

“If you  
expect us  
to make  
healthy  
decisions,  
we need  
sex ed.”

A REPORT ON:

**SEXUALITY EDUCATION IN THE NEW YORK CITY  
PUBLIC SCHOOL SYSTEM**



**NARAL**  
Pro-Choice New York Foundation



NATIONAL  
INSTITUTE FOR  
REPRODUCTIVE  
HEALTH

“ ENSURING OUR YOUTH  
HAVE ACCESS TO ALL THE  
RESOURCES NECESSARY  
TO MAKE HEALTHY  
DECISIONS ABOUT THEIR  
LIVES AND THEIR FUTURES  
SHOULD BE OF PARAMOUNT  
IMPORTANCE TO EVERY  
NEW YORKER.”

**Robert Jackson**

*Councilmember (D-Manhattan),*

*Chair of the Education*

*Committee*

Comprehensive school-based sexuality education that is appropriate to students' age, developmental level, and cultural background is an important part of the school curriculum at every grade.

A comprehensive sexuality program will provide medically accurate information, recognize the diversity of values and beliefs represented in the community, and complement and augment the sexuality education children receive from their families, religious and community groups, and healthcare professionals.

**Sexuality Information and Education Council of the United States (SIECUS)**

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# INTRODUCTION

**COMPREHENSIVE SEXUALITY EDUCATION (CSE)** addresses sexual development, reproductive health, interpersonal relationships, affection, intimacy, sexual orientation, and gender roles. The National Institutes of Health (NIH) defines CSE as “teaching both abstinence and the use of protective methods for sexually active youth.”<sup>1</sup> The goal of comprehensive school-based sexuality education is to help young people gain a healthy view of sexuality, provide them with sexual health information and skills, and empower them to make sound decisions now and in the future.

Adolescents need comprehensive reproductive and sexual health information and services, especially during adolescence, which is when many young people engage in sexual activity for the first time. In the United States, the average age of first intercourse is 16.9 and 17.4 years for men and women respectively.<sup>2</sup> More than 750,000 women under 20 become pregnant each year; 82 percent of these are unintended pregnancies.<sup>3</sup> Additionally, each year more than nine million teens and young adults under 24 are diagnosed with sexually transmitted infections (STIs).<sup>4</sup> A recent study from the Centers for Disease Control and Prevention (CDC) found that one in four teenage girls has had an STI.<sup>5</sup> CSE is an important component to reduce unintended teen pregnancy and prevent STI transmission.

Numerous studies and evaluations in peer-reviewed literature have demonstrated that CSE programs can delay the onset of intercourse, reduce the frequency of intercourse, reduce the number of sexual partners, and increase condom and contraceptive use.<sup>6,7</sup> CSE curricula for adolescents have been endorsed by numerous medical organizations, such as the American Academy of Pediatrics,<sup>8</sup> American College of Obstetricians & Gynecologists,<sup>9</sup> American Medical Association,<sup>10</sup> American Public Health Association,<sup>11</sup> Institute of Medicine,<sup>12</sup> and Society for Adolescent Medicine.<sup>13</sup>

**ADDITIONALLY, A PUBLIC OPINION STUDY FOUND** that 82 percent of adults support sexuality education that teaches students both abstinence and other methods of preventing pregnancy and STIs.<sup>14</sup> Although sexuality education programs are not currently in the majority of schools across the country, such programs achieved significant victories in 2010. Under the Obama Administration, the Office of Adolescent Health was created and, for the first time, federal funding has been introduced for teenage pregnancy prevention.

**“TEEN PREGNANCY IS A SERIOUS NATIONAL PROBLEM AND WE NEED TO USE THE BEST SCIENCE OF WHAT WORKS TO ADDRESS IT. THIS INVESTMENT WILL HELP BRING EVIDENCE-BASED INITIATIVES TO MORE COMMUNITIES ACROSS THE COUNTRY WHILE ALSO TESTING NEW APPROACHES SO WE CAN EXPAND OUR TOOLKIT OF EFFECTIVE INTERVENTIONS.”**

**Kathleen Sebelius**  
*U.S. Department of Health and Human Services Secretary, on new federal funding for pregnancy prevention programs*

# THE HISTORY OF SEXUALITY EDUCATION IN NEW YORK CITY

The New York City public school system, which began in 1842 with the creation of the Board of Education, has the country's largest public school population, with approximately 1.1 million students.<sup>15</sup> To date, sexuality education is not uniformly or consistently offered or taught in public schools.

**THE FIRST CALL** for sexuality education in New York City began in the late 1930s, when several members of the New York City Board of Education noticed increasing teenage pregnancy and STI rates. They proposed the introduction of a lesson on “sex instruction, in the mild form of a study of mammalian reproduction” into public city high schools.<sup>16</sup> However, the proposal was swiftly rejected by the board at large on both moral and political grounds. In rebuttal, angered board members voiced their opinions on the rejection, including noting how a member of the board who rejected the proposal “had an average of two pregnant girls a month leave her school.”<sup>17</sup> Such statements led to the United Parents Associations (UPA) of New York City passing a resolution in favor of instituting sex education in public schools in 1939. The resolution called for a continuous sex education program that included trained teachers covering biological, family life, and life process topics.<sup>18</sup>

Little action took place in response to the 1939 UPA resolution, leading to the reaffirmation of the resolution in 1967 by the current UPA president who, in representing 400,000 New York City parents,<sup>19</sup>

stressed the need for sex education that still did not exist in New York City public schools.<sup>20</sup> The UPA's commitment to the resolution served as the major force in bringing about the first wave of sex education programming in New York City, beginning in 1967 with the “Family Living, Including Sex Education” (FL/SE) program for grades Pre-K through 12.<sup>21</sup> The FL/SE curriculum stressed family living, including lessons aimed at helping students feel confident about their bodies, and recommended that information on sexuality be taught with a frank and straightforward attitude.<sup>22</sup>

