"CONDOMS AND CONSENT!" KNOWLEDGE, EFFICACY AND POSITIVITY IN A SEXUAL HEALTH PROGRAM

A Thesis submitted to the faculty of
San Francisco State University
In partial fulfillment of
the requirements for
the Degree

Master of Arts

In

Human Sexuality Studies

by

Kristen Marie Bricker

San Francisco, California

May 2015

CERTIFICATION OF APPROVAL

I certify that I have read Condoms and Consent! Knowledge, Efficacy and Positivity in a Sexual Health Program by Kristen Marie Bricker, and that in my opinion this work meets the criteria for approving a thesis submitted in partial fulfillment of the requirement for the degree Master of Arts in Human Sexuality Studies at San Francisco State University.

Rita Melendez, PhD
Professor of Sexuality Studies

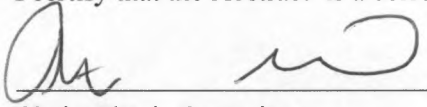
Alexis Martinez, PhD
Professor of Sexuality Studies

"CONDOMS AND CONSENT!" KNOWLEDGE, EFFICACY AND POSITIVITY IN A SEXUAL HEALTH PROGRAM

Kristen Marie Bricker
San Francisco, California
2015

Teen birth and abortion rates are higher in the US than any other industrialized country, and 15-24 year olds make up 50% of new sexually transmitted infections each year. US school policy promotes heteronormativity, and most programs ignore the needs of LGBTQ youth. The current study examines knowledge, attitudes and self-efficacy in a comprehensive sexuality education program in Northern Sonoma County. There are two phases of this mixed-methods study: the first consists of quantitative surveys; the second consists of qualitative interviews of program educators, field notes and analysis of anonymous questions from the students. Results indicate that education has a significant effect on knowledge ($p \leq .001$), sex-positive attitudes ($p \leq .005$) and self-efficacy in seeking and utilizing reproductive services ($p \leq .001$).

I certify that the Abstract is a correct representation of the content of this thesis.



Chair, Thesis Committee

5/14/15

Date

ACKNOWLEDGEMENTS

First and foremost I would like to thank Alliance Medical Center for allowing me to work on this project with them. Thank you to Rita Melendez and Alexis Martinez for your feedback and support, I could not have finished this project without you. Thank you to Katie, Amy and especially my fiancé Nikko; I know that it was not easy to live with me while working on my thesis, thank you for putting up with me! You kept me sane and reminded me that it is important to take breaks! Lastly, I would like to thank my family- Mom, Dad and Danielle- for supporting me through the long journey to this point, I love you.

TABLE OF CONTENTS

LIST OF TABLES

Table Page

LIST OF APPENDICES

Appendix Page

Literature Review

Importance of Sexual Health Education

Teen birth and abortion rates are higher in the US than in any other developed countries, with 15-24 year olds accounting for 50% of all new sexually transmitted infections (STI's) each year although only 25% of that population is sexually active (Kohler, Manhart and Lafferty, 2008). Sexual health education is one way in which to prevent unhealthy sexual behaviors that lead to unwanted pregnancy and STI's. As well as preventing unwanted pregnancy and STI's, school-based sexual health education may address social factors such as traditional gender and sexuality norms that are perceived to lead to negative sexual health outcomes. Programs that address these issues result in increased sexual agency and fewer rape supportive ideas (Grose, Grabe and Kohfeldt, 2014). Few studies of sexual health education incorporate adolescent perspectives; research focuses on facts about adolescent sex rather than examining what adolescents want out of sexual health education. Understanding adolescent knowledge and curiosity may increase the effectiveness of reducing negative health consequences for adolescent sexual risk taking behaviors (Charmaraman, Lee and Erkut, 2012). Research indicates that regret and lack of pleasure are common experiences in young people's sexual activity, yet young people rarely have access to programs that address these issues (Dickson, Paul, Herbison and Silva, 1998). Research shows that adolescents explain they wished they knew more about "actual sex" through sexuality education in order to make sex more enjoyable (Allen, 2012). Young people should be acknowledged as sexual

subjects and viewed as legitimately able to access information about sexual pleasure through sexual health education, thereby increasing self-efficacy in seeking and utilizing reproductive services in order to reduce the risk of pregnancy and STI's.

Abstinence Only vs. Comprehensive Sex Education

Abstinence-only programs are defined as curricula that include only abstinence. Comprehensive programs are defined as curricula that emphasize abstinence as the safest behavior and offer information on and promote the use of condoms and other contraceptives/prophylactics for those who do choose to have sex (Kirby, 2008). To be truly comprehensive, programs should also include information on healthy relationships, sexually transmitted infections, sexual violence, gender and sexuality, communication and anatomy. Proponents of comprehensive sexual health education argue that these programs have been shown to both delay the initiation of sex and prevent pregnancy and STI's at higher rates (Kirby, 2008). However, some argue that comprehensive sexual health education programs can send mixed messages to adolescents and promote adolescent sexual activity. Abstinence-only programs tend to utilize emotion-based arguments to prevent sexual activity, such as romantic notions of marriage, morals and fear of STI's. In order to do this, they often cite incorrect scientific information (Santelli et al., 2006). As a result, these programs actually promote irresponsible, higher-risk behavior by refusing to educate adolescents about reproductive health and decision making (Stanger-Hall and Hall, 2011). Abstinence-only education has minimal effect on sexual risk taking behavior and initiation of sexual activity (Kohler, et al., 2008).

Furthermore, the majority of the academic literature suggests that comprehensive sexual health education that includes abstinence as the most effective preventative measure is correlated with lower teen pregnancy and STI rates (Kirby, 2008; Kohler et al., 2008; Stanger-Hall and Hall, 2011). In a meta-analysis examining the difference between abstinence-only and comprehensive programs, Kirby (2008) found that comprehensive programs both increase rates of abstinence and improve other sexual health behaviors among youth, including delayed initiation of sex, reduced number of sexual partners, increased condom and contraceptive use and reduced sexual risk-taking behaviors. Similarly, Kohler et al. (2008) found that formal comprehensive sexual health education programs reduce the risk for teen pregnancy without increasing the likelihood that adolescents will engage in sexual activity, and confirmed results from randomized controlled trials that abstinence-only programs have minimal effects on sexual risk taking behavior.

Heteronormativity

US school policy promotes heteronormativity, defined as monogamous, marital, middle class, white heterosexuality. Sexual education policies and curricula demonstrate ambivalence towards lesbian, gay, bisexual, transgender and queer (LGBTQ) individuals and families by reproducing racialized, gendered norms about what forms of desire and family are appropriate and healthy (McNeill, 2013). State promotion of heteronormativity in education policy and curricula both enacts and legitimates homophobia in schools (McNeill, 2013). Schools are sites of the production of citizens and exert a disciplining

force on heterosexual and LGBTQ non heteronormative families. Within schools, sex education is one of the most explicit sites of the regulation of gender and sexuality. School based sexual health education has focused on one form of heterosexuality, whereas marginalized and other sexualities are most often excluded in this discourse and pedagogical practice. In conventional discourses of heterosexuality young men are rendered constantly desiring and always able to achieve sexual pleasure, which has regulatory effects and alienates those who do not conform (Pascoe, 2007; Allen, 2012). Traditional gender and sexuality social norms are empirically linked to negative sexual health outcomes. In terms of school climate this is harmful to all students regardless of their sexual identity (Elia and Eliason, 2010). Fields (2008) found that heteronormativity, sexism, and racism operate together to structure the content and delivery of school-based sexuality education. In the public schools she observed, sexual health education classes affirmed masculinist sexual hierarchies, desexualized students' bodily experiences and marginalized LGBTQ people. Heteronormativity is a specific normative form of heterosexuality that regulates LGBTQ individuals as well as heterosexuals (McNeill, 2013). Heteronormativity in sexual health education has repercussions for both LGBTQ and heterosexual youth. The entire school culture is affected by exclusion of LGBTQ youth (Elia and Eliason, 2010).

LGBTQ Youth

LGBTQ youth are less likely to receive comprehensive sexual health education than their heterosexual counterparts. Scholars express the need to create LGBTQ

inclusive sex education to improve health outcomes in these populations (Blake et al., 2001; Harper, 2007). Sexual health education is perceived as one way to prevent unhealthy sexual behavior but current sexuality education materials do not address the needs of LGBTQ youth and many are criticized for marginalizing and ostracizing these populations (Elia and Eliason, 2010). This can cause harm as most curricula instruct youth to adopt narrow views of sexual relationships and emphasize heterosexual marriage as the only example of healthy sexuality (Fine and McClelland, 2006). School-based sexual health education is a space in which to address these issues, however youth are seldom granted access to programs that do so (Allen, 2012). Research indicates that a safer more accepting school climate results from including positive representations of LGBTQ people, history and events as well as providing LGBTQ-specific resources (Kosciw et al., 2012). One study found a link between participation in a comprehensive program and more progressive attitudes towards women and less agreement with hegemonic masculinity ideology. Both traditional attitudes towards women and hegemonic masculinity ideology were negatively related to safer contraceptive beliefs (Grose et al., 2014). Participants in a study done by Gowen and Winges-Yanez (2014) provided suggestions for more inclusive education, such as addressing LGBTQ issues directly, emphasizing STI protection over pregnancy prevention, and discussing healthy relationships. The researchers argue that implementing such a program would make sexual health education more inclusive for LGBTQ students as well as the entire student population.

Including a discourse of erotics in sexuality education could also create a school culture in which students' desire and pleasure is legitimated and positively integrated (Allen, 2005). Recognizing and addressing students' requests to learn about pleasure in sexual health education constitutes them as legitimate sexual subjects whose sexuality is viewed positively (Allen, 2012). Sexual health education is a space in which students can be provided information and skills to increase the likelihood of experiencing sexual pleasure. However, Allen suggests that students often perceive a pedagogical situation differently, despite the intentions of the speaker and what is said. For example, the majority of students read the gender of partners as opposite, despite educators remaining gender neutral in their speech. Therefore, educators' attention to gender neutrality in their presentations inadequately challenges heteronormativity and heterosexual experiences as "normal" (Allen, 2012). Consequently, educators must do more that challenge heteronormativity with language, such as directly discussing LGBTQ issues and relationships as suggested by Gowen and Wingez-Yanez (2014).

Educators' Experience of Teaching Sexuality Education

Nationally, health education classes across grade levels commonly collaborate with outside agencies for sexual health education, and teachers in more than 40% of schools report involving guest speakers to cover at least some of the material. Teachers often face challenges with sexual health education, such as inadequate training and support, and guest speakers can help with these issues. Research suggests that students may find guest speakers to be more "expert" (Eisenberg, Wagenaar and Neumark-

Sztainer, 1997) and students may be more comfortable discussing sensitive topics with someone other than their teacher (Allen, 2005). Teachers who include guest speakers tend to cover more topics and discuss more controversial topics through sexual health education. This can have implications for teachers, school policy, and organizations that offer sexual health education and outreach (Eisenberg et al., 1997).

This study is an evaluation of Alliance Medical Center's comprehensive sexual health program. Alliance's program is truly comprehensive in that it covers a wide range of topics that have been identified by both researchers and students as important to sexual health (Gowen and Winges-Yanez, 2014). The program is inclusive of LGBTQ youth and works to break down traditional sexual and gender stereotypes. Discourses of erotics are included throughout the program, and students receive information that is relevant to their questions. This study will examine whether or not Alliance's program is effective in influencing knowledge, attitudes and self-efficacy in relation to sexual health.

Methods

The purpose of this study is to examine the effectiveness of a comprehensive sexual health program in a high-school setting. This study utilizes a two phase mixed-methods design. The first phase consists of pre and post quantitative surveys taken by students at Cloverdale High School (N=84). Surveys consist of three scales measuring knowledge, attitude and self-efficacy. Post-test surveys also include a scale composed of questions formulated from field notes and anonymous questions posed by the students. Students completed the pre-test one week before the sessions began, and completed the

post-test two weeks after the sessions ended. The surveys are meant to measure differences between levels of knowledge, sex-positive attitudes and self-efficacy in seeking and utilizing reproductive services from before to after participation in the program. The second phase consists of qualitative interviews with the program educators, as well as field notes and analysis of anonymous questions in the classroom. The purpose of the interviews is to determine the objectives and drawbacks of the program. Analysis of field notes and anonymous questions will provide information on what students think, know and want to know about sex and sexuality. The goal of the two-phase design is to better understand quantitative results with the aid of qualitative data that provides insight into the program.

Mixed-methods research combines qualitative and quantitative techniques in collecting and analyzing data. Utilization of mixed-methods design strengthens research studies (Creswell, 2009). I created a survey specifically for the Alliance program to collect quantitative data. In order to gain a better understanding of program goals and student need, qualitative data were collected by interviews, anonymous questions and field notes. After I analyzed both sets of data separately, I merged results.

