

# EVALUATION OF RESPONSIBLE SEXUAL BEHAVIOR EDUCATION

*In the Cleveland Metropolitan School District*

Philliber Research Associates



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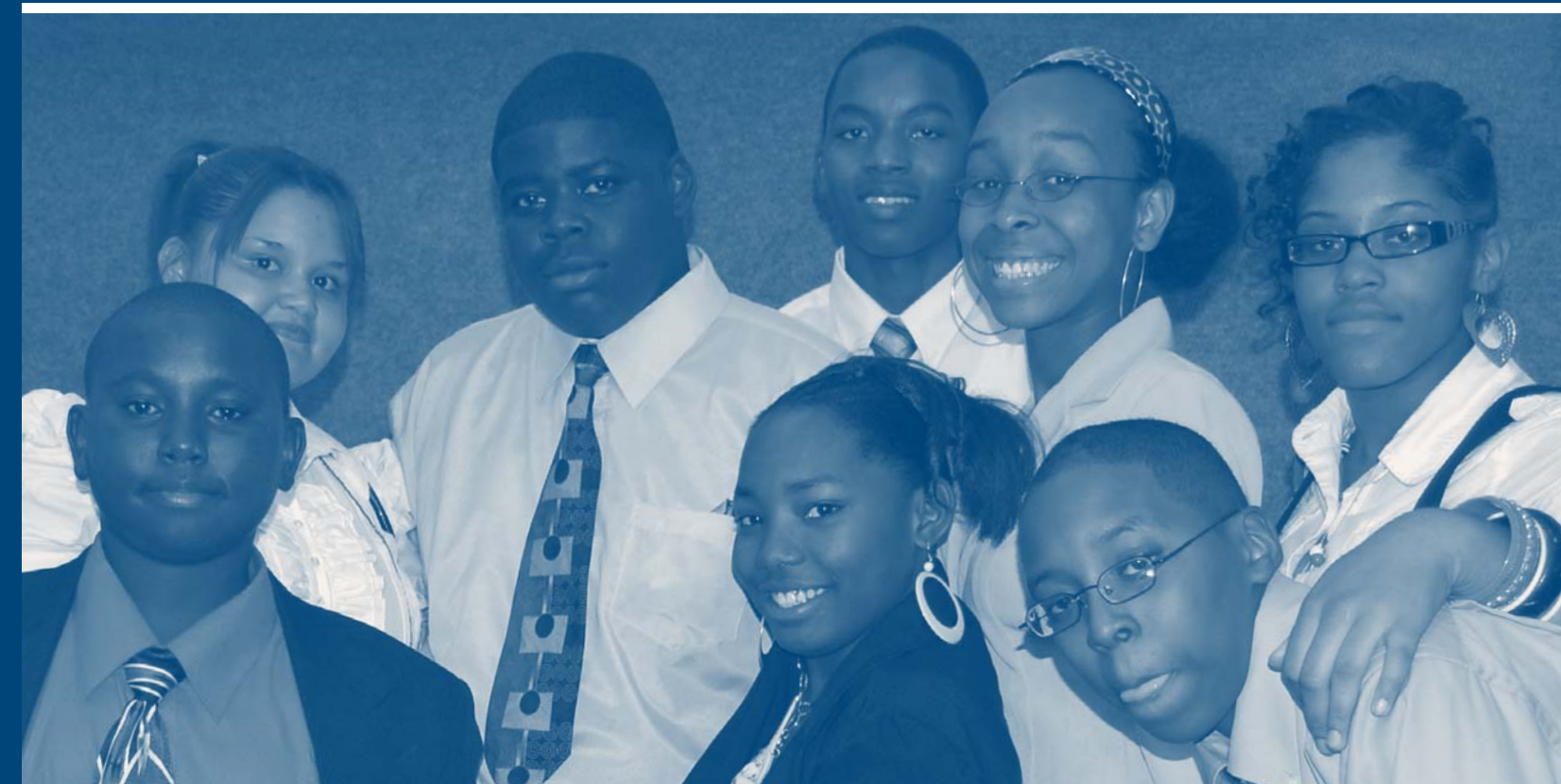
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This evaluation was funded and coordinated by the AIDS Funding Collaborative (AFC) in Cleveland in partnership with numerous community stakeholders.