In the same year, the New York State Legislature passed a law requiring health education in public schools, including sexuality education. However, in 1969, under pressure from critics who criticized the health education law for making sexuality education a requirement, the legislature decided to remove all sexuality education references from the health education law.<sup>23</sup> Subsequently, the FL/SE program was not proving to be as effective as hoped; teen pregnancy rates rose in the 1970s, and the need for a revised curriculum became even more evident.<sup>24</sup> During the 1984–1985 school year, additional

changes were incorporated into the FL/SE curriculum, including the addition of supplementary coordinators, teacher training programs, and parental programming.<sup>25</sup>

Despite the school board's initial plan to spread FL/SE throughout the whole school system in the late 1960s, without the legislative mandate or sufficient resources the curriculum had still not reached all students by the mid-1980s.<sup>26</sup>

**A MOMENTOUS STEP IN SEX EDUCATION** in New York State came in 1987 with the emergence of the mandated HIV/AIDS curriculum for grades K–12 in all public schools.<sup>27</sup> The mandate was added as a supplement to FL/SE for middle and high school students, and covered “the unique factors associated with AIDS,” including information on AIDS as a social and medical problem.<sup>28</sup> Even with these mandates in place, by 1989 most schools were still failing to comply with most of the health education requirements.<sup>29</sup>

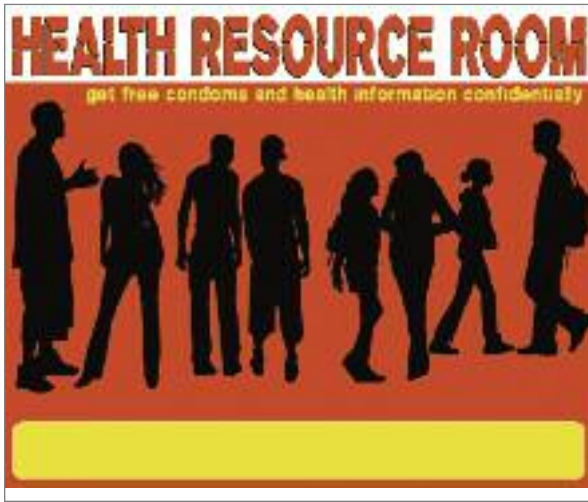
On a city-wide level, both HIV/AIDS education and condom availability (in public high schools) were mandated beginning in 1991 in order “to raise awareness about HIV/AIDS and encourage students to abstain from high risk behavior, including sexual intercourse and substance abuse.”<sup>30</sup> The New York City HIV/AIDS Education Mandate included components requiring education teams, parental sessions, program evaluation, and the formation of a health resource room in each school to provide condoms and information on STIs and HIV/AIDS.<sup>31</sup> The New York State Board of Regents also adopted a policy on HIV/AIDS instruction in 1991 and stressed the teaching of abstinence as the most important means of preventing HIV/AIDS.<sup>32</sup>

In response to increasing race-based violence in the late 1980s, New York City developed and introduced a new multicultural curriculum called Children of the Rainbow into public schools in

1991.<sup>33</sup> The curriculum included discussions on a range of ethnicities, nationalities, races, and controversially, sexual orientation.<sup>34</sup> Although only mentioned in three of approximately 450 pages of the curriculum, the inclusion of sexual orientation became a hugely controversial topic and was quickly attacked as unacceptable by conservative groups.<sup>35</sup> In response to the debate, Chancellor Joseph Fernandez approved changes to the curriculum including the delay of certain lessons on homosexuality, removal of certain books on homosexuality, and the use of the phrase “same gender” instead of gay and lesbian.<sup>36</sup> In spite of these changes and the support of 70 percent of surveyed parents for the curriculum, Children of the Rainbow was removed from almost all New York City school districts.<sup>37</sup> Following the controversy, Chancellor Fernandez resigned and the issue of sexuality education became a political land mine for many years.

**THEN, IN 2003**, Assemblyman Scott Stringer published a report called “Failing Grade: Health Education in NYC Schools,” in which he found that there was an “enormous discrepancy between State and City health education mandates for grades K–8 and actual practice in public school districts.”<sup>38</sup> The report recommended “the institution of a clear and accountable comprehensive health education program in our schools,” which would address topics “from physical activity and nutrition to substance abuse, STDs, and pregnancy prevention.” In order to implement such a health education program, the report recommended a full-scale evaluation of health education in all New York City public schools, the design of an up-to-date health education curriculum that would include CSE, the institution of regional implementation plans, and improved teacher training.<sup>39</sup>

**IN JANUARY 2004**, the New York AIDS Coalition (NYAC) followed the Stringer Report with its own report demonstrating that New York City public schools were failing to fulfill the 1991 HIV/AIDS Education Mandate and recommending that the



Health Resource Room poster from the Department of Education.

school system update its HIV/AIDS lessons, employ better-trained teachers, and institute an oversight system to ensure compliance.<sup>40</sup> In conjunction with this initiative, NYAC led the Public School Task Force, a coalition of organizations that came together to advocate for updates to the HIV/AIDS and FL/SE curriculums and for a CSE mandate. As part of its efforts, NYAC held a citywide public forum, which was attended by a variety of advocacy groups as well as concerned students and parents. A representative from the Department of Education (DOE) acknowledged that HIV/AIDS education in New York City public schools was inconsistently delivered and that most schools were “not meeting the number of lessons required by the mandate.”<sup>41</sup>

THE NEXT MONTH it was publicly noted by the Kaiser Family Foundation that the HIV/AIDS curriculum had not been updated in 10 years, nor had the sex education curriculum been updated in 20 years, and at least 75 percent of New York City schools violated state requirements for health education.<sup>42</sup> These claims led to a public hearing held by the New York State Assembly Standing Committee on Education and the Standing Committee on Health, where representatives from

NARAL Pro-Choice New York, the Sexuality Information and Education Council of the United States (SIECUS), Planned Parenthood of New York City, and the New York Civil Liberties Union (NYCLU) testified that sex education curricula were not adequately implemented and did not adequately educate the city’s youth.<sup>43</sup>

As a result of advocates’ efforts throughout 2004 and 2005, as well as mounting research showing its inadequacy, the New York City HIV/AIDS curriculum was updated in 2005, 14 years after the last revision.<sup>44</sup> The updates included new information about the course of HIV and its nature, treatment, and prevention, as well as “new medical information to ensure scientific accuracy,”<sup>45</sup> ways to support friends or loved ones who may be living with HIV/AIDS, and communication skills with parents/guardians, teachers and peers.<sup>46</sup> Mandatory health resource rooms were to include free condoms (upon request and in high schools only), health information, and health referrals for students.<sup>47</sup>