Program Description

As part of phase one, I observed sexuality education classes held by Alliance Medical Center. Alliance Medical Center's sexual health program serves four unified school districts in northern Sonoma County: Windsor, Healdsburg, Geyserville, and

Cloverdale. Curricula varies from school to school depending on time allotted at that school, teacher flexibility and perceived student need. Students participate in at least six sessions of sexual health education. This study focuses on ten sessions conducted at Cloverdale High School, each with a different but connected topic (Table 1). Cloverdale is a small town in Northern Sonoma County described below (Study Environment). The program begins with a lesson on anatomy, in which educators explain reproductive anatomy in detail, including the sperm production and maturation process, pregnancy and menstruation. The second class consists of a discussion of sexual response in regards to reproductive anatomy, systemic physiological changes and brain activity during sex. The third and fourth sessions focus on bacterial and viral STI's respectively, and what types of sex and bodily fluids can transmit them. The fifth class centers on HIV/AIDS, in which we discuss how HIV is transmitted and how it is not, and do an activity focusing on HIV myths. Session six covers birth control and disease protection and includes condom demonstrations and in-depth discussions of hormonal birth control methods. The seventh sessions' topic is abstinence, in which students discuss communication with partners, differing definitions of abstinence, and why people in high school choose or choose not to have sex. The eighth class focuses on gender and sexuality: educators discuss gender identity, gender expression, biological sex and sexual orientation using the Genderbread Person (Killermann, 2012). Educators from Verity, Sonoma County's Rape Crisis Center, lead the ninth and tenth sessions. Educators focus on healthy relationships during the ninth session, in a student-lead activity discussing aspects of healthy

relationships. The tenth and last session utilizes curriculum from Verity, called Teen Assault Prevention Program (TAPP), which covers sexual assault, sexual harassment, and consent. Each class concludes with anonymous questions posed by the students. The program focuses on sex positive messages regarding sexual health and sexual activity. The students complete participation in the program after two school weeks; they attend one session per day for ten days.

This program attempts to address the needs of all students, regardless of gender, gender identity, sexual identity and ethnicity/race. Educators do this through the use of inclusive language and explicit discussions of these issues. While the curriculum states that abstinence is the only method that completely protects against STI's and pregnancy, comprehensive information on birth control and disease protection is offered to students. The material is evidence-based and does not use fear-based methods of prevention. The curriculum focuses instead on the positive aspects of sex and sexuality and promotes pleasure and joy as the optimal sexual experience.

Alex Kelner, the director of the program, created the curriculum and oversees every session. The educators are volunteers, typically from Sonoma State University and the Santa Rosa Junior College, who usually participate in the program for school credit and teaching experience. Educators participate in extensive training at the beginning of each semester, spanning three weeks and comprised of 30 hours. Training includes an overview of the curricula, demonstration presentations, practice presentations,

Table 1: Session Topics

Session Number	Topic
1	Anatomy
2	Sexual Response
3	Bacterial STI's
4	Viral STI's
5	HIV/AIDS
6	Birth Control and Disease Protection
7	Abstinence and Sexual Decision Making
8	Gender and Sexuality
9	Teen Assault Prevention Program (Verity)
10	Healthy Relationships (Verity)

discussions of trauma and self-care, mandatory reporting and group bonding activities, among others. Each volunteer receives a binder containing the curriculum for the program, material regarding presentation skills and mandatory reporting and volunteer responsibilities. Volunteers typically stay with the program for one semester, however some stay longer.

I have volunteered with this program since the Fall of 2013 as a health educator. Since that time I have been promoted to Lead Health Educator, where I teach classes without supervision and aid in the training of new volunteers. I am responsible for teaching all classes at three of the alternative high schools in the area, and for corresponding with teachers of these classes to schedule session times.

Study Environment

Cloverdale is located in a rural area of Northern Sonoma County with a last recorded population of 8,738 residents (U.S. Census Bureau, 2013). The high school is located just outside of the downtown area, off of the main road through the town. The school backs up to a small neighborhood, with a church on one side and a field with small shack-like buildings on the other side. The campus is set up so that the classrooms are arranged in a square surrounding a quad with picnic tables and small patches of grass. Sessions took place in a biology classroom, located in the back corner of campus. The classroom looks like a typical high school biology class, with a white board and lab table at the front of the room, eight long tables facing the white board, and six lab tables in the

back of the room, three on each side. The biology classes have two teachers that split their time equally, Mrs. Smith teaches on Mondays and Tuesday and Mrs. Johnson teaches on Thursdays and Fridays and each teach every other Wednesday. "Smith" and "Johnson" are pseudonyms for the biology teachers at this school. Class times vary throughout the day and week, but are somewhere between 49 and 59 minutes. Wednesday class periods are shorter, to conserve an hour at the end of the day for teacher planning. Class size varies as well, with between 15 and 28 students.

Phase 1: Quantitative

Baseline Data Collection Procedure

Students filled out a self-report measure in their regularly scheduled biology class. All students (N=90) were asked to complete the pre-test survey via paper and pencil during a class period one week before the Alliance sexual health program. Mrs. Smith oversaw the distribution and collection of the first survey and second survey. Students were offered candy as an incentive to complete the second survey. The post-test survey administration occurred in the same way two weeks after the sessions ended.

Participants

Participants include all students enrolled in one of the biology classes at Cloverdale High School in Cloverdale, CA. Sexual health education takes place in this class. Cloverdale High School was chosen as the site for the study based on class time,

access to the students, teacher flexibility, and time allotted for sexuality education. The biology class consists of students in tenth, eleventh and twelfth grade, between the ages of fourteen and seventeen. Ninety students completed the first survey and eighty-seven students completed the second survey. Three students were dropped from the final analysis due to missing data. No students in these classes chose to opt-out of sexual health education.

Confidentiality

During the study, identifying participant information was protected. I collected no identifying information, and the teacher did not see the surveys. I asked students to record their student identification number on the survey for comparison purposes, however I do not have access to a record of these numbers, so I am unable to identify students. Verbal consent for the survey was obtained from the students. Students were told that the survey was optional and choosing to take it would not have an influence on their standing in the class. I assured key informants that they would remain unidentified in this study, except for the program director.

Instruments

A review of the sexual health program evaluation literature determined that there is no validated instrument to address all of my research questions. Therefore, I developed a survey based on a content review of the program curricula. I formulated questions based on information presented throughout the sessions. The post-test included items to

measure internal consistency reliability and address knowledge and attitude questions that arose during the sessions. I included post-test only items based off in-class and written anonymous questions submitted by students following each session.

Pre-test Measures

The pre-test survey consists of three scales measuring knowledge, attitudes and self-efficacy in seeking and utilizing reproductive services (Appendix 1). Self-efficacy refers to students' level of confidence in being able to perform a specific action. Scale one consists of fourteen items measuring knowledge of sexual health. Examples of items include "sex and gender are the same thing," "using two condoms is more effective than using one," and "a person cannot get an STI the first time they have sex." High scores on the knowledge subscale indicate a high level of knowledge about sexual and reproductive health. Subscale two consists of ten items measuring sex positive and sex negative attitudes. Examples of items include "I think sexual assault is a problem in my age group," "only religious people are abstinent," and "I think homosexuality is unnatural." For both the knowledge and attitude scales participants responded in a four point Likert-type format ranging from strongly agree to strongly disagree, with no neutral option. Responses range from "strongly agree" to "strongly disagree" (1=strongly agree, 2= somewhat agree, 3= somewhat disagree, 4= strongly disagree). High scores on the scales indicate high levels of knowledge and sex-positive attitudes, while low scores indicate low levels. Scale three consists of fifteen items measuring self-efficacy in seeking and

utilizing reproductive services. Examples of items include "put a condom on correctly," "talk to my partner about sex," and "seek sexual violence or dating violence services." Participants responded with a four-point Likert-type scale indicating their confidence level in completing the actions. Responses ranged from "very confident" to "not at all confident" (1= very confident, 2= somewhat confident, 3= barely confident, 4= not at all confident). Low scores on the self-efficacy subscale indicate a high level of confidence, while high scores indicate a low level of confidence.

Post-test Measures

The post-test included the same scales used in the pre-test. Additional questions were added to measure internal consistency reliability and address questions that were asked by students in class and in their anonymous questions (Appendix 2). Examples of post-test only questions include "the HPV vaccine works to prevent HIV," and "penis size matters." I added two questions to measure students perceived change of knowledge of sexual health; "on a scale of one to ten please rate your knowledge of sexual health before this program," and "on a scale of one to ten please rate your knowledge of sexual health after this program."

Phase 2: Qualitative

This study includes multiple forms of qualitative data. Seven key-informant interviews took place with the program director and volunteer educators. A second type of qualitative data includes field notes I collected during the sexual health education

sessions to better understand students' knowledge of sexual health. A third type of qualitative data includes the anonymous questions submitted by students following 33 out of 40 sessions. Information gathered from field notes and anonymous questions informed post-test only items on the post-test survey.

Procedure

Interviews

I conducted semi-structured interviews with Alex Kelner, the program director and six volunteer educators, whose names will be left out of the analysis. I used a guide for each interview, and asked follow-up questions where necessary. The guide for Alex's interview (Appendix 3) had different questions than the guide for the volunteers (Appendix 4). Examples of questions for Alex include "What theories or ideas are behind the curriculum development?" and "What do you feel needs improvement in this program?" Examples of questions for the volunteers include "How confident are you teaching this subject? Answering students' questions?" and "What do you think is the most important message that the education program sends to the students?" Interviews were conducted individually in varying locations depending on convenience for the participants. Two interviews occurred at the Teen Health Clinic in Healdsburg, the remaining interviews took place at varying Starbucks locations; one in Windsor, one in Novato, one in Cotati and two in Rohnert Park. Interviews were conducted between October and November of 2014, three months before classes at Cloverdale. Alex's

interview took 58 minutes to complete, whereas the interviews with volunteers lasted between 10 and 20 minutes. Volunteer educators were new to the program when interviews were conducted, and so had less insight. I voice recorded interviews and transcribed without the use of a program. Interviews were coded using a semi-structured approach and open-coding. Codes were developed after the interviews took place, and common themes were found across transcripts.

Key-Informants

Participants for interviews included key informants; Alex Kelner and volunteer educators, who interviewed voluntarily. I asked participants by email to participate in the study through an interview, and explained that choosing to interview would not have any bearing on their position as an educator. Volunteer educators attended Sonoma State university during the time in which they participated in the program.

Field Notes

I collected field notes during the classroom sessions, in which I recorded the number of students present, questions asked and comments made by students, as well as which educator(s) facilitated. Field notes consisted of questions asked during class, comments made by students, and level of attentiveness and participation. I sat at the front corner of the room, which allowed me to face the students and see the educators and white board or PowerPoint. Alex asked me to contribute to certain presentations, and to facilitate two of forty sessions. Due to scheduling conflicts I could not attend nine

sessions; during the sessions in which I was absent or facilitating Alex recorded field notes. Field notes were used to create post-test only questions, and to analyze which topics needed the most clarification and what the students were interested in learning.

Anonymous Questions Asked by Students

Educators and I collected anonymous questions posed by the students after each class period. We did not collect anonymous questions seven out of the forty sessions due to time constraints. If students did not have a questions to ask, they were given a prompt such as "write down something that surprised you from today," or "what made you uncomfortable during this presentation." Anonymous questions were coded according to dependent variables in the survey: knowledge, attitude and self-efficacy. One code was added for miscellaneous questions or comments, as well as those that were directed towards educators or the program. I used excel to code the anonymous questions. No changes were made to grammar or spelling errors in the questions. Grammar and spelling errors were left in to remain true to how students ask questions. They were analyzed to determine what students wanted to know more about after a presentation and what needed clarification. Anonymous questions were used to create post-test only questions as well. Questions were added to the post-test based off students' in-class and written anonymous questions in order to determine if students were retaining information gained from answers to their questions.

Statistics

Internal consistency reliability was determined using Cronbach's alpha. Bivariate analysis was used to determine relationships between independent and dependent variables. Independent t –tests and ANOVA were used in bivariate analysis. In order to analyze the changes in knowledge, attitudes and self-efficacy between pre and post-tests, I used paired t-tests. Univariate analysis was used to describe the scores on the items that only appear on the post-test. Alpha level for all analyses was .05.