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**Planned Parenthood of Northeast Ohio** – Kelly Faciana



This local stakeholders team provided critical guidance in the development of the evaluation plan, including survey instruments, and also worked with evaluators from Philliber Research Associates to facilitate implementation of the evaluation throughout the school year.

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**The Responsible Sexual Behavior Initiative**, which was implemented in the Cleveland Metropolitan School District (CMSD) beginning in the Fall of 2006, aims to provide comprehensive sexuality education to all students from kindergarten through twelfth grade within the school district. Four evidence-based curricula were chosen specifically for this initiative. During the 2007–2008 school year, modified versions of these curricula were implemented by facilitators from six contracted agencies and 11 trained CMSD health and physical education (PE) teachers. The four curricula are:

- **All About Life** (for grades K-3)
- **F.L.A.S.H.** (for grades 4-6)
- **Making Proud Choices** (for grades 7-8)
- **Safer Choices** (for grades 9-12)

**The AIDS Funding Collaborative (AFC)** contracted with **Philliber Research Associates (PRA)** in November 2007 to conduct the 2007-2008 (Year 2) evaluation. The evaluation plan included both quantitative and qualitative methods and, in addition to measuring student outcomes (i.e., changes in knowledge, attitudes, skills and behavioral intent), focused on implementation processes and progress and stakeholder support.

### Student Outcomes

To assess student outcomes related to delivery of the curricula (the intervention) PRA drew a random sample of schools (from those that had not yet been touched by the initiative) to participate in the evaluation. Eleven elementary schools and ten high schools were included in the final sample. PRA, AFC, and CMSD staff agreed not to collect data from kindergarten students due to concerns about comprehension and response reliability. For similar reasons, facilitators of *All About Life* were instructed to ask students in their first through third grade classes a single question at the conclusion of the intervention: “What have you learned in these classes?” No additional data were collected from these students. Students in grades four through twelve served as their own comparison group. Students were tested three times (with pre-tests at time 1 and time 2 and a post-test at time 3). Students received no intervention between the administrations of the two pre-tests. Students who completed both

pre-tests were used as the comparison sample while students who completed the second pre-test and the post-test comprised the intervention group. PRA used demographic data that participants provided on the surveys to create unique identifiers so that participants’ surveys could be matched to one another.

Outcome highlights include the following:

- The intervention groups for grades 4 through 12 showed significant increases in knowledge scores at post-test. Further, in each case the change in the intervention group was significantly higher than any change demonstrated in the comparison group.
- High school students demonstrated a statistically significant shift in their scores on items assessing attitudes about condoms, pregnancy and abstinence. These scores moved in the desired direction and the change was significantly higher than that experienced by high school students in the comparison group.

- Fourth grade students, fifth grade students and high school students in the intervention group had increased post-test scores for questions related to skills such as saying no, talking to their parents about sex and, for the high school students, condom negotiation. The change for high school students in the intervention group was statistically significant; however the change was not statistically higher than change experienced by the comparison group.
- Behavioral intent scores for all of the intervention group students moved in the desired direction. The change for high school students was statistically significant.

Moreover, students at all grade levels indicated enthusiastic support for the initiative:

- 78% of all students indicated that they learned a lot from the sexuality education sessions;
- 89% of the high school students rated the *Safer Choices* program as being very helpful; and,
- 93% of high school students would recommend *Safer Choices* to their peers.