In the HIV/AIDS lessons implemented in 2005, parents were given the opportunity to opt their children out of lessons that cover methods of prevention, but were required to provide instruction at home.<sup>48</sup> To explain the new curriculum, Joel Klein, Chancellor of the New York City DOE, released a guide called “HIV/AIDS Curriculum: A Supplement to a Comprehensive Health Curriculum,” in which he stressed that HIV/AIDS education should cover not only prevention but also the broad social impact of the epidemic,<sup>49</sup> as well as a wider range of sexual health topics.<sup>50</sup>

Furthermore, in response to mounting criticisms of the city’s outdated health education curriculum, the New York City DOE began implementing *HealthTeacher* in all grades beginning in 2005.<sup>51</sup> The new curriculum came with a wide range of criticisms including the lack of information on contraception for middle school students, the

absence of discussions on sexual orientation (which were only featured in HIV lessons if discussed at all), and other inadequate and inaccurate content. As a result, advocates met with New York City DOE officials and advocated for a new curriculum that could better meet the needs of New York City teenagers. Due to those advocacy efforts and other concerns, the city decided to limit *HealthTeacher* to elementary school students.<sup>52</sup>

IN 2005–2006, the New York City DOE and Department of Health and Mental Hygiene (DOHMH) put together an advisory group of sex education experts to review health education and sexuality education curriculum programs and consulted with Dr. Douglas Kirby, a prominent sex education researcher. Based on their recommendations, in 2007, the newly created Office of Fitness and Health Education (OFHE) officially recommended the use of *HealthSmart* and *Reducing the Risk* in New York City. While these programs are recommended in public middle and high schools,<sup>53</sup> these curricula are not required or mandated by law.

DURING THE 2007–2008 SCHOOL YEAR, the New York City DOE and DOHMH implemented a pilot program of evidence-based sex education in seven South Bronx public middle and high schools. The South Bronx was chosen due to the community's high rates of teen sexual activity and teen pregnancy. Participating teachers received materials, professional development, and ongoing technical assistance. A comprehensive process evaluation of the pilot was designed and utilized to assess the program's effectiveness.<sup>54</sup> The program used the evidence-based curriculum, *Reducing the Risk*, as well as three lessons from the "Abstinence and Sexual Health" component of the *HealthSmart* curriculum for high school students. Additional information was also provided on relationship violence, risky behaviors, and lesbian, gay, bisexual, transgender, and questioning (LGBTQ) issues.<sup>55</sup>

Along with four main evaluative points in the process evaluation came a series of recommendations for the DOE, including (1) "comprehensive health/sex education should be formally incorporated into school schedules to allow for sufficient instructional time, and to reflect the commitment of school leaders for student health and achievement" and (2) "a New York City-specific student outcome evaluation of the sex education curricula should be undertaken to assure that the recommended curricula are effective in the New York City context."<sup>56</sup>

After nearly 30 years of federal support for abstinence-only-until-marriage programs, on September 30, 2010, the U.S. Department of Health and Human Services (HHS) announced \$155 million in teen pregnancy prevention funding to support implementation of evidenced-based and innovative teen pregnancy prevention programs. The grants were made directly to states, non-profit organizations, school districts, universities, and other entities. New York State received \$11,832,504 in teen pregnancy funding, which included grants to the following New York City-based organizations: Grand Street Settlement, Morris Heights Health Center, New York City Mission Society, Planned Parenthood of New York City, and Cicatelli Associates. The New York City DOHMH also received \$1.5 million each year for five years to implement and expand a comprehensive project aimed at reducing teen pregnancy and birth rates by 10 percent in two communities in the Bronx. Part of this grant will support the implementation of evidence-based teen pregnancy prevention curricula in the target high schools, as well as strengthen collaboration with community services and organizations.

# SEXUALITY EDUCATION CURRICULA IN THE NEW YORK CITY PUBLIC SCHOOL SYSTEM

The New York City DOE recommends the *HealthSmart* curriculum for all middle schools. *HealthSmart*, along with *Reducing the Risk*, is the recommended comprehensive health education curriculum for high schools.

*HealthSmart* is a K-12 health education curriculum designed to improve the quality of students' lives and provide them with a framework for making healthy choices for life. The learning activities in *HealthSmart* are designed to help students develop health-related skills, make and celebrate healthy choices, and advocate the healthy choices of their peers.<sup>57</sup> The New York City DOE recommends that all middle schools participate in the program and offers the instructional materials free of charge to teachers who take OFHE's professional development sessions. Such sessions are offered throughout the school year, and teachers of any subject may register for the sessions and teach the curriculum.<sup>58</sup> The *HealthSmart* Middle School Program is founded on five components: epidemiology, national health education standards, behavioral and educational theory, cultural characteristics of youth and their families, and development characteristics of adolescents.<sup>59</sup>

*HealthSmart* Middle School consists of the following seven units representing critical issues facing adolescents of this age group: (1) abstinence and puberty, (2) emotional and mental health, (3) HIV, STD and pregnancy prevention, (4) improving health behaviors, (5) nutrition and physical activity, (6) tobacco, alcohol and other drug prevention, and (7) violence and injury prevention.<sup>60</sup> Each unit contains several lessons, lasting approximately 45 minutes each.

The abstinence and puberty unit stresses abstinence and provides students with skills and tactics to make healthy decisions and resist peer pressure. Components of this lesson include the reproductive systems, qualities of healthy relationships, obstacles regarding abstinence, communication skills, and planning ahead to protect abstinence.<sup>61</sup>

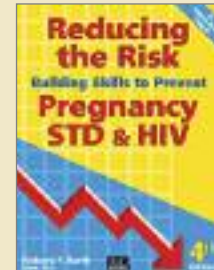
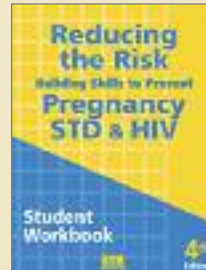
The HIV, STD and pregnancy prevention unit further stresses abstinence and assists students in methods of preventing and reducing the risk of HIV, STDs, and pregnancy. Activities in this section include examining negative consequences of risky behaviors, strategies for building healthy relationships, and reducing sexual stereotypes and appropriate communication skills to reduce risks (if sexually active) or to remain abstinent.<sup>62</sup>

*Reducing the Risk* (RTR) replaces the sexuality and sexual behavior portion of *HealthSmart* in high schools.<sup>63</sup> Both curricula combined make up the recommended comprehensive health education program for New York City high schools. RTR is an evidence-based sex education and HIV-prevention program for students in grades 9 through 12, suggested to be taught in either grade 9 or 10.