Results

Characteristics of Participants

As shown in Table 2, more boys took the pre-test (n=47, 52.2%) than girls (n=43, 47.8%). However equal numbers of boys and girls took the post test. No one in the sample identifies as anything other than male or female, and all reported their sex and gender as the same, on both tests. In terms of other demographic characteristics, the majority of participants identify as Hispanic/Latino (n=43, 47.8%), others identify as white (n=35, 38.9%), multiracial (n=10, 11.1%) and Native American (n=2, 2.2%). Participants are between the ages of 14 and 17, 46.7% (n=42) at 15 years of age, 31.1% (n=28) are 16, 12.2% (n=11) are 14 and 10% (n=9) are 17. The mean age of participants is 15.4 (SD= .84). When asked for either of their parents or guardians highest level of education, 24.4% (n=22) report "less than high school," 31.1 (n=28) report "high school diploma or equivalent," 21.1% (n=19) report "some college but no degree" or

Table 2 Participant Characteristics

	Pre-Test	
Characteristic	*n*	*%*
Gender		
Female	43	47.8
Male	47	52.2
Ethnicity		
Hispanic/Latino/a	43	47.8
White	35	38.9
Multiracial	10	11.11
Native American	2	2.2
Class Period (time of day)		
2 (8:55 AM)	25	27.8
4 (11:00 AM)	15	16.7
6 (1:10 PM)	28	31.1
7 (2:05 PM)	22	24.4
Age		
14	11	12.2
15	42	46.7
16	28	31.1
17	9	10.0
Total	*90*	

"Associate's degree," 8.8% (n=8) report "Bachelor's degree," 5.5% (n=5) report "Master's degree" or "Doctorate degree," and 8.8% (n=8) did not indicate their parents/guardians highest level of education. 90 participants completed the pre-test, three participants were dropped from analysis of Scale 1 (knowledge) and three participants were dropped from analysis of Scale 3 (self-efficacy), for a total of 84 participants for complete analysis. 87 participants completed the post-test, one participant was dropped from analysis of Scale 1, and three were dropped from the analysis for incomplete data throughout the survey.

Knowledge Scale

Results indicate that there is a significant difference between pre-test and post-test scores on the knowledge scale ($p<.001$), with the average score on the post-test, 48.7 (SD=5.62) being significantly higher than the average score on the pre-test, 44.22 (SD=4.88). Statistically significant differences can be seen in individual items as well, as shown by Table 2. Results also indicate a difference in perceived level of knowledge by students before and after the program, such that students perceived themselves as knowing more about sexual health after the program, with a mean of 8.59 (SD=1.13) as compared to before, with a mean of 5.47 (SD= 1.92). ($p<.001$).

Cronbach's alpha was used to assess reliability of the knowledge scale and demonstrated moderate to high reliability ($\alpha=.82$). The pre-test shows no significant difference between genders, ethnicities, class signifiers, age or class period for knowledge. However, the post-test does show a significant difference between ethnicities

on knowledge, with the average score of 46.58 (SD=6.38) for Hispanic/Latino students, 51.06 (SD=3.94) for white students, 46.5 (SD=7.78) for Native American students and 50.2 (SD=2.99) for multiracial students, (p=.005).

Anonymous Questions: Knowledge

Analysis of the anonymous questions supports the quantitative data, as the majority of questions posed by students were knowledge-based questions (69%). For example, one item on the knowledge scale addressed the physical appearance of genitals, "All penises and all vaginas look pretty much the same." No significant difference exists on this item between the pre and post-tests. However, the average score on the pre-test for this item is 3.21 (SD=.93) which is lower than the average score on the post-test, 3.42 (SD=.90) suggesting that most students disagree with this statement. A three on this scale indicates that participants somewhat disagree with the statement. Some anonymous questions pertain to this item, and some suggest that students agreed with this statement prior to this program; "Is it bad if someone has a curved penis?"; "I learned that not every penis is the same."; "What I have learned is that penises and vaginas are different for everybody."; "Today I learned that everyones body parts look different." These questions and comments suggest that students did not previously know that genitals do not all look the same. Some questions also express concern for how genitals are "supposed" to look, such as the student who asked if it is "bad" if someone's penis looks a certain way. Four items on this scale addressed STI's (Table 3). Scores on two of the items differed

Table 3 Scores on the Knowledge Scale

Please indicate how you feel about the following statements	*Mean Pre*	*Mean Post*	*t*	*df*
All STI's are easily curable.	3.11	3.26	-1.58	83
Condoms are effective at preventing pregnancy/STI's.	1.93	1.60	-3.49***	83
A person can't get an STI the first time they have sex.	3.31	3.51	-1.70	83
Emergency contraception works if someone is already pregnant.	3.23	3.26	-11.83****	82
All vaginas and all penises look the same.	3.21	3.42	-.398	83
Birth control makes people gain weight.	2.67	3.20	-1.92	83
Sex and gender are the same thing.	2.17	3.24	-5.31****	82
Using two condoms is more effective than using one.	3.20	3.69	-7.71****	82
A person cannot get pregnant if they have sex in water.	3.60	3.75	-4.46****	82
People under 18 can't get birth control without parent or guardian consent.	3.13	3.25	-2.04*	82
A person can get an STI from oral sex.	1.93	1.36	5.11****	82
Pulling out is just as effective as condoms at preventing pregnancy.	3.23	3.65	-3.93****	82
The pull-out method protects someone against STI's	3.53	3.73	-3.01***	82
Only women can be sexually assaulted	3.71.	3.64	.735	82
Total	44.22	48.69	-7.94****	82

<.05* <.01** <.005 <.001*******

significantly between the pre and post-test. On the item "A person can get an STI from oral sex," students scored an average of 1.93 (SD=.95) on the pre-test, and an average of 1.36 (SD=.69) on the post-test, indicating that more students agreed with this statement after participation in the program, ($p<.001$). A one on this scale indicates that participants strongly agree with the statement. On the item "The pull-out method protects someone against STI's" students score an average of 3.53 (SD=.74) on the pre-test, and an average of 3.73 (SD=.63) on the post-test indicating that more students disagreed with this statement after participation in the program ($p<.005$).

Some anonymous questions regarding knowledge pertain to topics explicitly covered in class. Examples of these questions include; "When would I go get tested for an STI if there are no symptoms? How would I know to get a test done?"; "I heard that when someone does it for the first time it hurts."; "Can you get preggers from butt sex?"; "Is it normal for a girl to not cum while sex?"; "Can you get pregnant from oral sex?" Answers to these questions are given through the curriculum, however many students ask about these topics before they are covered.

Two items on the knowledge scale address condom use and efficacy: "Condoms are effective at preventing pregnancy and STI's" and "Using two condoms is more effective than using one." Scores on both items changed significantly between the pre and post-test. Students score an average of 1.93 (SD=.85) on the pre-test and 1.60 (SD=.66) on the post-test for the item about condom efficacy, ($p=.001$). Students agree with this statement at higher rates after participating in the program. On the item pertaining to

using two condoms students first score an average of 3.19 (SD=.98) and score an average of 3.69 (SD=.75) after participation, ($p<.001$). Students disagree that using two condoms is more effective at higher rates after the program. Several anonymous questions are related to these items: "Does using two condoms actually work or is 'safer'?"; "If I know my partner doesn't have an STI and shes on birth control should I still use condoms?" Students are curious as to how to best protect themselves from STI's and pregnancy through the use of condoms. Other questions suggest this as well, however they do not correspond directly to items on the scale: "What is the best condom brand?" Students also ask general questions about condoms, such as "Are all condoms water based?"; "What is the point of numbing condoms?"; "How would you get an insertive condom out if it breaks?" Some students ask questions about obtaining condoms as well: "Where is the cheapest place you can buy condoms?" All of these questions suggest that students are interested in gaining knowledge in how to use and obtain condoms as well as general information about condoms, such as the purpose of certain types of condoms.

Some anonymous questions do not directly relate to items on the knowledge scale, but lend insight into what students already know or hear about sex. Many students ask questions about sex myths or things that they heard about or saw through various media outlets: "Is Blue Waffels a real STI? Or is it made up?"; "How common would the STI Blue Waffle be?" "Blue Waffle" is a fabricated STI that circulated the Internet, and many high school students believe it to be real. Students ask questions about other myths perpetuated by media as well: "When a guy gets kicked or hurt on the genitals (balls) is it

true when someone says 'you're not having kids?'"; "Is it true semen whitens teeth?"; "The craziest thing I heard was that my moms friend was in a hot tub and ejaculated and she got pregnant."; "Is it true you can get cancer from shaving and cutting your vagina?"; "Is it true that black people have bigger penis' than white people?"; "The craziest thing I've heard about sex is that eating cum grows your penis size? True or False?"; "Can you actually do a sex position that can break a penis? (grey's anatomy)." These questions suggest that students hear a lot of misinformation about sex, but are unsure whether or not to believe it. Questions imply that students are getting this false information from various media outlets, parents and peers, and society.

Students posed anonymous questions about sexual pleasure, masturbation and specific sex acts. Each of these topics were discussed in the presentations- however, they were not discussed in great detail. Many questions about sexual pleasure ask how sex feels and how to make sex feel better. Questions about sexual pleasure include: "How long does it take to orgasm?"; "Do guys and girls get the same feeling when they orgasm?"; "What usually triggers an orgasm?"; "I want to learn about sexual pleasures"; "Do sexual positions cause better orgasms?"; "Does being high out of your mind make sex feel better?"; "Does the foreskin make sex better or is it better without it?" Many of the questions about pleasure focus on orgasms, or how to make sex feel better.

Many students also ask questions about masturbation: "How do females masterbate?"; "Is it bad to finger yourself? What is squirting when you masterbate?"; "Is jacking off every day bad?"; "Does masturbating/ejaculating while intoxicated or high off

weed make it feel better or is that just a saying or something that is only in your head?"; "Is it true that masturbation give you acne?" Some of these questions are associated with frequency of masturbation, suggesting students are curious as to whether or not masturbation is harmful if done "too much." Students also express curiosity about female masturbation through these questions, such as how they masturbate and what "squirting" is. These questions suggest that students have heard varying things about masturbation, such that it can cause acne, it is harmful if done too often, and that it is "bad" and are curious as to whether or not these things are true.

Students also express curiosity about anal sex acts: "The weirdest thing I have heard about sex is the mouth to anus thing."; "Why do people do mouth to anal? I mean, I don't want poop on my face, and it sounds gross."; "A surprising thing was that people do annul fingering."; "Is it really possible for two girls to have anal sex?"; "Why do people do anal?"; "Can you have anal sex if your partner is on her period?"

Other questions regarding specific behaviors address what something is or how it is done: "What is dry humping?"; "What is oral sex?"; "I heard girls squirt: how does that work?"; "Is it true that if you eat/drink pineapple your vagina smells/tastes better? If so are there other fruits that do that? Do all fruits do that?" These questions suggest that some of the sexual behaviors that the educators bring up in the program are unknown to the students. It is possible they have heard of them but do not know what they are, or that they only know them by their slang terms, such as "blow jobs."

Attitude Scale

The scale measuring attitudes had 10 items and the Cronbach's alpha for the attitude scale is moderate (α=.74). Analysis of the pre-test shows a significant difference in sex-positive attitudes between genders: girls with an average of 32.62, (SD=3.92) score higher on the attitude scale than boys with an average score of 29.73, (SD=5.24), ($p<.005$). The same pattern in gender difference appears in the post-test as well, with girls scoring an average of 33.9, (SD=4.39) which is higher than the average score for boys at 30.83, (SD=4.35, $p<.005$). Attitude shows no other significant differences between independent variables on either the pre-test or the post-test. Results show that there exists a significant difference between pre-test and post-test scores on the attitude scale: with an average score of 31.23 on the pre-test, (SD=4.69) being lower than the average score on the post-test, 32.37, (SD=4.61, p=.005). Students have higher levels of sex positive attitudes after participation in the program. Individual items also indicate statistically significant differences, as shown in Table 4.

Anonymous Questions: Attitude

One item on the survey addresses homosexuality, "I think homosexuality is unnatural," and scores on this item did not change significantly between the pre and post-test. However the mean score on the post-test was high, indicating most disagreed with this statement (M=3.33, SD=.896). A significant difference in gender exists on this item on the post-test as well, such that females (M=3.56, SD= .629) disagreed at higher rates than males (M=3.02, SD=1.07, p=.005).