At this early stage of implementation it is not anticipated that exposure to the curricula will result in significant behavior change among youth. However, the evaluation plan includes monitoring trend data collected through the District’s biennial participation in the Center for Disease Control and Prevention’s Youth Risk Behavior Survey (YRBS) over time to detect changes in relevant aspects of students’ reported behavior.

### Fidelity to Curriculum Implementation

Three methods were used to measure fidelity to the initiative protocol for curriculum delivery: observation forms completed by PRA and Cuyahoga County Board of Health (CCBH) staff, facilitator reflection forms completed by external facilitators and trained CMSD health and PE teachers who implemented the curricula, and surveys completed by classroom teachers. Overall, observers gave high marks to facilitators’ delivery of the curriculum. Students appeared to be

engaged as evidenced by their asking questions, participating in discussions and seeming to understand the topics. More than a quarter of the facilitators made some modifications to the curricula. The most notable barrier to delivery of the curriculum was that during approximately one third of the observations, facilitators spent more than a few minutes during each class period managing disruptive behavior. Both classroom teachers as well as the facilitators themselves rated the curriculum delivery favorably.

CMSD health and PE teachers who implemented the curricula were asked a series of questions about their training and their experiences delivering the curricula. Overall average scores indicated the teachers thought the training that they received prior to implementing the curricula was good. The highest ratings were given to the clarity of training objectives and organization of the presentation. The lowest ratings were given for the adequacy of time to cover curriculum material, opportunity to practice delivering curriculum material and overall level of preparedness to implement the curriculum. In general, trained CMSD health and PE teachers felt they were able to present various topics related to sexuality education including male and female reproductive anatomy, pregnancy and HIV/STD prevention, puberty, decision-making and gender roles. They were least sure of their ability to teach students about resources in the community and to discuss sexual orientation. In terms of comfort level in addressing various aspects of the curricula, trained CMSD health and PE teachers indicated moderate to high levels of comfort discussing topics such as HIV/STD transmission, delaying sex, puberty, male and female reproductive anatomy, sexual abuse and dating. Condom use, sexual intercourse and homosexuality were among the topics teachers felt least comfortable discussing. Finally, most CMSD trained health and PE teachers agreed that sexuality education should continue to be presented in the classroom, that the benefits outweigh the burden of interrupting class time, and that they feel comfortable presenting sexuality education in the classroom.

## EXECUTIVE SUMMARY

### Progress Toward Implementation of the Initiative

During the 2007-2008 school year, 41,442 students were assigned to receive the curricula. A total of 26,326 of these assigned CMSD students in grades K-12 actually received programming during the 2007-2008 school year<sup>1</sup>. This represents 64% of the students targeted by the initiative in Year 2. Barriers to curriculum delivery included lower than anticipated involvement of previously trained teachers, late funding and subsequent execution of contracts with external agencies, scheduling conflicts, and late start-up of the evaluation process which resulted, in some cases, in delay of curriculum delivery.

### Stakeholder Support

There appears to be strong support for the intervention among a broad range of stakeholders including local government officials, top level CMSD administrators and staff, Board members and parents. More could be done to keep various constituent groups abreast of the initiative. For instance, key stakeholders identified lack of sustained external communication about the initiative as a potential challenge to ongoing support among school board members, school administrators (e.g., principals) and the general public. In addition, although most parents were in agreement that it is important for schools to be involved in sexuality education, they also indicated that there were some gaps in their knowledge regarding the specifics of the Responsible Sexual Behavior initiative.

### Recommendations

Recommendations for improvement of the initiative were derived from a number of sources including focus groups with facilitators, CCBH and CMSD staff, and CMSD teachers. They deal with logistics, teacher training, curriculum content and delivery, and

evaluation considerations. These recommendations are offered as an aid to planning and preparation for future implementation of the initiative.