RTR is based on several health behavior schools of thought, including the social learning theory, social inoculation (social influence) theory, and cognitive behavioral theory.<sup>64</sup> The main behavioral goal of reducing unprotected sex is taught through the lessons on both abstinence and contraception.

## **REDUCING THE RISK CURRICULUM<sup>65</sup>**

The *Reducing the Risk* curriculum consists of 16 lessons, each lasting between 45 and 90 minutes, which are focused on “building skills to prevent pregnancy, STDs & HIV.”<sup>66</sup> The lessons in RTR are:



### **CLASS 1**

Introduction to RTR: Pregnancy Prevention

### **ALTERNATIVE CLASS 1**

HIV Prevention

### **CLASS 2**

Abstinence: Not Having Sex

### **CLASSES 3 & 4**

Using Refusal Skills

### **CLASS 5**

Delaying Tactics

### **CLASS 6**

Avoiding High-Risk Situations

### **CLASSES 7 & 8**

Getting and Using Protection

### **CLASSES 9, 10, & 11**

Skills Integration

### **CLASS 12**

Preventing HIV and other STDs

### **CLASS 13**

HIV Risk Behaviors

### **CLASS 14**

Implementing Protection from STDs and Pregnancy

### **CLASS 15**

Sticking with Abstinence and Protection

### **CLASS 16**

Skills Integration



The curriculum uses experiential activities in order to build students' skills regarding negotiation, decision making, and communication. Furthermore, the program clearly emphasizes teaching refusals,

delaying tactics, and alternative actions students can use to abstain or use protection.<sup>67</sup> It also encourages the discussion of abstinence and contraception between parents and their child.<sup>68</sup> RTR's objectives state that by the culmination of the program students should be able to:

- Evaluate the risks and consequences of becoming an adolescent parent or becoming infected with HIV or other STDs.
- Recognize that abstaining from sexual activity or using contraception are the only ways to avoid pregnancy, HIV infection, and other STDs.
- Conclude that factual information about contraception and protection is essential for avoiding pregnancy, HIV infection, and other STDs.
- Demonstrate effective communication skills for remaining abstinent and for avoiding unprotected sexual intercourse.<sup>69</sup>

### THE NEED FOR CSE IN NEW YORK CITY

**While New York City is a leader in many areas of reproductive health advocacy, the city is lacking implementation of effective CSE. The need for CSE in all of New York City public schools is blatantly clear:**

- **Nearly half (48%) of all public high school students in New York City have had sex**, and approximately one in five New York City teenagers have had four or more sex partners. About one in 10 New York City youth (11%) had sex before age 13 years.<sup>70</sup>
- **One in three public high school students in New York City are currently sexually active** (had sex in the last three months).<sup>71</sup>
- **The teen pregnancy rate for New York City is much higher than the national rate**, and in 2007 the rate began to rise in some of the most underserved neighborhoods.<sup>72</sup>
- **HIV/AIDS rates among young men in New York City are on the rise**; new HIV diagnoses have recently doubled for men ages 13-19 years who have sex with men.<sup>73</sup>

Additionally, 88 percent of surveyed New Yorkers agree that students should have information about contraception and the prevention of sexually transmitted infections.<sup>74</sup>

# STAKEHOLDER INTERVIEWS

In order to explore how sexuality education is currently being implemented and how it can be improved in New York City public schools, the National Institute for Reproductive Health (National Institute) and NARAL Pro-Choice New York Foundation (NPCNY) undertook a research project in the spring of 2010. Through in-depth interviews with over 20 key stakeholders such as students, parents, teachers, and elected officials, we gathered information about the current sexuality education programs and curriculum being implemented in New York City. The purpose of this report was to provide insight on the perspectives of key stakeholders in New York City public schools and to compile recommendations for how to improve and expand sexuality education.

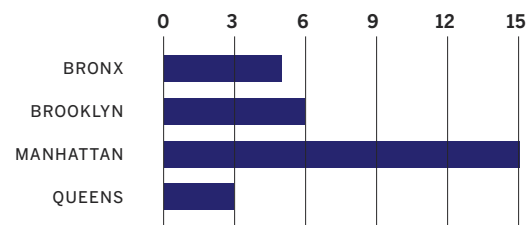
## STAKEHOLDERS: WHO'S BEING IMPACTED?

### YOUTH

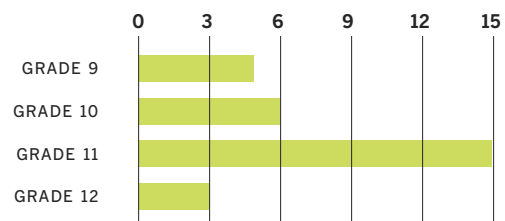
Although they are arguably the group most affected by CSE, young people are often left out of any discussion or decision-making on education policy. For this reason, we decided to focus the majority of our interviews on youth. Youth were identified from after-school programs including the National Institute's Teen Outreach Reproductive Health Challenge (TORCH), the Teen Health Initiative at NYCLU, and the Leadership, Empowerment and Awareness Program (LEAP) for Girls at Love Heals. Participants were also recruited through outreach with youth-serving organizations throughout New York City and social media outreach on Twitter and Facebook.

### YOUTH SAMPLE (N=29)

#### BY BOROUGH



#### BY GRADE



A total of 31 youth completed an online survey or paper questionnaire addressing their experience and perspective of middle and high school sexuality education. Of the 31 respondents, two participants attended private schools in New York City and were not eligible to participate in the project. Of the remaining 29 surveys, in-depth follow-up interviews were conducted with four youth. For the list of interview questions and represented schools, see Appendix.