Table 4 Scores on the Attitude Scale

Please indicate how you feel about the following statements	***Mean Pre***	***Mean Post***	***t***	***df***
People who have sex are cooler than those who don't.	3.45	3.51	-.673	83
I only need to know about birth control if I am able to get pregnant.	3.26	3.23	.405	83
I think sexual assault is a problem in my age group.	2.48	2.42	.490	84
I would have sex with my partner if they were drunk.	3.43	3.56	-1.26	84
Men want sex more than women.	2.49	3.16	-5.742****	84
I would be able to tell if someone wanted to have sex by their body language.	2.34	2.31	.367	83
Only religious people are abstinent.	3.27	3.56	-3.067***	84
It's OK to send naked picture to someone without asking them first.	3.63	3.68	-.664	84
People my age have a lower risk of getting an STI than older people.	3.48	3.40	.75	84
I think homosexuality is unnatural.	3.27	3.33	-.553	83
Total (Score)	31.23	32.37	-2.92***	83

<.05 <.01** <.005*** <.001*****

The change in attitudes between pre- and post-test scores is supported by the questions written and asked by students during sessions. Some of these questions expressed curiosity about homosexuality: "Do you believe homosexuality is a choice?"; "Is it true that 'gay' people are born that way or do they choose to be 'gay' as they grow up?"; "Do people that are 'gay or lesbian' have an offset of testosterone/estrogen?"; "Can someones sexual orientation change at anytime or is it just during puberty?" These questions suggest that students have heard different things about why someone might identify as gay or lesbian, and are curious as to whether or not they are true. Other students asked questions about stereotypes of homosexual people: "Is it true that people who go for the same gender has more sex than people that doesn't go for the same gender? (dumb? I know)." This student has heard this about homosexuality but doesn't necessarily believe it to be true.

During sessions in which students discuss gender and sexuality, they express concern for gender non-conforming people: "One thing that made me uncomfortable was why transgender people get bullied,"; "One thing that made me uncomfortable was how people become violent over those who are different gendered." These statements indicate that students sympathize with those who are treated differently for having marginalized identities. Some students indicated that they did not previously know the effect that violence can have on people, "I learned about how much it can hurt somebody to call them names."

Students also express curiosity about transgender individuals and transgender issues: "Can a transgender get pregnant?"; "After you stop drinking hormone pills can your body change back?"; "How many people are transgender?"; "Do different countries have different probabilities of having transgender infants?" Some questions suggest that students are unfamiliar or uncomfortable with the topic of transgender people: "The weirdest thing I have heard about sex is that girls can get surgery to have a penis." Some students express concern over deception by transgender people: "So if I have sex with someone who was born a male/female and they didn't tell me could I sue?" Students also express concern about intersex individuals and intersex issues: "Is it possible to have no sex organs at all?"; "If you have too many (Y) chromosomes, are you going to have health probs?"; "Do the doctors ever check to see what kind of organs are on the inside? Or do they just operate without checking?" These questions express concern for how intersex conditions can manifest in a person, and concern for individuals who experience nonconsensual surgery in infancy.

Students also asked questions regarding their own sexuality: "Is it normal to not have any interest in sex right now?"; "What if I kissed a girl and I liked it but wouldn't have no interest of dating them what am I considered as?" These questions suggest that students are not yet sure how to identify, and are questioning the difference between behavior and identity. "Thank you for talking about the different sexualities. I am bisexual in a heterosexual relationship and feel uncomfortable officially letting people know about it. My partner and close friends know." This person is thanking us for

discussing these issues, and indicates that they do not identify publicly as bisexual for fear of being stigmatized. One student expressed concern for another person who is being treated poorly for their sexuality, "What should I do if I know someone is bullied for being bisexual? Yes they are bi." This last statement suggests that the student may have assumed that the educator would not believe that this person identifies as bisexual.

One question on the attitude scale pertains to attitudes towards traditional gender norms: "Men want sex more than women." The mean score for this item on the post-test is 3.16, (SD=.99) which is significantly higher than the average score on the pre-test, 2.49 (SD=1.04, $p<.001$). Students ask questions pertaining to traditional gender norms throughout the program; "Do boys crave more sex than females? If so, why?"; "Can guys be raped by women?"; "Why do girls get called names for having sex and guys don't?"; "Why do companies pay women less than men?" These questions are challenging and questioning traditional gender norms, such as sexism in the workplace and the hyper-sexualization of men. Some questions indicate that some students at this high school have a particular attitude towards girls who have sex. "What about the girls that have no respect for themselves and all they do is get there cheeks pounded S/O [shout out] CHS [Cloverdale High School] GIRLS." A culture of "slut shaming" may exist at this high school, with this question suggesting that the girls at this high school have no respect for themselves simply because they are having sex. "Slut shaming" is the act of making someone, usually a women, feel shameful or inferior for engaging in sex. Other questions challenge the sexualization of female bodies: "Why are brest over sexuilized? They're

literally balls of fat on a womens chest that produce food for a baby." This question suggests that some students recognize the over-sexualization of female bodies, and are attempting to understand why that happens. "What are your thoughts on menimism?" "Meninism," is antithetical to feminism and focuses on ways in which men are oppressed in society. Some students also perceive conversations concerning gender equality and the oppression of women as treating men unfairly: "Something that made me uncomfortable today was how Alex was saying everybody was equal but she remained sexist towards men."

One item on this scale addresses sexual assault: "Sexual assault is a problem in my age group." Students scored and average of 2.48, (SD=1.01) on the pre-test, which does not differ significantly from average scores on the post-test, 2.42, (SD=.99), (p=.625). However, these scores suggest that most students somewhat agree with this statement. Students also express surprise and curiosity about rape and sexual assault in their questions: "Something surprising is that there is still a lot of rape these days"; "I was surprised how often sexual harassment/rape occurs."; "I was surprised he said that if someone gives you a compliment some people can take it offensive."; "I was surprised how big rape culture really is."; "Surprised me to know that rape is the number one under reported crime." These comments suggest that students were previously unaware of how often rape and sexual harassment occur, and were unaware of the implications of rape culture prior to participation in the program. "What happens if you rape someone your own age? Can two people under 18 give consent and it be legal?"; "If a minor and an

adult have consentual intercourse, is it still considered statihitory rape?" Students are curious as to the laws around age of consent and when age difference constitutes sexual assault. "Do you believe anyone is ever 'asking for it' by the way they dress?"; "Today I learned that women get rapped. Why do men lie about raping women saying they couldn't control themselfs." These questions pertain to rape myths, such as victim blaming and men claiming sexual desire as a justification for sexual assault. This suggests that these students are exposed to rape culture, but are not sure whether or not rape myths hold any truth.

Self-Efficacy Scale

Results showed no significant differences between levels of independent variables and self-efficacy scores. Pre-test and post-test comparisons reveal a difference between scores with pre-test scores (M=35.56, SD=9.37) being significantly higher than post-test scores (M=26.83, SD=8.69), ($p<.001$). Higher levels of confidence in seeking and utilizing reproductive services are present after going through the program. Significant differences are also present in individual items, as shown in Table 5. Very few anonymous questions pertain to self-efficacy (2.7%). However, questions that students ask correspond with items on the self-efficacy scale that show significant results.

Anonymous Questions: Self-efficacy

Four items on the self-efficacy scale pertain to condom use. The scale asks students to rate their confidence that they would be able to carry out certain behaviors. All four items show statistically significant difference between the pre and post-test, as

Table 5 Scores on the Self-Efficacy Scale

Please indicate how confident you are that you would be able to do the following actions.	***Mean Pre***	***Mean Post***	***t***	***df***
Put a condom on correctly.	2.21	1.62	4.81****	84
Talk to my partner about sex.	2.08	1.58	4.44****	84
Seek reproductive services.	2.63	1.86	6.24****	84
Get birth control and STI protection.	2.18	1.58	4.69****	83
Get emergency contraception.	2.38	1.95	3.34***	83
Talk to my parent or guardian about sex.	2.51	2.12	3.72****	83
Seek sexual violence or dating violence services.	2.79	2.11	4.92****	83
Ask my partner for consent.	2.05	1.42	5.57****	83
Use an insertive condom correctly.	2.69	1.99	4.97****	83
Explain how pregnancy works.	1.95	1.73	1.89	83
Use emergency contraception correctly.	2.61	1.93	5.92****	83
Use birth control correctly.	2.35	1.77	4.56****	83
Use a dental dam correctly.	3.15	2.20	6.85****	83
Talk to my partner about birth control.	2.06	1.51	4.61****	84
Talk to my partner about using condoms.	1.87	1.51	2.72**	84
Total	35.56	26.83	8.76****	83

<.05 <.01** <.005*** <.001*****

shown in Table 5. Although few anonymous questions pertain to self-efficacy, many that do address condom use: "Whats the correct way to put on a condom if your not circumsized?"; "I would like to learn about how to put a condom on."; "How does someone find out what size condoms to use?" These questions suggest that students want to know how to use condoms correctly, and how to find the right condom for their body.

Two items on the scale address using and obtaining birth control and STI protection: "Use birth control correctly," and "Get birth control and STI protection." The average score on the item about use on the pre-test is 2.35 (SD=1.06), which is significantly higher than scores on the post test, 1.77 (SD=.88), indicating that students felt more confident in using birth control after participation in the program ($p<.001$). The average score on the item about obtaining birth control and STI protection on the pre-test is 2.18 (SD=1.12) which is significantly lower than the average score on the post-test, 1.58 (SD=.81), also indicating more confidence in obtaining birth control after participation, ($p<.001$). One item also addresses seeking reproductive services; students score an average of 2.63 (SD=.95) on the pre-test and an average of 1.86 (SD=.88) on the post test, again indicating a raise in confidence, ($p<.001$).

Students express interest in using and obtaining birth control through their questions: "If your on birth control, does your partner need to wear a condom?"; "If I take birth control and forget to take it one day is it not safe to have sex without a condom?"; "I want to learn about different types of contraceptions and how affective they are."; "How does birth control work?"; "I liked learning how to be safe and protect

myself." These questions indicate that students have the desire to know how to use birth control, how it works, and what type of birth control would be the most effective for themselves. Students are curious as to how to protect themselves from STI's and pregnancy and are actively seeking that knowledge. "If the condom rips and fluid falls into my partners vagina and I'm not prepared to have a kid what should I do?" This question expresses further concern for the effectiveness of birth control methods. Students are aware that condoms are not 100% effective, and are curious as to how to prevent pregnancy should the condom fail. "If I wanted to get tested at the clinic, without my parents consent, how would I do so?" This question indicates that students are interested in STI testing, but are unaware of how to get tested without their parents' knowledge or consent. One item which addresses this issue is "Seek reproductive services." Students score a mean of 2.63 (SD=.95) on the pre-test, and a mean of 1.86 (SD=.88) on the post-test, suggesting a raise in confidence between tests at the $p<.001$ level. This indicates that students feel more able to get tested after participation in the program, with no difference in confidence between levels of independent variables.

An item on the self-efficacy scale relates to seeking sexual violence and dating violence services. Students score and average of 2.79 (SD=1.07) on the pre-test and an average of 2.11(SD=1.06) on the post-test for this item, indicating a raise in confidence between the pre and post-test at the $p<.001$ level. Students ask questions relating to sexual and dating violence, including sexual harassment and aspects of healthy relationships: "Can a perfect relationship turn into a bad relationship for example one of

the partners wants more power than the other partner?"; "Do you think if your boyfriend touches you and you kinda like it but your also kind of uncomfortable, is that considered sexual harasment?" This question suggests that this student is experiencing the physical aspects of sexual behavior positively but may not be mentally or emotionally ready for those behaviors. They are questioning whether or not this constitutes sexual harassment. "How do people know when their not in a happy relationship?"; "If the person who abused me emotionally wants to be friends after we've broken up, should I be their friend or not?"; "How much conflict is healthy?" These questions focus on what a healthy relationship looks like, with some students seeking advice on their own personal relationships. These questions indicate that some students are able to recognize an abusive relationship, while others ask clarifying questions as to what constitutes a healthy relationship.

One question on this scale pertained to talking to parents and/or guardians about sex. Students scored an average of 2.51 (SD=1.12) on the pre-test and 2.12 (SD=.17) on the post-test on this item, suggesting a raise in confidence between the two testing periods at the $p<.001$ level. One question pertained to talking to parents about sex, however it indicates that the student is uncomfortable in doing so; "My favorite thing about sex ed was learning about all the things that are strangely more comfortable talking about in a public classroom than in a bedroom with my parents." This comment suggests that the student expected talking about sex in a public space would be more

uncomfortable than talking in private with their parent(s), but found the opposite to be true.

Post-test Questions

Post-test items were created to reflect questions that students asked in class. (Appendix 2) Results show a significant effect of ethnicity on knowledge at the $p<.05$ level on the post-test only items, the mean score for Hispanic/Latino/a students is 31.15 (SD=4.29), 34.42 (SD=4.19) for white students, 31 (SD= 5.66) for Native American students and 32 (SD=3.77) for multiracial students, which means that white students score higher on these items than students of other ethnicities/races. In bivariate analysis there were no other significant differences on independent variables and dependent variables. However, the mean score for the post-test only scale was high at 32.52 (SD= 4.44) indicating students retained knowledge based off their anonymous and in class questions. Table 6 shows the means and standard deviations for each item on the post-test only scale.