- Allow external agency facilitators and CMSD health and PE teachers to conduct their own scheduling.
- Begin curriculum delivery earlier in the school year.
- Work for increased communication to principals and teachers to get buy-in and encourage teacher cooperation.
- Allow facilitators/teachers more time to deliver the curricula.
- Provide more structured training for delivery of curriculum.
- Provide specific training about how to deal with sensitive topics.
- Consider adopting more culturally appropriate curricula or replace existing videos and scenarios with more relevant materials.
- Update/revise curricula to include more interactive material and more current topics such as cyber relationships and relational power dynamics.
- Place additional emphasis on components of the curricula that address attitudes/beliefs and skills.
- Continue to monitor the impact of using a modified version of the curricula.
- Explore health and PE teachers' concerns about the plan for sole reliance on internal facilitators.
- Begin the evaluation earlier in the school year.
- Incorporate the evaluation process into teacher training.

## INTRODUCTION

Reviews of the literature about effective strategies for reducing teen pregnancy and risky sexual behaviors have consistently shown that the most effective interventions take a comprehensive approach to teen pregnancy prevention meaning that they include information about both abstinence and contraception (Advocates for Youth, 2003; Kirby, 2007). Effective comprehensive teen sex education programs have been shown through rigorous research and/or evaluation to increase the age at first sexual experience, reduce the overall number of sexual partners reported by teens, increase contraceptive use, reduce the frequency of sex, and reduce the incidence of unprotected sex (Kirby, 2007). It is of note that there is much less rigorous research available about abstinence only approaches than is available about comprehensive strategies. However, the research that exists regarding abstinence only approaches suggests that overall they do not delay the initiation of sex, increase the likelihood that sexually active teens will stop having sex, or reduce the number of sexual partners reported by teens (Kirby, Laris & Rolleri, 2006; Kirby, 2007). Indeed, a recent evaluation of four abstinence only interventions which had been identified by experts as being “promising” utilized an experimental design to determine their impacts on teen sexual behavior. The results indicated that participants that received the abstinence only interventions were not significantly different from participants in the control group with respect to abstinence or sexual activity (Trenholm et. al, 2008).

In 2002, the Cleveland Metropolitan School District (CMSD) adopted a Comprehensive Health Plan based on two national models – the Surgeon General’s Healthy People 2010 and the Centers for Disease Control and Prevention’s (CDC) Comprehensive School Health Program. Developed with broad community support and involvement, the plan was intended to “improve the health and well-being of the District’s students, families, and staff” (CMSD, 2006). It includes four goals focused on responsible sexual behavior among students:

1. Prevention of school-age parenthood;
2. Support for pregnant and parenting school-age students;
3. Prevention of the transmission of STDs, including HIV/AIDS, to students; and
4. Support for students living with STDs, including HIV/AIDS.



<sup>1</sup> Revised 2007-08 enrollment numbers for the District indicate that there were a total of 48,514 students enrolled in grades K through 12.

## INTRODUCTION

In concert with these goals, in 2002 sexuality education under the CCBH Teen Wellness Initiative, supported by the Cuyahoga County Family and Children First Council (FCFC) funding began in 7th and 8th grades in CMSD. In 2006, the CCBH Teen Wellness Initiative received additional funds through the Cuyahoga County Temporary Assistance to Needy Families (TANF) funding which allowed for programming to expand significantly as CMSD embarked on a mission to provide comprehensive sexuality education to all students in the District. In 2006-2007, the first year of the K-12 Responsible Sexual Behavior (RSB) initiative, using a combination of internal CMSD-employed health services liaisons and educators from six community partner agencies, modified versions of four age-appropriate comprehensive sexuality education curricula<sup>2</sup> were delivered to approximately 36,500 students in grades kindergarten through 12 in CMSD schools. That same year, intensive training was also initiated with a group of 14 physical education and health teachers to enable them to teach the curricula in their respective schools. An independent evaluation of the initiative's first year revealed that students in kindergarten through eighth grades showed statistically significant improvement in knowledge based on analysis of pre- and post-intervention surveys. High school students demonstrated an overall improvement in knowledge. However, changes from pre- to post-assessment among high school students were not statistically significant.