The 29 respondents varied in grade level and represented schools in the Bronx (17%), Brooklyn (21%), Manhattan (52%), and Queens (10%).

### **TEACHERS**

While curriculum content is clearly an integral component to a successful program, research suggests that the most important factor in sexuality education program implementation is a well-qualified and willing classroom teacher.<sup>75</sup> The teacher's knowledge level of the subject, perception about the importance of teaching the curriculum, intent to teach the curriculum, and level of comfort with the curriculum's subject are the most critical qualities for a successful educator.<sup>76</sup> Teachers are instrumental to the implementation of CSE and offer a unique perspective and set of recommendations for the execution of programs. Teachers were recruited through word of mouth, colleagues, and coalition partners, and we limited our search to health educators and school administrators. For the list of interview questions for teachers, see Appendix.

### **ADVOCATES**

Working with a coalition of partners from the Sexuality Education Alliance of New York City (SEANYC), we gathered a broad range of advocates from across the City. These participants represented a wide range of organizations and perspectives in the fight for CSE, including SIECUS; Love Heals, the Alison Gertz Foundation for AIDS Education;

the HIV Law Project; Planned Parenthood of New York City; and NYCLU. Advocates described past and present policy and advocacy efforts in New York City as well as current barriers for implementing CSE. For the list of interview questions for advocates, see Appendix.

### **PARENTS**

Along with school-based education, parents remain an indispensable source for educating youth. Research has shown that parental involvement and positive communication helps young people make healthy decisions and delay sexual activity.<sup>77</sup> Parents also generally support CSE; over 20 years of surveys on the local, state, and national levels confirm that 80 to 85 percent of parents want their children to receive comprehensive, medically accurate, age-appropriate sex education.<sup>78</sup> Parents are in an invaluable position to advocate for CSE as members of local school boards or school health education committees.<sup>79</sup> Parents were recruited through word of mouth, colleagues, and coalition partners, and were limited to parents of public school students. For the list of interview questions for parents, see Appendix.

### **OFFICIALS FROM DOE, DOHMH, AND CITY COUNCIL**

Elected officials play a critical role in ensuring that CSE is available and supported with adequate resources. While some concerns were raised about financing a full CSE program in every public school, at a minimum, every member we interviewed supported the basic concept of CSE. Several council members also expressed frustration that passing CSE legislation has been a challenge. We also had numerous conversations with staff from DOE and DOHMH, who provided critical background information for the report. For the list of interview questions for officials and council members, see Appendix.

## STAKEHOLDERS: IDENTIFYING THE ESSENTIALS

### LACK OF UNIFORMITY AND CONSISTENCY

Without an explicit requirement for CSE, sexuality education is not taught uniformly in a specific grade or consistently through the school day or year. In fact, the majority of surveyed youth reported receiving either limited or no sexuality education in middle school and high school. Advocates and teachers also agreed that there should be uniform standards for implementation, as well as guidelines that outline expected outcomes for students' knowledge and skills.

*" [Class] ends up spreading out so much... [Let's] say you had class on Tuesday, a whole week goes by till you get them again, and [I have] to spend half the class reviewing what we did last week, and then I only have half the class to teach something new."*

HEALTH AND PHYSICAL EDUCATION TEACHER

*" In middle schools they have to do one year of health, so they put it in 7th grade, whereas we have it in 8th grade. There's no guideline for it, they just put it wherever, wherever you have room."*

HEALTH AND PHYSICAL EDUCATION TEACHER

*" We need a separate mandate...or it's not going to get brought up... And I think any mandate needs to have teeth, it needs to have an enforcement mechanism written into it. And there needs to be meaningful assessment that's not a high-stakes test."*

ADVOCATE

*" If health is just taught once in high school and once in middle school then to me, it's inefficient. Because health should have the same focus as English or Math and we're not going to give our kids math lessons once in middle school and once in high school. We should do it all throughout. It should be*

*an ongoing thing. As their bodies change and develop, there should be constant reinforcement. I think it should be more than the six lessons per year. It should be part of a health program."*

ADVOCATE

*" There needs to be more than one semester of health education [in both middle school and high school]. The kids consistently tell us they want and need more. And health is just considered a throwaway subject. You take it and you pass it so you can graduate."*

ADVOCATE

### INCOMPLETE INFORMATION

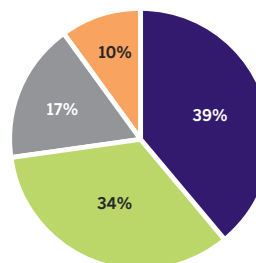
Participating youth, parents, and advocates noted that while the curriculum covered a wide range of topics, the information they received was not comprehensive enough and did not place enough focus on prevention.

*" We'd have a full discussion on how you distinguish HIV from AIDS versus things people really want to know about or need to know about more. It was more about like what your white blood cell count needs to be before you have AIDS. And so it was more like you were taking a science class than a sex ed or health class."*

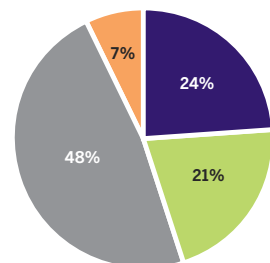
HIGH SCHOOL SENIOR

### DESCRIBE THE SEXUALITY EDUCATION LESSONS YOU HAD:

IN MIDDLE SCHOOL:



IN HIGH SCHOOL:



■ Did not receive sexuality education  
■ Received very limited education  
■ Received sexuality education  
■ Unknown

*“No, [sexual orientation is] definitely not in HealthSmart. I know that. That’s definitely something that should go in there.”*

HEALTH AND PHYSICAL EDUCATION TEACHER

*“Schools need to discuss the media and its impact with students. The media has taken over sexual development at such a young age without offering any of the information. There is so much in the media about celebrities adopting babies and having babies, so the 16 year old girls in high school think it’s cool to have a baby.”*

PARENT

### UNCLEAR MESSAGING ON STIs

In addition to expanding the current curriculum to be more comprehensive, instruction needs to include messaging around the prevention of both pregnancy and STIs. Advocates felt that the messaging around pregnancy prevention has overshadowed the conversation, leaving many youth uninformed about STIs.