One item addresses penis size; students score and average of 1.58 (SD=.77) on the item "Penis size doesn't matter" indicating that most students agree with this statement. Many students expressed concern about penis size in anonymous questions; "Does penis size matter?"; "What is the average erected penis size?"; "Does your penis shrink as you get older like 50-80 years old?"; "Should someone actually be worried to have sex if they had a small penis?" Students express a lot of concern about penis size, suggests that many believe penis size to be important before completing the program. These questions

Table 6

Post-test Only Means

Please indicate how you feel about the following statements Strongly Agree (1) – Strongly Disagree (4)	N	Mean	Standard Deviation
Smoking does not lower my sperm count.	85	1.86	1.10
Penis size doesn't matter.	85	1.58	.77
I can't get someone pregnant if we have sex in a hot tub.	85	3.45	.97
Most people in high school are having sex.	84	2.24	.90
People have different definitions of abstinence.	84	1.75	.85
The HPV vaccine works to prevent HIV.	84	3.05	.99
Only gay men can get HIV.	85	3.74	.69
Only people in 3rd world countries die from HIV/AIDS.	84	3.45	.87
I can't get an STI if my partner doesn't have one.	84	1.75	1.07
Birth control can cause cancer.	84	3.48	.75
Total	84	3.25	4.43

suggest that some students in the class may be self-conscious of their own penis size, or curious as to whether a penis has to be a certain size in order to have sex. These questions also suggest that student are considering a specific type of sex in regards to penis size- heterosexual intercourse.

Two items on this scale address HIV/AIDS myths: students score an average of 3.45 (SD=.87) on the item "Only people in third world countries die from HIV/ AIDS," indicating most students disagree with this statement. On the item "Only gay men get HIV" students score an average of 3.74 (SD=.69), indicating most disagree with this statement as well. Participants ask questions about HIV myths, such that gay men are more susceptible to HIV and that people suffer from HIV only in non-industrialized countries such as Africa; "Why in 3rd world countries, does mostly everyone, like in Africa do people have Aids and die, even small children?"; "Is it true that more homosexuals have AIDS than heterosexuals?" These questions indicate that students have heard myths about HIV/AIDS, and want to know whether or not they are true. This suggests that students do not immediately believe the myths that they hear regarding HIV/AIDS.

One item on this scale pertains to contracting STI's from a partner that does not have one. Participants score an average of 1.75 (SD=1.07) on the item "I can't get an STI from sex if my partner doesn't have one" indicating that most students agree with this statement. Students express a lot of concern about the possibility of contracting an STI even when neither partner has one; "Can you get infected if both you and your partner

have oral sex but both of you were each others first and both haven't done anything with anyone else? Only each other."; "What if your parents don't have an STI and you've never had sex or in contact with someone who has a STI but get a STI out of nowhere?"; "How many times can you have sex before getting STD's? (both are healthy)." Although the educators state multiple times that one partner has to be infected in order for the other partner to contract an STI, students are still concerned about contracting STI's through an uninfected partner. This suggests that students fear STI infection, possibly so much so that certain parts of the presentation are missed. (maybe word this differently or say something else because there can be other reasons that students missed this information)

One item on this scale addresses how many people are having sex in high school, "Most people in high school are having sex." Students score an average of 2.24 (SD=.90) on this item, indicating that most somewhat agree with this statement. In anonymous questions, participants indicate that they were surprised at the amount of people who are having sex in high school: "I was surprised that 50% of all high school students don't have sex."; "I was surprised about the low percentage of people having sex in high school."; "The 50/50 surprised me."; "I learned that 50% of students in high school have sex."; "Today I learned that it's a 50/50 between people having sex and no sex." These comments suggest that students did not previously know the average numbers of students having sex, and some suggest they thought the numbers were higher.

Interviews

Key informants mentioned sex positivity and social justice as the most important parts of the program, which is evidenced in quantitative results on attitude. The majority of the educators' main goal when speaking to the students is to deliver messages of sex positivity. For example, Alex says:

> We're talking about pleasure. Because, I say that sex is awesome on a pretty regular basis to teenagers which is something that ten years ago I would have gotten in so much trouble for saying that, for saying "sex is great!" (laughs) right, uhm so it's definitely much more focused on the positive things that sex brings to our life rather than like the scary, negative consequences, I mean we talk about STI's and unintended pregnancy obviously, but again we reframe again too, unintended pregnancy as it's not, it's not a moral failing right, like if nobody ever talked to me about these things how do I know? It's not about demonizing teen parents, it's about helping them.

Alex suggests that this program is more sex positive than most others, and that it has become more positive over time. She says that the program discusses the possible negative consequences of sex, but reframes those in a way that most programs do not. While other programs may regard teen pregnancy and STI's as "moral failing," this program does not attach religious or moral values to the consequences of sex, and instead attempts to put a positive spin on it.

According to Alex, students in this area are taught negative attitudes toward sexuality, which she attributes partly to being raised in a rural area.

> When I first started doing this I was working in a very rural community, uhm, and it was again, you know, a lot of, a lot of push back against the challenges to the gender normativity

and things like that. Uhm, many many more rape supportive ideas, you know and things, victim blaming, all those kinds of things going on.

Alex states that rural communities hold traditional gender norms, and are uncomfortable with challenges to those norms. Rape culture may be especially prevalent in these communities, such as holding to ideas of victim-blaming. In order to challenge this in these communities, the program focuses on LGBTQ issues and sexual assault prevention.

We are, we are doing uhm, sexual violence prevention as a mandatory part of our, of our, program, it's not required by the state, although there is some, some lobbying going on to do that, but that's been happening for a long time so, who knows when that will actually happen…and that can be a little bit jarring for some of them, because you know, they're like "what do you mean you want to come in and talk about rape," and I'm like, you know "it's rape prevention," so, it's all about sort of reframing that.

Teachers and school administrators are hesitant to include conversations about rape and sexual assault within sexual health education. Alliance's program can provide teachers and administrators information on the importance of sexual violence prevention to sexuality health education. Alex also mentions resistance from parents as something that effects what can be said in the classroom:

You know it's pretty radical to talk to seventh graders about anal sex and oral sex, even though they know what it is (laughs) uhm but there hasn't always been a willingness to do that in the classroom. Uhm, we don't specifically have curriculum on abortion but if the kids ask questions I do like to be able to provide them with answers, uhm, that's taken a lot of practice though, that's something that you know takes a long time to develop and even sometimes still I have to like, deflect some of those questions. Uhm, just because I, I don't want parents showing up at my door with you know, pitchforks and torches, trying to kill me for what I said to their kids. (laughs).

The sexuality education program I observed is unconventional in that it explicitly talks about sex acts that most would not discuss with younger students, however there are still some topics that need to be handled delicately, such as abortion. Some topics in sexual health education are those that people have strong beliefs and values about, and educators must be careful not to make parents, teachers, and school administrators angry with what is said to the students. Volunteer educators in the program agree with this, and they state some of the reasons why people may be uncomfortable with certain topics in this community.

I think that because of this where it's pushing us more towards like not wanting to encourage kids to have sex instead of really having conversations about sex and I think that's just in American culture, and other cultures too but it's like we have this really bad like stigma against just like sex or openly talking about sex uhm I think that it's super important to be able to talk to kids and uh and not make it be awkward so they can ask you things.

The reason we hold a stigma about talking to young people about sex, is for fear of encouraging them to engage in sex, when they otherwise would not have. However, openly talking about sex and sexuality gives students the space and opportunity to ask questions in a non-judgmental environment. Another educator suggests that this program in particular works against this stigma, stating:

I think the stigma against talking about it is already kind of been taught to them, they don't like to talk about sex or girls don't want to talk about their vaginas or boys don't want to talk about their penises without giggling and laughing and making a joke out of it. Which is sad, but again I think we begin to push past that through like the second and third

presentation days, where they're willing to kind of talk about issues. I think that it, the information really sticks with them too which is kind of good.

Students are able to talk about sex if it is made into a joke; the only way it is acceptable for them to talk about their bodies and sexual behavior is in a humorous manner. However, the stigma is challenged through this program; students are able to have discussions about sex and because of this the information is comprehended. Other educators also point to sex positivity as a way to get across to the students: "I think it's just by us at least being enthusiastic about the subject. And not talking quote unquote bad about it, not saying negative things about it but always reinforcing the positive." Enthusiasm on the part of the instructors is important to the program, as well as reinforcing the positive aspects of sexuality over the negative aspects. "Not just hearing that "sex is bad, sex is bad, sex is bad," all the time but for at least once in a while you'll hear that 'sex is good, and this is what makes it good and this is what makes it fun.'" Students can be given information about how to make sex a positive experience, rather than only hearing that "sex is bad" which can lead to negative experiences of sex and sexuality. Another educator makes this same point: "That sex is fun! You know, that sex is fun, but you need consent, you know there's certain steps you have to go through in order for it to be fun and safe." Consent, according to educators, is a way to experience positive sexuality, as well as a safe experience. Consent is important to discussion of sexual assault, as well as birth control and disease protection, and sexual health in general. One educator stresses the importance of thinking of the students in positive terms

as well: "Strength based learning. I have found that to be very influential of not just looking at the negative things but looking at what someone says, finding something positive about it and work off of that." This program utilizes a "strength-based learning" approach, which utilizes positive reinforcement to redirect and reframe maladaptive behaviors and skills towards more effective learning, communication and interactions.

The educators' comments about sex positivity in the program mirror those of Alex.

> I try to really reframe the conversation around partner communication away from just refusal for sex, I mean we talk about that, we talk about if I'm not ready here's some things that I can say to my partner, you know, some communication skills there. But I also want them to be able to communicate about the things they do wanna do and the things they are comfortable with, so we talk about you know hand jobs and fingering and we talk about like does this count, does this count, like, we have those discussions. Uhm, and I try to make that more uhm, what Freire called problem posing education as opposed to like banking education where I don't assume that I'm gonna know every single thing uhm about what they should or shouldn't do. Uhm that I can pose the question to them about those things and I can talk to them about you know, how do they feel, does that count as sex, you know is that something that I'm comfortable doing, and we can sort of analyze the situation together, rather than me saying you're allowed to do this but you're not allowed to do this.

The program works toward encouraging students to communicate about sex, rather than simply teaching them how to refuse sex. Students should learn how to communicate about what they do want to do, what they like, and what they are comfortable with. One way the program accomplishes this is through explicitly discussing various sexual behaviors, such as fingering, and having conversations with students about "what counts" as sex. One way the program does this is through Freire's notion of problem-posing

education, which emphasizes critical thinking as necessary to deeper learning, rather than banking education with treats students as empty vessels for knowledge to be deposited into. Alex does not tell students what they should or should not do, and she is honest with students about them setting their own boundaries for sexual activity. Instead of telling students what they are allowed to do, she encourages them to come up with their own answer based on their personal feelings about boundaries, comfort and preparation regarding sexual activity. Alex also states that the most important message for students in this program is positive sexuality.

> The most important thing for me and for this program is the positive part of sexuality. Like, really focusing on the joy, the pleasure, the happiness you know that comes from having a satisfying and safe healthy sexual life, uhm that to me is the most important thing because I feel like it's sort of like when you tell people, like if you're gonna tell somebody that they need to go on a diet and you tell them all the things that they can't eat, like that's not really very helpful, so tell them all the things they can eat (laughs) do all of the, focus on the positive things, uhm and then you know, then people will start to feel that pleasure and that joy that comes from the positive things and they, they take steps in their everyday life themselves and then as groups and as communities to support those positive things, to lessen the bad things cause they want those things to be happy like, our development director has this, she makes this joke about uhm, the way that we talk to the kids about sex and she says "so the tingles are good, we like the tingles, so we wanna protect the tingles, so they'll stay good" (laughs). And that's like, that's the perfect thing is that the good feelings, the good things about sex are awesome and great and so we do all of this stuff so that they'll stay awesome and great.

Sex positivity is the most important part of this program. Joy and pleasure are imperative to sexual health. One way to encourage pleasure in students' sexual lives is to focus on the positive aspects of sexuality, instead of the negative. It is important to tell students what they can do, instead of what they cannot. Alex uses a diet analogy to make this

point: a person on a diet will not succeed if they are only told the things they cannot eat. A person cannot achieve a healthy sexual life if they are only told what they cannot do, they also need to know what they can do and ways in which they can achieve a happy, healthy sexual life.

Social Justice

Another goal of the program is to teach healthy sexuality through a social justice lens, which includes discussion of race, class, and challenged to gender norms and heteronormativity.

> Uhm, and so I really wanted to integrate social justice principles and ideas into comprehensive sexuality education. So we deal with issues of race and class, we talk about gender, we do uhm, a lot of things that we traditionally don't focus on in [sexuality education] which is why our curriculum is a little bit longer. Uhm, and so we also do like a lot of media literacy stuff and we talk about capitalism with the kids and things like that. And so maybe that's one of my motives too, or one of the objectives of the program would be to place the social position of sexuality in a more socially just way, a more socially just position.