During the current school year (2007-2008) funding for the initiative fell from \$1.3 million from Cuyahoga County TANF in 2006-2007 to a total of \$790,000 from TANF and private funders in 2007-2008. As a result, the plan for curriculum delivery shifted to educators from contracted agencies (external facilitators), and the 14 physical education and health teachers trained in the spring of 2007 (internal facilitators) who were expected to present the curricula in each of

their respective schools. The initiative had an original internal goal of reaching at least 85% of the 48,514<sup>3</sup> students in the District's 85 elementary and 22 high schools. However, because of a delay in securing all of the funding, the target number of students to be reached in Year 2 of the initiative was reduced by approximately 15% such that 41,442 students were scheduled to be reached in Year 2 of the initiative.

In November of 2007, Philliber Research Associates (PRA) was hired by the AIDS Funding Collaborative (AFC) to conduct the evaluation of the second year of this comprehensive sexuality education initiative. The goal of the Year 2 evaluation was to move beyond assessment of knowledge change among students by determining whether students experience a change in attitudes, behavioral intent, and/or refusal/negotiation skills. In addition, the process of policy change vis-à-vis sexuality education in the District was to be monitored over time. The evaluation plan includes both process (i.e., monitoring the level of fidelity to the curriculum content and planned program delivery) and outcome strategies.

This end-of-year report on the implementation and outcomes of CMSD's Responsible Sexual Behavior (RSB) initiative presents pre- and post-test data collected from students in ten of the eleven elementary and nine of the ten high schools that are part of the random sample of schools drawn for the evaluation. (Data collection was not completed at two of the sampled schools.) Comparison data were also collected from a group of RSB students at the schools randomly selected to participate in the evaluation prior to the implementation of the intervention.

In addition to student outcomes, this report also presents information about the implementation of the initiative, progress related to internal capacity, and buy-in from stakeholders.

## METHODOLOGY

At the time PRA was hired, 25 out of the 85 elementary schools and 12 of the 22 high schools had either already received the curricula or were scheduled to receive the curriculum in the next six weeks. CMSD, AFC, and Cuyahoga County Board of Health (CCBH) agreed to suspend curriculum delivery in the remaining schools in order to allow PRA time to finalize the evaluation plan and draw a random sample of schools from those that had not yet been touched by the intervention. Once the plan was finalized and approval was received by AFC, CMSD and an Independent Review Board, PRA randomly selected eleven elementary and ten high schools to participate in the evaluation.



Once a randomly selected school was scheduled to receive the curricula, opt out consent forms were sent home to parents with instructions to return them to the school if they did not want their children to participate in the curricula and/or the evaluation. Several days after consent forms were sent home and, in most cases, one or more weeks before the curricula were scheduled to be delivered, PRA staff visited the classrooms. During this visit, PRA staff explained the nature of the evaluation, asked students to sign an assent form if they were willing to participate in the evaluation, and distributed a baseline pre-test to students. Students took another pre-test on the first day of curriculum delivery as well as a post-test on the

final day of curriculum delivery. PRA used demographic information provided by the students on each of the surveys (e.g., initials, date of birth, and school) to create unique identifiers which allowed research staff to match students' surveys. This modified interrupted time series design<sup>4</sup>, wherein students were tested three times, was chosen so that evaluators could compare any post-intervention change to change that occurred between the two pre-tests (e.g., change that occurred without having any intervention). On average, one week elapsed between the initial and second pre-tests and approximately five days occurred between the second pre-test and the post-test.

PRA, AFC, CCBH and CMSD agreed that no student level data were to be collected from kindergarten students who may not have the capacity to accurately and consistently respond to the evaluation questions. This was based, in part, on AFC, CMSD, and CCBH's experience collecting data from students in grades K-3 during the 2006-2007 school year. Similarly, students in first through third grade were considered too young to reliably respond to written surveys. Therefore, on the last day of delivery of the *All About Life* curriculum, facilitators were instructed to verbally ask students one question, "What have you learned in these classes?" and record the students' responses.