*“I had a conversation with some young girls and they were all talking about pregnancy and unprotected sex and one girl said to me, if any of my friends have unprotected sex they just go to the pharmacy the next day to get Plan B. And I was like, you know what, there is no Plan B for HIV. And so I think that would be the take-away message to any legislator or policy maker that has the power to create some kind of funding because the message is not coming across as we were expecting it to. It’s being lost in translation, with all of the emphasis being put on pregnancy. These kids are completely forgetting about STIs and HIV. So we need to get the message to them that it’s just as important to protect yourself from HIV as it is to protect yourself from pregnancy.”*

ADVOCATE

*“I asked my peer educators the year before last, ‘If you were having heterosexual sex and the condom broke, would you be more scared of pregnancy, or would you be more scared of HIV or STIs?’ And everybody said, ‘I’d be more scared of pregnancy.’”*

ADVOCATE

*“I think that any discussion about sexual reproductive health has to include HIV/AIDS and STDs or STIs. One of the phrases that our health educators use is that ‘If you can get pregnant, you can get an STI, including HIV.’ And a lot of young women, we have to explain to them why that is possible. And we’ve had a couple of women who found out that they were HIV positive after the birth of their children. They became pregnancy and HIV positive simultaneously.”*

ADVOCATE

### MISTIMED DELIVERY OF INFORMATION

Teachers, students, and advocates all agreed that sexuality education is being taught too late. Information needs to be delivered in a context that is age-appropriate and relevant to students’ needs.

*“There can be certain things that they do in 6th and 7th grade, and they kind of wait until 8th grade [to teach it].”*

HEALTH AND PHYSICAL EDUCATION TEACHER

*“In a perfect world, it should start in probably sixth grade, maybe younger. And there should be some component of sex education throughout schooling, especially in areas that have high rates of teen pregnancy, STIs, including HIV. The messaging should be consistent and constant.”*

ADVOCATE

*“My first sex education class was in 9th grade, and it wasn’t really helpful because most of my friends were sexually active.”*

HIGH SCHOOL SENIOR

*“[I recommend] giving sex education as soon as possible! Before, 6th grade.”*

HIGH SCHOOL SENIOR

### LIMITED RESOURCES

As part of the New York City AIDS Education Mandate, all high schools are required to have a Health Resource Room where students can obtain free condoms, health information, and health referrals.<sup>80</sup> Many of the students that participated in the interview project were unaware or unsure of where they could obtain free condoms or health information in their schools. The youth also identified the need for additional resources that are reliable and medically accurate, as many youth rely on Internet research or the advice of their peers.

*“I want to learn more about sex ed, I think it’s important because it’s a part of everyone’s life. Other kids want to know more too, but they’re unsure how to ask—and they’re afraid of being made uncomfortable by their friends for wanting to know, like if they ask for condoms their friends will think they’re having sex. Some of them get information from their friends—for example, my friends always ask me, because they know I’m in TORCH.”*

HIGH SCHOOL SENIOR

*“There are a lot of girls in my school who’re getting pregnant now. They should learn about how to use a condom properly, how to understand [that] sex is something that you have to take responsibility of—like something you have to own up to and be aware of what you’re doing. You don’t want to be in a situation where you’re confused of who to talk to and where to go. They should give you resources....”*

HIGH SCHOOL SENIOR

### INADEQUATE TRAINING

Teachers do not feel sufficiently trained to teach health and sexuality education classes. Limited resources and a lack of professional development opportunities prevent teachers from improving curriculum content and incorporating new activities into lessons.

*“Resource-wise there’s not too much—or at least, I haven’t been given too much. I mean, really it’s bare minimum, basic stuff. I went to a two-day professional development last year, and it was helpful in the fact that they gave us all the materials, but other than that it wasn’t really that great.”*

HEALTH AND PHYSICAL EDUCATION TEACHER

*“The training is not sufficient.”*

GUIDANCE COUNSELOR

*“[Schools] should also think about training their counselors too. Because counselors are oftentimes the people that some students would go to talk about whether they had a positive test result or some kind of interaction with HIV. And these counselors should be trained to give accurate information about HIV, as well as to refer appropriately.”*

ADVOCATE

*“Most of the teachers that teach health, that’s a new course to them— they’re just mostly physical education. [A good teacher is] someone who’s trained in speaking to adolescents, because they’ll know how to be – how to gain trust of the adolescents. You have to talk to teenagers in a certain way for them to respect you and for them to listen to you, and be even friendly to you—it’s a certain technique, and it takes training.”*

HIGH SCHOOL SENIOR

*“It needs to be culturally compete—teachers need to get real training on how to discuss this in a classroom where people are from 30 different countries, and everybody’s family has a different narrative about sex. There should be more professional development and support for teachers, [and] there should be stronger certification requirements.”*

ADVOCATE

### **INAPPROPRIATE CLASSROOM SETTING**

Responses from the youth surveys and interviews indicated the need for improvements in classroom environment and structure. Students identified the need for health education to be taught as a separate course by a health teacher.

*“ [Health class was] in the gym, sitting down—it was awkward...We didn’t have health [class]. We had gym. And one day of gym was HIV/AIDS.”*

HIGH SCHOOL SENIOR

*“I think that even being taught by your gym teacher or another teacher is kind of creepy because it doesn’t make the class seem as real and it could mess up a relationship with a teacher... I think it’s more effective if you have a teacher who’s the health teacher.”*

HIGH SCHOOL SOPHOMORE

### **CONCERNS ABOUT CONFIDENTIALITY**

The importance of students having access to staff with whom they can have open and/or anonymous discussions was evidenced in the findings. Students are more willing to share concerns and seek out staff support when they believe the discussion will be kept private and are clear on the school’s confidentiality policy.