The program is unique in that it focuses on social justice issues such as race and class that most other programs do not cover, and because of this more time is required in the classroom. Media literacy and discussions of capitalism are present in the curriculum. Social justice issues are important to sexual health education; to introduce students to the intersections of race, class, sexuality etc. sexual health education must be approached from a social justice standpoint. The program also challenges heteronormativity as a way to achieve social justice goals.

We don't, we don't use like "male" and "female" and "men" and "women" because we know that not everyone with a penis identifies as a man, not everyone with a vulva or a vagina or a uterus identifies as a woman, uhm, some women don't have a uterus, right, so there's all these kinds of like things that we do to challenge that so we don't use those kinds of words. We talk more about like a "person with a penis" or a "person with a vagina." We actively teach the kids, we have specific lessons about gender where we talk about what it means to be trans, what it means to be uhm, to have an intersex body. Uhm we talk about different definitions of sex and gender. Is it about chromosomes, is it about gonads, is it about you know, the body parts that we can see on the outside, is it about the clothes that I wear. Uhm, and we then break down some of those stereotypes. We also integrate a lot of sexual violence prevention into our curriculum, so we do uhm, we talk about the intersections of gender with those things as well and we do a partnership with the rape crisis center to do that.

The program challenges heteronormativity through the use of specific language. The program remains inclusive during discussions of anatomy and reproductive function to those who do not identify with the gender that corresponds to their biological sex. The program includes explicit discussions on gender identity, intersex, sexual orientation and attempts to break down stereotypes related to gender and sexuality. The curriculum questions what defines sex, and allows students to think critically about gender and sex. Sexual assault prevention works towards the goal of social justice as well, through discussions of gender. Notions of social justice seem to be important to the volunteer educators as well. "It's like well at the end everything is ok cause no one's exactly the same you know, everyone's body is different."; "I think it's that every body is different, I think that Alliance and this program is very clear in that all kinds of people do all kinds of things and that's ok. I think that's so important and I think that a really important message that the kids are getting." These two educators are suggesting that one main

message of the program is that variation in bodies and identities exists and is a good thing.

Gender identity is one thing that kinda like pops up on the top of my head is that it is ok to have an individual uhm like identity whether it is homosexual, heterosexual, queer, whatever it may be uhm, and kinda getting that out there just cause we are changing, we are like, we're changing as a society and you can't, it's not just two buckets anymore, there's multiple different labels, uhm that some people may identify themselves as and kinda just being accepted and open to other individuals uhm, so definitely that's one important message that students are understanding so they know that the person over there who doesn't identify like them isn't someone who should be shunned or different or bullied or just treated differently because of who they are uhm, that's one thing that I feel is important that they learned

Teaching students to be accepting of various identities and bodies is important, and points to a changing society as one reason that this is important. As society becomes more progressive in terms of LGBTQ rights and visibility, students should be taught about these issues in order to be understanding, to reduce rates of bullying and discrimination.

Reception by Students, Teachers and Parents

While reception for these discussions is generally positive, Alex has had some experiences in which parents in particular challenge why gender identity and are being taught to their children.

They [teachers] really like the youth empowerment, they really like that we're challenging the kids to think critically, uhm they think it's important that we talk about trans issues too. Uhm, I have had, I did have one parent call and who was like kind of irate that we were talking about that and why did they need to know about that in sixth grade, uhm so we talk about the laws in California and how all of our programming you know we're ensuring that we're following the law and we just voted on this thing that trans kids are allowed to you know use the bathrooms and be on the sports teams and stuff for their gender identity uhm and that the kids need to be a part of that process, so they need to understand so they're not scared, so they don't say mean things to people, uhm so they don't get upset, so they

understand what's going on. They're really the ones that are gonna be the most affected by this so they need to be a part of that. Uhm, I did have one seventh grade parent who called the principle and was like really, really mad that we were talking about uhm anything other than vaginal sex, uhm but, other than that I haven't really had a lot of parent feedback that's been negative most of it's been pretty positive.

While teachers have not had negative reactions to the program, some parents do get angry that these transgender issues and sexual behaviors are being taught to their children. One parent perceives their children as too young to be receiving information on transgender issues. The parent was able to talk to Alex personally, and she was able to inform the parent on the laws in California, and give an evidence based answer for why students are learning about these issues. The other parent who spoke to the principal was angry that students were learning about anything other than heterosexual, vaginal intercourse. There could be many reasons this parent did not want their child to learn about other sexual behaviors in middle school. Vaginal sex is often what is portrayed in the media, so it is possible the parent assumed their child already knew about this but did not know about other behaviors. It is also possible that this parent was angry because of the popular thought that vaginal sex is reserved for heterosexual couples, while other types of sex occur between homosexual couples. However, Alex does not get much negative feedback, and these were isolated incidences.

The program also offers students space to ask questions about topics that they usually do not have the opportunity to address in a school setting.

The kids too they usually are so excited that they get a chance to talk about these things and ask these questions and uhm, you know they see crazy things on the internet or hear words they don't know what they mean, uhm, so they're usually pretty excited to be able to talk about all that and ask all those questions. Especially in junior high you know when there's all that kind of you know, wacky weird new stuff happening with your body, they're so excited that there is someone there to who knows about that (laughs).

Students are excited at the opportunity to discuss topics related to sexuality that they often see representations of in the media. Students are being exposed to concepts, ideas and words that they do not know the meaning to, and this program gives them an opportunity to further explore what they are hearing. It is especially important to students at the middle school level, because their bodies are changing as they go through puberty, and the program allows them access to someone who can tell them about what is happening to their own bodies. Volunteer educators also state that having space to ask questions and acquire knowledge about sexuality is important to youth.

Letting students know that they're not their own island, that we are a bridge to get help. And the whole, you know, health clinic is there to answer questions, to get help, to receive care, and that they're not fighting their own battle.

Through the program students are offered resources-access to health care and answers to questions- which may make them feel less alone in their search for knowledge and care regarding sexual health. In addition to access to information, students appreciate the program on a personal level, in which they feel supported and encouraged to seek services and help. Students may also be receiving support in terms of gender and sexual identity.

I feel being so young they will still ask questions about it because they are curious about these things so that are out there so I feel that they react well for their age as far as understanding how things work and not just kind of being closed off to it and then not knowing when they're older. Whether it's like sexual identity and how that works or gender identities, or just yeah, and body as well.

Students feel comfortable asking questions because they are still young, and that it is more difficult to access this information as an adult. Furthermore, younger students are more willing to listen to and hear messages about sexual identity and gender, which will allow them to be knowledgeable about these issues as adults. Sexual and gender identity are important topics to be discussed at a young age, as well as the difference in bodies. Educators also perceive the program as interesting and fun for the students. "It gets the conversation going like I'm sure it's fun for them to talk about so I think that they enjoy it, I know that they enjoy it, a lot of them (laughing)." While the program is fun for students, it also has the ability to start other conversations about sexuality in the lives of students. Other educators express surprise at how well the students handle the information.

But given the information that were giving them and what they're exposed to on like social media and on television I'm surprised at how well they handle it and how receptive they are and how interested they are in the content.

Educators expect students to be less receptive to the program because of what they are exposed to in the media and on social media. Regardless of these influences, educators perceive students as interested and able to respond maturely to the material.

Expanding to Other Communities

As well as benefitting the students, educators also regard the program as beneficial in their own lives and to their own communities.

I've also learned a lot about sex education and health education that I uhm, decide to preach to other people that I know and that they find really interesting, cause they don't know about STI's and our society has kind of a stigma against knowing about those things and you shouldn't really know about them. So I think people seeing how I, how open I am, about talking about it makes them feel a lot more comfortable.

Training in the program has allowed educators to share that information with their own peers and in their own community. The stigma in our society inhibits others from talking openly about sex, however they are now able to discuss sexuality which makes others around them more comfortable in those discussions.

I'm much more adept to going out and preaching what I've learned. And understanding that, I would say the majority of people I know feel like their own island when it comes in to talking about anything to do with health education, whether its eating healthy, dieting, all the way to you know, is my penis big enough, and does that matter and should I feel, should I not feel confident about my penis and should I only have sex in the dark so people can't see how big my penis is. Uhm, being able to really openly discuss that and again with the knowledge I've learned from this internship, volunteering here, has really allowed me to discuss that with people and I think the stigma against, what people have, the stigma that people, that our society pushes people to have is, this isn't ok to talk about, this is you know the 1950's and we don't talk about this unless were married and in the bedroom, and we can't talk to anyone else about it, so the fact that I'm able to tell people to talk about it I think that is very important and it propagates them to do the same thing with other people.

Our society has a stigma against openly discussing issues of sexuality, which can have negative effects of access to information, body image, and attitudes about sexuality. The

program has allowed them access to new information, which they are now able to share with others in their community. By reaching out to others in their community, those people are then more equipped and likely to do the same.

It helps me grow as well, as far as knowing how to be aware of different things that I'm saying also just like even outside of the classroom when I am volunteering I can still like educate other people I know based off like things that I'm doing things and things that I personally learned that I didn't know at the time and I can also kinds see how I've been taught to think like a certain way so trying to just going back a stopping myself before I make an assumption or anything like that.

Educators are able to spread the messages of the program to others outside of the scope of the schools, but they are still working on incorporating those messages into their own life. The program has allowed them to begin questioning stereotypes and biases that they have been taught to think throughout their life.

Barriers to Education and Clinical Services

While Alex and the volunteer educators in this program perceive it to be beneficial to students and society in general, there are still limitations in place that do not allow them to do all that they can to send messages of sex and body positivity, or to make it accessible to all students.

Uhm, I hate that we can't use like, real pictures of real genitalia. I've been moving to more realistic drawings, uhm and, so that's been, I haven't really had anybody say anything about that. That's mostly at the high school level, they are much more realistic than when we first started, which I'm really excited about. Uhm, they're still all white people genitalia though, and I wish that wasn't the case. Uhm, I wish we could have, I feel like they're so disembodied, like they're not, they're just these drawings, I wish we could really show them what real bodies actually look like I would love that but for some reason, its ok to

show diseased genitalia when you want to scare them but you know god forbid that they be able to look at you know, actual pictures. Although I don't do that diseased genitalia thing, that gross and that doesn't work, that's another way that I think we're really different from, although there are a lot of educators that have moved away from that, thank god.

Using pictures of real genitalia from people of all colors would be beneficial for the program, however the program is not able to do so due to school regulations. As a way around this, she has slowly been moving towards using pictures that are more realistic, in order to present pictures that are as close as possible to what genitalia actually look like. However, she has so far been unable to incorporate pictures of genitalia of people of color. She would like to be able to present students with embodied pictures of genitalia as a way to promote body positivity. School regulations are misguided in that the only images of actual genitalia that can be shown are those that are diseased. However, this program does not show pictures of STI's which somewhat sets it apart from other programs. There are topics that do not get covered extensively in this program, and that it would be beneficial for students to be able to cover more topics.

Uhm, I wish that we could spend more time with them. I feel like, even though we spend more time than any other program in the county on this, I wish that we had even more. I wish we could talk more about consent and you know, variation, not just in bodies but in behavior. I think it would be really cool if we could spend a lot more time on difference in behaviors sexually and kind of, you know, people doing different things. Uhm, lately I feel like the kids have been asking a lot of questions about like, they don't call it BDSM, but they ask about things. And I don't know if that's like Fifty Shades of Grey, which fuck you lady who wrote that, uhm (laughs) uhm or if its, you know I'm not really sure where that's coming from but lately I feel like there's a lot of questions about stuff like that and they're like "I heard that people do this" and so I wish that we could talk more openly about those things.

While this program is allowed a lot of time in each classroom, there are still topics that she would like to cover but is unable due to time limitations. Students would benefit from more time covering topics of consent and sexual variation. Students are interested about certain issues that the program is not able to cover extensively, although they would benefit from conversations on these topics. Students are getting misinformation about these topics from the media, with her example of inadequate representations of BDSM in the popular book and movie "50 Shades of Grey." Other educators have experienced situations in which not all students are able to understand the presentations, and would like to see those issues addressed.

I wanna say that, offer it in Spanish. Like making it bilingual so that maybe down the line, offer it in Spanish, offer it bilingually for those students that don't know English fluently or even have at least one person who is able to speak Spanish and have them go into these classes and make sure that you know these students understand what is being taught to them.

Offering the program in Spanish would allow the program to be able to serve all students in the area, regardless of language barriers. It would be beneficial to have one educator at each presentation who can translate, in case there are any students having a difficult time understanding English.

Educators also point to financial limitations in the program, which if addressed would allow Alliance to better serve the community.

I think if we had more like people (laughs) I definitely, I know that Alliance is small and we're like a non-profit and uhm I just wish that we had more like hands so we could plant

more roots and do more and it wasn't just, you know I think we're spread really thin and I think that we could do so much more if we had the right….ingredients? If we had the right tools to use, you know we're so limited. So I think that that would be, I mean we could improve curriculum, we could do a lot more like analysis of what kids are learning and where kids are at and before and after, so I just wish we had more resources.

