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<tr>
<td></td>
<td>3. No impact</td>
</tr>
<tr>
<td></td>
<td>4. Don’t Know</td>
</tr>
<tr>
<td>13e. Graduation Rates</td>
<td>1. Helped</td>
</tr>
<tr>
<td></td>
<td>2. Hindered</td>
</tr>
<tr>
<td></td>
<td>3. No impact</td>
</tr>
<tr>
<td></td>
<td>4. Don’t Know</td>
</tr>
<tr>
<td>13f. Fostering school pride or connectedness</td>
<td>1. Helped</td>
</tr>
<tr>
<td></td>
<td>2. Hindered</td>
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<tr>
<td></td>
<td>3. No impact</td>
</tr>
<tr>
<td></td>
<td>4. Don’t Know</td>
</tr>
<tr>
<td>Q14a. How did your school spend the sex education stipend we provided?</td>
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<tr>
<td>Q14b. Looking back was this a good use of the money? Why or why not?</td>
<td></td>
</tr>
<tr>
<td>Q15a. Other than the cost of the curriculum and teacher training, how much do you think it would cost per year to implement this sex education curriculum effectively?</td>
<td>$_________ per year</td>
</tr>
</tbody>
</table>
| Q15b. Please tell me what you would spend this money on. | 1.  
2.  
3.  
4.  
5.  |
| Q15c. Do you consider this a reasonable amount to incorporate into your budget? | 1. Yes, reasonable amount  
2. No, not a reasonable amount |
| Q16. Now that the pilot is over, how strong is your support for the sex education curriculum you offered? | 1. Strong Support  
2. Moderate Support  
3. Slight Support  
4. No Support |
<table>
<thead>
<tr>
<th>Question</th>
<th>Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q17. Do you want to continue this sex education curriculum next year?</td>
<td>1. Yes</td>
</tr>
<tr>
<td></td>
<td>2. No</td>
</tr>
<tr>
<td></td>
<td>3. Not sure</td>
</tr>
<tr>
<td>Q18. Would you recommend this curriculum to other principals?</td>
<td>1. Yes</td>
</tr>
<tr>
<td></td>
<td>2. No</td>
</tr>
<tr>
<td></td>
<td>3. Not sure</td>
</tr>
<tr>
<td>Please explain why or why not.</td>
<td></td>
</tr>
<tr>
<td>Q19. What advice would you give other principals who are thinking about offering this curriculum?</td>
<td></td>
</tr>
</tbody>
</table>
Q20. What other comments would you like to share?