Throughout this report asterisks (\*) indicate whether or not a difference or change is statistically significant. Tests of significance examine whether any given difference between groups is large enough that it is likely to be due to something other than chance. The reader should also know that statistical significance is affected by sample size. In very small samples, like some of the samples in this report, differences must be very large to be statistically significant, whereas in very large samples, small differences can be statistically significant, even if they are not practically very important.

<sup>2</sup> The four evidence-based curricula chosen for the initiative are *All About Life* (grades K-3), *F.L.A.S.H.* (grades 4-6), *Making Proud Choices* (grades 7-8), and *Safer Choices* (grades 9-12).

<sup>3</sup> This number reflects revised enrollment figures for the District.

<sup>4</sup> This is a quasi-experimental research design in which a single group of subjects are administered a sequence of baseline measurements followed by an intervention and then post-intervention measurements.

# STUDENT OUTCOMES



PRA developed surveys which were completed by students in the intervention and comparison groups that asked knowledge, attitude, behavioral intent and skill questions related to the content of each curriculum. The table below summarizes the themes covered in each area.

(See Appendix A for a copy of each of the surveys.)

**Table 1. Overview of Survey Themes by Curriculum**

Curriculum	Knowledge	Attitudes	Behavioral Intent	Skill
<b>F.L.A.S.H.</b>	<ul style="list-style-type: none"> <li>• Puberty</li> <li>• Good touch/bad touch</li> <li>• Decision-making</li> <li>• HIV</li> <li>• Safer sex</li> </ul>	<ul style="list-style-type: none"> <li>• Sex in the media</li> </ul>	<ul style="list-style-type: none"> <li>• Delaying sex</li> </ul>	<ul style="list-style-type: none"> <li>• Saying no</li> <li>• Talking to parents about sex</li> <li>• Decision-making</li> </ul>
<b>Making Proud Choices</b>	<ul style="list-style-type: none"> <li>• Peer pressure</li> <li>• Abstinence</li> <li>• HIV</li> <li>• Reproductive health</li> <li>• Sexual abuse</li> <li>• Community resources</li> </ul>	<ul style="list-style-type: none"> <li>• Sex in the media</li> <li>• Reasons to have a baby</li> </ul>	<ul style="list-style-type: none"> <li>• Delaying sex</li> </ul>	<ul style="list-style-type: none"> <li>• Saying no</li> <li>• Talking to parents about sex</li> </ul>
<b>Safer Choices</b>	<ul style="list-style-type: none"> <li>• HIV/STDs</li> <li>• Condom use</li> <li>• Safer sex</li> <li>• Community resources</li> </ul>	<ul style="list-style-type: none"> <li>• Attitudes about condoms</li> <li>• Attitudes about pregnancy</li> </ul>	<ul style="list-style-type: none"> <li>• Sexual refusal</li> <li>• Intent to use condoms</li> </ul>	<ul style="list-style-type: none"> <li>• Condom negotiation</li> </ul>

Fourth through twelfth grade students attending schools in the sample were surveyed three times. The first two administrations of the survey occurred prior to the students receiving the intervention. Those students with matching surveys at time 1 and time 2 make up the comparison group. The final administration of the survey occurred at the conclusion of the intervention. Those students with matching surveys at time 2 and time 3 make up the intervention group.

As part of the analyses, PRA determined the average percentage of desirable (e.g. correct) responses given at pre- and post-test by students in the intervention and comparison groups for each curricula. PRA then used t-tests to determine whether the change that occurred between pre- and post-test for the intervention group was significantly higher than the change that occurred between pre- and post-test for the comparison group.