If the program had more employees or volunteers it would be able to serve more schools, and therefore more students, in the community. With more help, a number of things about the program could be improved, including the curriculum, analysis of the program, and the number of students reached.

I wish we definitely had more time. And to talk about things like uhm, drugs and substance abuse cause I think all that goes together, and I know Alex is working on some of that now but it's nearly impossible with, she's spread so thin.
In order to be able to spend more time and cover more topics such as drug and alcohol abuse prevention, the program needs access to more staff members and educators. With more staff for the program, more students and schools will be able to benefit: "You know and the more funding we get the more we can expand it, staff wise, volunteer wise or even the schools that we outreach to." The program would benefit from more staff, and emphasizes that while volunteers help they are not able to make large time commitments because of other responsibilities.

I think that uhm definitely Alex needs a lot of help, uhm I think that if she had like maybe just the support, an assistant, just because we are all volunteers and we all do have work and school, like I wish that I could help her a lot more than I do uhm so I think that if there was another staff person that would definitely help the program.

More staff for the program would be beneficial because volunteers also have work and school responsibilities, and so are not able to offer as much assistance as they would like or is needed.

As well as experiences limitations in the classroom and in the education program, there are certain limitations related to teen clinic as well.

It's much more difficult to access clinical resources in a rural community. Uhm, the buses…suck, you know, the schedules are, are few and far between, it takes forever, uhm everything is far away, uhm, you know, the kids don't, they don't have as much money to pay 'cause a longer bus trip costs more money, uhm, and you know time wise it's really difficult for them to get to us. And then, uhm, you know like being able to get away if they can't tell the truth to their parents or guardians about where they're going. Uhm, so that's a real challenge in the linkage part of the education to the clinical services, that's a huge part.

Although the students are receiving information on reproductive health in the classroom, it remains difficult for them to actually access those resources at the clinic. In a rural community it is especially difficult for youth to access services because they are more difficult to travel to. Another barrier to access for youth in addition to location is how often clinic is open.

Uhm I wish that we had a stronger linkage to our clinical services, right now because clinical services are very, very expensive right now we're only open like one afternoon a week. Uhm, I really wish that we could be open more often and I wish we had more staff that was able to do more education in clinic as well that was trained through our department, uhm, and I also wish that we had more training for the clinical staff, not just in teen clinic but also in our primary care clinic.

Clinical services are expensive, so the teen clinic at Alliance is only able to be open one afternoon per week making it more difficult for students to access these services. It would

be beneficial to train the clinical staff through the education department in order to allow them to better serve their patients.

I really would like to do some more training for our providers on you know, updating birth control methods for teenagers and you know… I also want to do some more training with them on screening for sexual and relationship violence for teenagers and like, how do we talk to them about those things, uhm, and then talking to them about you know, communicating with my partner…training the staff, the clinical staff, on how to have like a one on one conversation about that because not a lot of them have that kind of training and I would like to do more training with them on social conditions and their effect on sexuality so like, I'd like to, you know a lot of them, they know what Tuskegee was and they know a little bit about like coercive sterilization but I wish we could do some more historical kind of stuff about medicine, especially since like fifty-two percent of our student population is not white, I'd really like to spend some time on that.

Teen patients at the clinic would benefit from clinicians having access to more knowledge on birth control methods, sexual and teen dating violence, communication and the effect of social conditions on sexuality. If clinicians had the skills to address these issues with the patients, many patients would benefit and it would reinforce what the students learned in the classroom. This is especially relevant for people of color patients, because of a history of mistreatment by medical institutions.

We carry our bias as oppressors but we also carry our bias as oppressed and so we know that communities that are not white have, have a lot of and I mean with good reason, uhm a lot of mistrust of the medical establishment, and I think if we have better training on those kinds of things I think that the patients will feel that in the way that their provider treats them uhm, and will have a little bit more trust in their provider and be able to kind of talk to them about some of those other things if the provider at least has a base knowledge of cultural issues you know that kind of connect and intersect with sexuality and race and culture.

If providers had access to trainings on cultural issues in relation to the medical establishment, it could have the potential to make communities of color feel more comfortable seeking services and care. It would also help LGBTQ youth gain better access to medical treatment, and one way this would benefit is through feeling safe to ask a provider questions.

I think that it makes them think that they can't talk about it, uhm that if they ask a provider that question that the provider's not gonna know the answer, they're not gonna know how to help them or that they're gonna think that the provider thinks that they're weird you know, or like deviant or something, that they're gonna judge them.

LGBTQ youth often refrain from asking questions of providers or seeking reproductive services for fear of not being understood or being judged by the provider. If providers received training on how to best communicate and serve LGBTQ teens, those teens could receive better reproductive health care and would feel more comfortable and safe seeking that care.

Discussion

Significant change in pre and post-test scores indicate the program is effective in raising knowledge, attitude and self-efficacy regarding sexuality and reproductive health. However, scores on these scales were relatively high before the program began, as indicated by the pre-test. The program has room to focus less on general topics, and more on uncommon sexual health topics. However, since the scores did change significantly, students still benefit from the material presented. Furthermore, many scores on individual

items on the knowledge and self-efficacy scales changed significantly, while much less changed on the attitude scale. More time needs to be spent throughout the program on addressing sex positive attitudes such as challenging gender norms, rape supportive ideas, and gender and sexual identities, especially considering this is a major goal of the program.

A gender difference in sex positive attitudes was found, such that females scored higher than males on average on this scale. According to Habarth (2015) this can be explained by expected differences in gender due to gender norms and roles. Most of the educators in this program are female, and it is possible that male students may respond differently to a male educator delivering messages of sex positivity than a female educator.

Ethnicity was an important factor to consider for the knowledge scale. White students scored significantly higher than students of other ethnicities/races. Since most educators in the program are white, it is possible that the material is less accessible to students of color. The program is in need of a Spanish-speaking educator in order to address these issues, as was mentioned in an interview with one of the volunteer educators.

Scores between the pre and post-test on the self-efficacy scale experienced the most change, overall and with individual items. According to the integrated behavioral model, one of the best predictors of intent to follow through on a behavior is self-efficacy, along with attitude and perceived behavioral control (Montano and Kasprzyk,

2008). The program may be successful in influencing the behaviors of students regarding the utilizing and seeking of reproductive services.

The analysis of anonymous questions indicates that students are exposed to a lot of concepts regarding sexuality, and they use the space of anonymous questions as an avenue to work through their understanding of these concepts. Students took the anonymous questions seriously, which indicates a genuine interest in the topic and in access to knowledge about these issues. Through the anonymous questions, students express their desire to learn about sexual pleasure, which relates to Allen (2012) who states that sexuality education can offer students knowledge about sexual pleasure, thereby increasing sexual health outcomes. However, many questions regarding pleasure focused on orgasm, which suggests that educators should focus more on pleasure gained from sexual experiences, and attempt to move the focus away from orgasm as the only means of pleasure during sexual activity. Students also asked many questions related to body positivity, in particular expressing concern about penis size. More time throughout the sessions needs to be utilized to discuss body positivity and self-esteem issues.

Post-test only questions were developed based on anonymous questions and the questions students asked during class time. Scores on the post-test items indicated that students comprehended the information given after questions were asked. The use of time for anonymous questions is beneficial to the students, as they are able and encouraged to ask about anything related to sex and sexuality, and they are able to understand and remember the answers given.

Interviews with Alex and the volunteer educators indicate that the most important goal of the program is to deliver messages of sex positivity. However, many indicated that in order to best serve the students and the community, certain limitations to access to education and health care need to be addressed. These include staffing, clinician training and educative materials. Students and members of the community would benefit from these changes to the program. However, some limitations cannot be addressed without changing school policy on sexual health education, and so may not be able to be changed.

Throughout the course of this study, some limitations were presented at each phase. Only one school that receives sexual health education from Alliance was surveyed in this study. Therefore, results from this high school are not generalizable to the other schools in the county or to any school-aged children beyond Cloverdale High School. Furthermore, although this program serves middle schools in the county as well, these students were not surveyed either. The small sample size also could have influenced not identifying a statistically significant difference where one exists.

Each semester Alliance Medical Center receives new volunteers, and because of this some of the sessions in this evaluation were taught by new educators. During some instances, these classes were the first that the educator had ever taught. It is possible that receiving the education from someone less experienced could have influenced scores on the post-test.

The survey itself also contains limitations to this study. The scales used in this study have not been previously validated, and validation of the scales was beyond the

scope of this project. Due to this, the validity of the scales used is unknown. Furthermore, the length of the survey was influenced by the amount of time students would have to complete them. Given more time, more questions could have been present on the scale, which could lend more information about the program as well as possibly increase the reliability coefficient of the scales. School scheduling also did not allow for much time between the end of participation in the program and students taking the post-test. The short period of time could have influenced scores on the post-test such that they may be higher sooner after completing the program. Furthermore, this study did not include a control group, so post-test results could have been influenced through outside events.

The sessions at Cloverdale High School for this study looked different than sessions usually do in this program. For instance, during this study classes were taught every day for two weeks. Usually, classes are taught one or two days a week over the course of one or two months. It is possible that students comprehend information differently depending on the amount of time between each session. Given more time between sessions, students are able to reflect more on the material and have more time to generate questions.

Missing data had to be addressed in this study as well. Some students did not complete the entire survey, and some skipped specific scales. Scales that were skipped varied from student to student. Furthermore, some students who completed the first survey were not present to complete the second survey, which resulted in the loss of data and a small reduction in sample size.

Future research into this topic could attempt to create a program evaluation that is generalizable to a larger population. A more generalizable study could lend information on what students are learning from sexual health education on a larger scale. Including a control group would allow for studies to rule out outside influences as affecting the results.

Overall, results from this study indicate that Alliance's Sexual Health Program is beneficial to students, as well as the communities of volunteer health educators. Results suggest that students are exposed to information about sexuality before encountering sexual health education. Although already being exposed to information, students still seek knowledge about various topics regarding sex and sexuality. Knowledge, attitudes and self-efficacy in seeking and utilizing reproductive services are all positively influenced after completing the comprehensive program.

Alliance's Sexuality Health Education Program utilizes sex positive, inclusive curricula of which students are able to understand and relate. The program addresses the needs of the students and what the students want out of sexuality education. This includes discussions of sex that include pleasure, and ways in which to make sex more enjoyable. By doing this, the educators are acknowledging the students as sexual subjects with sexual agency and autonomy.

Alliance's program is truly comprehensive, covering anatomy, STI's, birth control and disease protection, abstinence, communication, healthy relationships, sexual and dating violence, and gender and sexual identities. The curriculum is inclusive of LGBTQ

students, not only by utilizing non-heteronormative language but by directly discussing LGBTQ issues, which makes the education accessible to LGBTQ youth and improves the school climate around these issues.

The program was developed using research-based scientific information that is constantly being updated and altered to suit the needs of the students. The use of guest speakers makes the information relatable and students comfortable discussing these issues. By offering students detailed and thorough information on sex and sexuality, Alliance Medical Center's comprehensive program gives students the tools they need to enjoy a healthy sexual life.

References

Allen, L. (2005). 'Say everything': Exploring young people's suggestions for improving sexuality education. *Sex Education, 5*(4), 391-406. doi:10.1080/14681810500278493

Allen, L. (2012). Pleasure's perils? Critically reflecting on pleasure's inclusion in sexuality education. *Sexualities, 15*(3/4), 455-471. doi:10.1177/1363460712439654

Blake, S., Ledsky, R., Lehman, T., Goodenow, C., Sawyer, R., & Hack, T. (2001). Preventing sexual risk behaviors among gay, lesbian, and bisexual adolescents: The benefits of gay sensitive HIV instruction in schools. *American Journal of Public Health, 91*(6), 940-946.

Charmaraman, L., Lee, A.J., & Erkut, S. (2012). "What if you already know everything about sex?" Content analysis of questions from early adolescents in a middle school sex education program. *Journal of Adolescent Health, 50*(5), 527-530. doi:10.1016/j.adohealth.2011.10.004

Creswell, J.W. (2009). *Research design: Qualitative, quantitative, and mixed methods approaches.* California: SAGE Publications

Dickson, N., Paul, C., Herbison, P., & Silva, P. (1998). First sexual intercourse: age, coercion, and later regrets reported by a birth cohort. *BMJ, 316*(29) doi: 10.1136/bmj.316.7124.29

Eisenberg, M.E., Wagenaar, A., & Neumark-Sztainer, D. (1997). Viewpoints of Minnesota students on school-based sexuality education. *Journal of School Health, 67*(8), 322-326. doi: 10.1111/j.1746-1561.1997.tb03465.x

Elia, J.P., and Eliason, M.J. (2010). Dangerous Omissions: Abstinence-only-until-marriage school-based sexuality education and the betrayal of LGBTQ youth. *American Journal of Sexuality Education, 5,* 17-35.