*“If they had questions at any point, I just had them write it down on an index card [anonymously]. And at the end, I made my own PowerPoint, and I just picked like ten questions, and whatever the*

*question was we discussed it.”*

HEALTH AND PHYSICAL EDUCATION TEACHER

*“I think the kids kind of feel like they can’t trust teachers, but it’s because we’re mandatory reports, so if they say anything then we have to address it.”*

HEALTH AND ENGLISH TEACHER

*“ [Educators] have to build the trust of each person in the room in order to be able to present.”*

HIGH SCHOOL SENIOR

*“The teachers should work on creating a safe space and coming up with ground rules as a class. Establishing a number of rules that we developed together to make it a comfortable place for everyone to learn about it”*

HIGH SCHOOL SENIOR

*“ [Students are] afraid to learn about sex from their teachers, because there are parent/teacher meetings and they’re afraid their parents will find out what they learned, what they asked in class.”*

HIGH SCHOOL SENIOR

### **CRITICAL ROLE OF PARENTS AND PEERS**

The interviewed youth stated that their experiences as peer educators were hugely influential to the attitudes and behaviors of those around them, and advocated for continued investment in such programs. Along with peer education, parental involvement provides another complement to the sexuality education students receive at school. Incorporating youth programs and parents into school-based programs reinforces classroom-based sexuality education.

*“ [Being a peer educator] makes you more empowered to make healthy decisions, rather than not knowing and being confused about it.”*

HIGH SCHOOL SENIOR

*“I’m not going to speak for every peer education group, but at TORCH we believe in not telling you to do this or do that, we’re basically empowering you to make the right decisions, and guide you through making better choices, rather than telling you, ‘Oh, don’t have sex, don’t have sex.’ Some people do preach about that, rather than—us, we try to—we do our best to listen.”*

HIGH SCHOOL SENIOR

*“I think a really big piece of this too is the parent piece, and it must be part of every program and cannot be forgotten. Even if kids are learning about sex in school, if it’s not reinforced at home, it’s going to get very confusing. And many adults*

*don’t have a clue about their body, and relationships, and what a healthy relationship looks like, and what real communication is. And the reality is that if they had this growing up, to build a solid foundation to become sexually healthy adults, it wouldn’t be as big of an issue.”*

ADVOCATE

*“Parents must be proactive too. And talk to [their children] about it even they don’t want to be talked to. People who feel the way I do need to be really proactive and get on school boards. It’s all about communicating how we feel.”*

PARENT

## YOUTH VOICES SPEAK!

**What do you think would be the ideal sex education program for New York City schools?**



**“NOT ABSTINENCE.** A lot of important health information, as well as information about sex that could help out a lot—how to use a condom properly, contraception, STDs, pregnancy, and more.” — HIGH SCHOOL SENIOR

“It should include anatomy, sex and sexuality, sexual orientation, gender/biological sex, protection, contraception, STDs, and relationships. I think that sex ed encompasses a whole lot more than what people realize...everything from anatomy—which people assume we just understand, but we don’t... So everything from anatomy to abortion to healthy relationships. That’s all an aspect of it.”

— HIGH SCHOOL SOPHOMORE

“A program that covers the basics of pregnancy, contraception, abortions, and relationship problems. Then I would relate those with real issues and how politics play a role. At the end I would leave the class to discuss what a healthy relationship would be like.” — HIGH SCHOOL SOPHOMORE

“All-inclusive/raw facts. People need to know the specifics of HIV/AIDS and STDs. They also need to know about prevention and where they can go to get it.” — HIGH SCHOOL JUNIOR

“Contraception, STIs, consequences, relationships—basically, what we do at TORCH, because it goes beyond just talking about sex itself; we try to empower people to make the right decisions. We’re not—we’re not in the right shoes to say, ‘Don’t do that, don’t do this’—we’re there to say, oh, if you decide to do this, it’s best to be safe with what you do. Like, a health class that can help empower you, rather than sitting up there, say, well, ‘This STI means this and that, so you can copy that in your notebook,’ it has to be more like a discussion so students can learn and be engaged.” — HIGH SCHOOL SENIOR

# RECOMMENDATIONS

Based on stakeholder interviews, the National Institute for Reproductive Health and NARAL Pro-Choice New York Foundation recommend the following for improving sexuality education in New York City.

## ESTABLISH A UNIFORM AND CONSISTENT SEXUALITY EDUCATION PROGRAM; INCREASE ACCOUNTABILITY AND EVALUATION MEASURES TO ASSESS PROGRAM IMPACT

Cities across the country have taken action on the local level to introduce sexuality education policies. Cleveland, Chicago, and Washington, D.C., have all mandated and implemented curricula that emphasize age-appropriate and medically accurate information in grades K-12. These policies establish clear standards for local school districts and increase the commitment to combat poor health indicators among youth. A requirement in New York City would guarantee that students have the opportunity to learn vital information and hold schools accountable for securing programs and training teachers.

## EXPAND THE CURRENT CURRICULUM TO SUPPLEMENT LESSONS ON PREGNANCY AND STI/HIV PREVENTION

A comprehensive sexuality education program should educate youth on interventions that provide information and tools to make healthy sexual choices. In addition to educating youth on pregnancy and STI/HIV prevention, a comprehensive sexuality education program should include lessons that address the full range of information, feelings, values, and attitudes about sexual health, as well as develop personal and interpersonal



skills around communication, decision making, and critical thinking.<sup>81</sup>

## STRENGTHEN THE LINKAGE BETWEEN PREGNANCY AND STI/HIV PREVENTION

Approximately one third of sexually active youth in New York City reported not using condoms, which puts them at risk for STIs, HIV, and unplanned pregnancies.<sup>82</sup> When teaching the current curriculum, instruction should focus on reducing rates of both unplanned pregnancies and STIs by emphasizing the importance of using condoms in addition to other forms of contraception. Currently, this method of dual protection is uncommon in New York City, with only four percent of sexually active youth reporting condom use with another form of birth control.<sup>83</sup>

## IMPLEMENT SEXUALITY EDUCATION PROGRAMS BEFORE HIGH SCHOOL

In New York City, 41 percent of 9th graders and 58 percent of 12th graders reported engaging in sexual behavior.<sup>84</sup> Additionally, about one in ten (11%) have had sex before age 13 years.<sup>85</sup> Sexuality education programs are most effective when they start before young people reach puberty, and before established patterns of behavior are developed.<sup>86</sup> Receiving sex education before sexual debut protects youth from engaging in sexual intercourse at an early age and increases use of contraception.<sup>87</sup> With nearly half (48%) of the City's youth reporting that they have had sex, it is imperative that sexuality education programs deliver information that is age-appropriate and sequenced through all grades.<sup>88</sup>

## INCREASE AWARENESS OF AND RESOURCES FOR HEALTH RESOURCE ROOMS AND THE CONDOM AVAILABILITY PROGRAM

New York City's HIV/AIDS Education Mandate requires all public high schools to create a Health Resource Room with health information, referrals, and condoms for students who request them. The requirement is limited to grades 9–12 and requires one female and one male volunteer to staff the room during the day for at least ten periods each week. It is critical for students to know that Health Resource Rooms are an available resource with a range of services accessible during the school day.