## Student Demographics

Table 2 presents demographic characteristics of students comprising the study's comparison and intervention groups. The comparison group consisted of 1,751 students in grades four through 12; there were 1,430 fourth through 12th grade students in the intervention group. Average age and grade level were identical for both groups: the average age was 14.6 years and just over half (55%) were in grades nine through 12. Just over half of the comparison group (53%) and intervention group (55%) were female. Sixty-one percent of students in both groups were Black. These data are also consistent with overall characteristics of the CMSD student body.

**Table 2. Demographic Characteristics of Students**

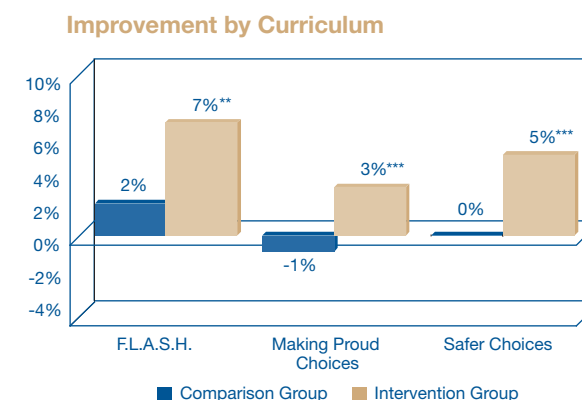
	Comparison Group (N=1,751)	Intervention Group (N=1,430)
<b>Average Age</b>	14.6 years	14.6 years
<b>Grade</b>		
4th	9%	10%
5th	9%	9%
6th	7%	6%
7th – 8th	20%	20%
9th – 12th	55%	55%
<b>Gender</b>		
Male	47%	45%
Female	53%	55%
<b>Ethnicity</b>		
Black	61%	61%
Hispanic	18%	19%
Multiracial	11%	10%
White	8%	8%
Other	2%	2%

## Overall Change

Table 3 below presents a summary of the overall changes in student knowledge, attitudes, skills and behavioral intent across the three curricula included in the outcome assessment. The table contrasts the percentage of correct (or most desirable) responses achieved for comparison and intervention groups for each curriculum<sup>5</sup>. Although a slight improvement in correct responses was observed within the comparison group for the *F.L.A.S.H.* curriculum, it was not as great as changes within the intervention group. In fact, for all three curricula, the changes in correct responses were significantly higher for the intervention group.

**Table 3. Percent Correct by Condition and Curriculum**

Curriculum	Comparison Group				Intervention Group			
	N	Pre-test	Post-test	Change	N	Pre-test	Post-test	Change
<b>F.L.A.S.H.</b>	429	63%	65%	+2%	365	64%	71%***	+7% <sup>6</sup>
<b>Making Proud Choices</b>	353	71%	70%	-1%	283	70%	73%**	+3% <sup>7</sup>
<b>Safer Choices</b>	969	79%	79%	0%	782	80%	85%***	+5% <sup>7</sup>



<sup>5</sup> It is of note that in this design, students who completed both pre-tests make up the comparison group. The second pre-test serves as their post-test. Students who completed the second pre-test and the post-test serve as the intervention group.

\*\* Difference between pre- and post-test is statistically significant at  $p < .01$ .

\*\*\* Difference between pre- and post-test is statistically significant at  $p < .001$ .

<sup>6</sup> Difference between comparison and intervention groups is statistically significant at  $p < .01$ .

<sup>7</sup> Difference between comparison and intervention groups is statistically significant at  $p < .001$ .