Fine, M., & McClelland, S. (2006). Sexuality education and desire: Still missing after all these years. *Harvard Educational Review, 76*(3), 297-338.

Gowen, L.K. & Winges-Yanez, N. (2014). Lesbian, gay, bisexual, transgender, queer, and questioning youths' perspectives of inclusive school-based sexuality education. *Journal of Sex Research, 51*(7), 788-800. doi:10.1080/00224499.2013806648

Grose, R.G., Grabe, S., & Kohfeldt, D. (2014). Sexual education, gender ideology, and youth sexual empowerment. *Journal of Sex Research, 51*(7), 742-753. doi:10.1080/00224499.2013.809511

Habarth, J.M. (2015). Development of the heteronormative attitudes and beliefs scale. *Psychology and Sexuality, 6*(2), 166-188. doi: 10.1080/19419899.2013.876444

Harper, G.W. (2007). Sex isn't that simple: Culture and context in HIV prevention interventions for gay and bisexual male adolescents. *American Psychologist, 62*(8), 806-819. doi:10.1037/0003-066x.62.8.806

Killermann, S. (2012). *The genderbread person.* Retrieved from http://itspronouncedmetrosexual.com/2012/01/the-genderbread-person/

Kirby, D.B. (2008). The impact of abstinence and comprehensive sex and STD/HIV education programs on adolescent sexual behavior. *Sexuality Research and Social Policy, 5*(3), 18-27. doi:10.1525/srsp.2008.5.3.18

Kohler, P.K., Manhart, L.E., & Lafferty, W.E. (2008). Abstinence-only and comprehensive sex education and the initiation of sexual activity and teen pregnancy. *Journal of Adolescent Health, 42*(4), 344-351. doi:10.1016/j.jadohealth.2007.08.026

Kosciw, J.G., Greytak, E.A., Bartkiewicz, M.J., Boesen, M.J., & Palmer, N.A. (2012). *The 2011 national school climate survey: The experiences of lesbian, gay, bisexual, and transgender youth in our nation's schools*. New York, NY: Gay, Lesbian, and Straight Education Network.

McNeill, T. (2013). Sex education and the promotion of hteronormativity. *Sexualities, 16*(7), 826-846. doi:10.1177/1363460713497216

Montano, D. & Kasprzyk, D. (2008). Theory of reasoned action, theory of planned behavior, and the integrated behavioral model. In Glanz, K., Rimer, B.K., & Viswanath, K. (Eds.) *Behavior and health education: Theory, research, and practice* (pp. 67-96). San Francisco: Jossey-Bass.

Santelli, J., Ott, M.A., Lyon, M., Rogers, J., Summers, D., & Schleifer, R. (2006). Abstinence and abstinence-only education: A review of U.S. policies and programs. Journal of Adolescent Health, 38, 72-81. doi:10.1016/j.jado health.2005.10.006

Stanger-Hall, K.F. & Hall, D.W. (2011). Abstinence-only education and teen pregnancy rates: Why we need comprehensive sex education in the U.S. *PlosOne, 6*(10), 1-11, doi: 10.1371/journal.pone.0024658

U.S. Census Bureau. (2013). *State and county Quickfacts: Sonoma County, CA.* Retrieved March 23, 2015, from http://quickfacts.census.gov

Appendix 1: Pre-test

ID_____

Alliance Medical Center Survey

What town do you live in? _____

What is your ethnicity? _____

What is your gender? _____

What is your sex? _____

What is your age? _____

Please indicate how you feel about the following statements.

		Strongly Agree	Somewhat Agree	Somewhat Disagree	Strongly Disagree
1	All STI's are easily curable.	1	2	3	4
2	Condoms are effective at preventing pregnancy and STI's.	1	2	3	4
3	A person cannot get an STI the first time they have sex.	1	2	3	4
4	Emergency contraception (the morning after pill) works if someone is already pregnant.	1	2	3	4
5	All vaginas and all penises look pretty much the same.	1	2	3	4
6	Birth control makes people gain weight.	1	2	3	4
7	Sex and gender are the same thing.	1	2	3	4
8	Using two condoms is more effective than using one.	1	2	3	4
9	A person cannot get pregnant if they have sex in water.	1	2	3	4
10	People under 18 can't get birth control without their parent or guardians consent.	1	2	3	4

11	A person can get an STI from oral sex.	1	2	3	4
12	Pulling out is just as effective as condoms at preventing pregnancy.	1	2	3	4
13	The pull-out method protects someone against STI's.	1	2	3	4
14	Only woman can be sexually assaulted.	1	2	3	4
15	People who have sex are cooler than people who don't.	1	2	3	4
16	I only need to know about birth control if I am able to get pregnant.	1	2	3	4
17	I think sexual assault is a problem in my age group.	1	2	3	4
18	I would have sex with my partner if they were drunk.	1	2	3	4
19	Men want sex more than women.	1	2	3	4
20	I would be able to tell if someone wanted to have sex by their body language.	1	2	3	4
21	Only religious people are abstinent.	1	2	3	4
22	It's OK to send naked pictures to someone without asking them first.	1	2	3	4
23	People my age have a lower risk of getting an STI than older people.	1	2	3	4
24	I think homosexuality is unnatural.				

Please rate how confident you are that you would be able to do the following actions

		Very Confident	Somewhat Confident	Barely Confident	Not At All Confident
1	Put a condom on correctly.	1	2	3	4
2	Talk to my partner about sex.	1	2	3	4
3	Seek reproductive services.	1	2	3	4
4	Get birth control and STI protection.	1	2	3	4
5	Get emergency contraception (the morning after pill).	1	2	3	4

6	Talk to my parents or guardians about sex.	1	2	3	4
7	Seek sexual violence or dating violence services.	1	2	3	4
8	Ask my partner for consent.	1	2	3	4
9	Use an insertive condom correctly.	1	2	3	4
10	Explain how pregnancy works.	1	2	3	4
11	Use emergency contraception correctly.	1	2	3	4
12	Use birth control correctly.	1	2	3	4
13	Use a dental dam correctly.	1	2	3	4
14	Talk to my partner about birth control.	1	2	3	4
15	Talk to my partner about using condoms.	1	2	3	4

What do you want to know about sex?

What do you already know about sex?

Who do you talk to about sex?

Appendix 2: Post-test

Period _____ **ID**_____

Alliance Medical Center Survey

What town do you live in? _____ What is your race/ethnicity? (Please choose one)

What is your gender? _____ ____ Hispanic/Latino ____ Asian/Pacific Islander

What is your sex? _____ ____ African American ____ Caucasian (white)

What is your age? _____ ____ Native American ____ Multiracial

What is the highest level or degree of school that either of your parents/guardian has completed? (circle one)

(1)Less Than High School (2) High School Grad- Diploma or Equivalent (3) Some College But No Degree

(4) Associates Degree (5) Bachelor's Degree (6) Master's Degree (7) Doctorate Degree

Please indicate how you feel about the following statements.

		Strongly Agree	Somewhat Agree	Somewhat Disagree	Strongly Disagree
1	All STI's are easily curable.	1	2	3	4
2	Condoms are effective at preventing pregnancy and STI's.	1	2	3	4
3	A person cannot get an STI the first time they have sex.	1	2	3	4
4	A person cannot get STI's from oral sex.	1	2	3	4
5	Pulling out is not effective at preventing STI's.	1	2	3	4
6	Emergency contraception (the morning after pill) works if someone is already pregnant.	1	2	3	4
7	All vaginas and all penises look pretty much the same.	1	2	3	4

8	Birth control makes people gain weight.	1	2	3	4
9	Sex and gender are the same thing.	1	2	3	4
10	Using two condoms is more effective than using one.	1	2	3	4
11	A person cannot get pregnant if they have sex in water.	1	2	3	4
12	Men can be sexually assaulted.	1	2	3	4
13	People under 18 cannot get birth control without their parent or guardians consent.	1	2	3	4
14	A person can get an STI from oral sex.	1	2	3	4
15	Pulling out is just as effective as condoms at preventing pregnancy.	1	2	3	4
16	The pull-out method protects someone against STI's.	1	2	3	4
17	All vaginas and all penises are different.	1	2	3	4
18	Only woman can be sexually assaulted.	1	2	3	4
19	A person can get pregnant if they have sex in water	1	2	3	4
20	Using two condoms is not more effective than using one.	1	2	3	4
		Strongly Agree	Somewhat Agree	Somewhat Disagree	Strongly Disagree
1	People who have sex are cooler than people who don't.	1	2	3	4
2	I only need to know about birth control if I am able to get pregnant.	1	2	3	4
3	I think sexual assault is a problem in my age group.	1	2	3	4
4	I would have sex with my partner if they were drunk.	1	2	3	4
5	It's OK to send naked pictures to someone without asking them first.	1	2	3	4
6	Men want sex more than women.	1	2	3	4

7	I would be able to tell if someone wanted to have sex by their body language.	1	2	3	4
8	Only religious people are abstinent.	1	2	3	4
9	I would not have sex with my partner if they were drunk	1	2	3	4
10	People my age have a lower risk of getting an STI than older people.	1	2	3	4
11	I think homosexuality is unnatural.	1	2	3	4
12	Anyone can be abstinent.	1	2	3	4
13	I should know about birth control, even if I can't get pregnant.	1	2	3	4
14	I can't tell if someone wants to have sex by their body language.	1	2	3	4
15	Sexual assault is not a problem with people my age.	1	2	3	4
		Strongly Agree	Somewhat Agree	Somewhat Disagree	Strongly Disagree
1	Smoking does not lower my sperm count enough to prevent pregnancy.	1	2	3	4
2	Penis size doesn't matter.	1	2	3	4
3	I can't get somebody pregnant if I have sex in a hot tub.	1	2	3	4
4	Most people in high school are having sex.	1	2	3	4
5	People have different definitions of abstinence.	1	2	3	4
6	The HPV vaccine works to prevent HIV infection.	1	2	3	4
7	Only gay men get HIV.	1	2	3	4
8	Only people in 3rd world countries die from HIV/AIDS	1	2	3	4
9	I can't get an STI from sex if my partner doesn't have one.	1	2	3	4
10	Birth control can cause cancer.	1	2	3	4

Please rate how confident you are that you would be able to do the following actions

		Very Confident	Somewhat Confident	Barely Confident	Not At All Confident
1	Put a condom on correctly.	1	2	3	4
2	Talk to my partner about sex.	1	2	3	4
3	Seek reproductive services.	1	2	3	4
4	Get birth control and STI protection.	1	2	3	4
5	Get emergency contraception (the morning after pill).	1	2	3	4
6	Talk to my parents or guardians about sex.	1	2	3	4
7	Seek sexual violence or dating violence services.	1	2	3	4
8	Ask my partner for consent.	1	2	3	4
9	Use an insertive condom correctly.	1	2	3	4
10	Explain how pregnancy works.	1	2	3	4
11	Use emergency contraception correctly.	1	2	3	4
12	Use birth control correctly.	1	2	3	4
13	Use a dental dam correctly.	1	2	3	4
14	Talk to my partner about birth control.	1	2	3	4
15	Talk to my partner about using condoms.	1	2	3	4

On a scale of one to ten, please rate your knowledge of sexual health **before** this program. (circle one)

1 2 3 4 5 6 7 8 9 10

Lowest Highest

On a scale of one to ten, please rate you knowledge of sexual health **after** this program. (circle one)

1 2 3 4 5 6 7 8 9 10

Lowest Highest

What did you like about the presentations?

What didn't you like about the presentations?

Appendix 3: Program Director Interview Guide

1. Tell me about the program.
2. How was the program developed?
3. Follow-up question: Was the program developed from the ground-up or was there already a program in place?
4. What theories/ideas are behind the curriculum development?
5. How does the program address the needs of the community?
6. Tell me about the volunteers.
7. How are they chosen?
8. How do teachers react to the curriculum in your opinion? Parents? Students?
9. What, if anything, do you feel needs improvement?
10. What is most important in educating youth about sex and sexuality?

Appendix 4: Volunteer Educator Interview Guide

1. What made you want to volunteer for Alliance Medical Center?
2. Tell me about your background with the subject of sexuality/education.
3. Is sex education important for youth? Why or why not?
4. How confident are you teaching this subject? Answering students' questions?
5. Tell me about your experience with the training for this position?
6. What do you feel is the most difficult part of this job?
7. In your experience, how do the students react to this program?
8. What is the best part of this program? For you? For the students?
9. How, if at all, has this program influenced your own beliefs or behaviors?
10. What would you change about this program to make it more effective/ improve it?
11. What do you think is the most important message that the education program sends to the students?