## IMPROVE TEACHER TRAINING TEACHER TO INCREASE KNOWLEDGE OF AND COMFORT WITH SEXUAL HEALTH ISSUES AND PROGRAM CURRICULA

As the Bronx pilot process evaluation illustrated, teacher knowledge and confidence was significantly impacted by professional development and ongoing support and technical assistance.<sup>89</sup> Training programs should include updated, comprehensive resources for educators to bring back to the classroom, along with interactive discussions on subjects

often overlooked, such as cultural and LGBTQ competency.

## OFFER HEALTH AS A SEPARATE COURSE WITH DEDICATED HEALTH TEACHERS

The Bronx pilot process evaluation found that of 11 participating teachers, some had been science teachers or physical education teachers, but only one had taught sex education. In addition to proper training, health and sexuality education should be taught by a dedicated teacher in a separate class.

## ESTABLISH STRONG AND CLEAR CONFIDENTIALITY POLICIES FOR TEACHERS AND SCHOOL SUPPORT STAFF

In order for instruction to be most successful, youth need to feel safe and comfortable with an educator or other staff person.<sup>90</sup> Confidentiality is a critical element for educators to consider when developing and maintaining trusting relationships with students.<sup>91</sup>

## INCLUDE PEER EDUCATION AND PARENT INVOLVEMENT PROGRAMS AS PART OF CSE

While school-based programs offer the best method for ensuring that a majority of students receive comprehensive information, an ideal CSE program includes a peer education and parental involvement component. Peer education programs build on the trust young people have with their peers and train youth with medically accurate information that is then spread across a wide network of peers.<sup>92</sup>

Additionally, although parent-child communication has been proven to positively impact youth behaviors, many parents still do not initiate conversations about sexual health with their children.<sup>93</sup> In order for youth to be fully informed about their sexual health, it is imperative that students receive support and reinforcement from a variety of sources.

# APPENDIX

## YOUTH QUESTIONS

- Q1** Describe the health education you had in MIDDLE SCHOOL. Do you remember if the *HealthSmart* curriculum was used?
- Q2** Describe the sex education lessons you had in MIDDLE SCHOOL. If you had sex education, which topics were covered (pregnancy and STI prevention, contraception, abstinence, healthy relationships, etc.)?
- Q3** Describe the health education you had in HIGH SCHOOL. Do you remember if the *Reducing the Risk* curriculum was used?
- Q4** Describe the sex education lessons you had in HIGH SCHOOL. If you had sex education, which topics were covered (pregnancy and STI prevention, contraception, abstinence, healthy relationships, etc.)?
- Q5** Have you ever had an outside organization come in and teach at your school or an assembly on sex education? If so, which organization?
- Q6** Does your school have a Health Resource Room? If so, do you know anyone who has ever obtained condoms from it?
- Q7** Does your school offer on-site primary care through a School-Based Health Center? If so, does it provide contraception?
- Q8** Do you feel you learned what you needed to know about sex education in the classes you had at school? Why or why not?
- Q9** What do you think would be the ideal sex education program for New York City schools?

The following schools were represented: Bard High School Early College, Boys and Girls High School, The Bronx High School of Science, Bronx Center for Science and Math, Brooklyn Technical High School, Bushwick School for Social Justice, High School for Civil Rights, East New York Family Academy, High School for Health Professions and Human Services, Hillcrest High School, Hostos Lincoln Academy, The International High School, Manhattan Hunter Science High School, Martin Luther King Jr. High School, Talent Unlimited High School, Townsend Harris High School, Urban Academy, and Validus Preparatory Academy.

## ADVOCATE QUESTIONS

- Q1** Describe the current status of sexuality education in New York City.
- Q2** Do you feel this is sufficient? What would you like to see changed?
- Q3** What are the barriers to implementation?
- Q4** What do you believe middle school and high school students should know before graduating?
- Q5** What would your ideal sexuality education curriculum look like?

## TEACHER QUESTIONS

- Q1** Is health education or sexuality education required in your school?
- Q2** What health or sexuality education curriculum do you use? Do you use *HealthSmart* or Reducing the Risk?
- Q3** Do you feel you were given enough training in the curriculum content?
- Q4** Can you identify any gaps in the curriculum? What subjects do you wish you or your students had more information on?
- Q5** What topics do you cover in your class? Do you teach the required HIV/AIDS lessons in health class? If not, what classes are those lessons taught in?
- Q6** In what grade is the health course taught? How is the course structured?
- Q7** Do you think what you cover is sufficient? Have you received any feedback from students on the curriculum?
- Q8** Do you bring guest speakers into your class? If so, who?
- Q9** What do you believe middle school and high school students should know before graduating?
- Q10** Is there a health resource room in your school? Can students access condoms in your school?
- Q11** If you could design your own sex education program, what would it look like?

## PARENT QUESTIONS

- Q1** Did you have to sign a permission slip prior to the start of the sexual health unit?
- Q2** Describe the health education your son/daughter had in middle school and/or high school. If your son/daughter had sexuality education, which topics were covered (pregnancy and STI prevention, contraception, abstinence, healthy relationships, etc.)?
- Q3** Do you feel the current curriculum is sufficient? What would you like to see changed?
- Q4** What would your ideal sexuality education curriculum look like? What do you believe middle school and high school students should know before graduating?

## ELECTED OFFICIAL QUESTIONS

- Q1** Describe the current status of sexuality education in New York City.
- Q2** Do you feel this is sufficient? What would you like to see changed?
- Q3** What are the barriers to implementation?
- Q4** What do you see as the next steps for sexuality education in New York City?

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