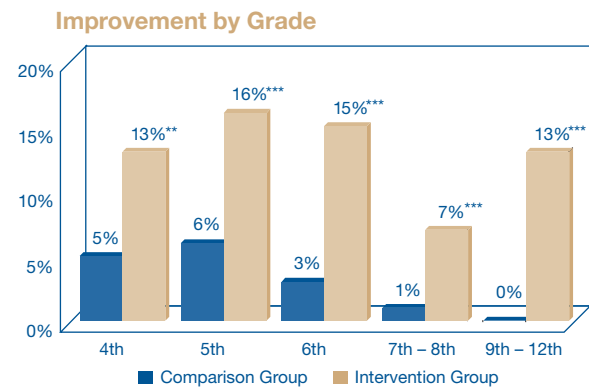


## Change in Knowledge

Students were asked a series of six to ten knowledge questions tailored to each curriculum and designed to assess students' understanding of the key concepts covered in the curricula (e.g., puberty, safety, decision-making, STDs, HIV/AIDS, safer sex). Students in both comparison and intervention groups in grades four and five showed knowledge increases that were statistically significant. However, the knowledge gains for the intervention group were significantly higher than the gains for the comparison group. Comparison group students in grades six through twelve showed either no or small (but not significant) gains in knowledge, while the students in the intervention group in grades six through twelve showed significant knowledge gains (*see Table 4 below*). Knowledge changes among males and females were similar (*not shown*). See Appendix B for an item analysis that details how comparison and intervention students in each grade performed on each knowledge item.

**Table 4. Knowledge Change by Condition and Grade Level**

Grade	Comparison Group				Intervention Group			
	N	Pre-test	Post-test	Change	N	Pre-test	Post-test	Change
4th	152	60%	65%**	+5%	138	65%	78%***	+13% <sup>8</sup>
5th	156	54%	60%**	+6%	136	62%	78%***	+16% <sup>9</sup>
6th	121	66%	69%	+3%	91	67%	82%***	+15% <sup>9</sup>
7th – 8th	353	64%	65%	+1%	283	65%	72%***	+7% <sup>9,10</sup>
9th – 12th	969	74%	74%	0%	782	74%	87%***	+13% <sup>9,11</sup>



\*\* Difference between pre- and post-test is statistically significant at  $p < .01$ .

\*\*\* Difference between pre- and post-test is statistically significant at  $p < .001$ .

<sup>8</sup> Difference between comparison and intervention groups is statistically significant at  $p < .01$ .

<sup>9</sup> Difference between comparison and intervention groups is statistically significant at  $p < .001$ .

<sup>10</sup> There was a significant difference by grade with 7th graders having a higher change score than 8th graders.

<sup>11</sup> There was a significant difference among grades with 9th graders having the greatest change and 11th graders exhibiting the least change.

A separate analysis was conducted for surveys completed by students attending sessions taught by CMSD health and PE teachers<sup>12</sup>. That analysis, presented in Table 5 below, shows that the comparison group in the CMSD-taught sample experienced a slight decline in knowledge but the intervention group showed a statistically significant increase in knowledge scores. Due to the small number of surveys collected from students taught by CMSD teachers, an analysis by grade is impossible.

**Table 5. Knowledge Change Among CMSD-Taught Students by Condition**

	Comparison Group				Intervention Group			
	N	Pre-test	Post-test	Change	N	Pre-test	Post-test	Change
Safer Choices	44	78%	77%	-1%	32	76%	85%**	+9% <sup>13</sup>

Within some of the grade levels, there were items that 50% or fewer of students in the intervention group answered correctly at post-test. This suggests that students need more instruction than has been provided thus far through the intervention. These items are listed by grade level below.

**Grade 4:** Most people who abuse kids are strangers (41% answered false at post-test).

**Grades 7 & 8:** More than half of the kids my age have had sex (9% answered false at post-test).

## Change in Attitudes

Surveys for sixth through twelfth grade students included questions that measured attitudes about topics such as responsible sexual behavior and condom use. The scores on items measuring attitudes among comparison group students in sixth grade and intervention group students in grades seven through twelve moved in the desired direction. The shift for ninth through twelfth grade intervention group students was statistically significant. Intervention group students in grade six showed a slight (but not significant) negative shift in attitudes. Among high school students the difference between the intervention and comparison groups was statistically significant.

**Table 6. Changes in Attitudes by Condition and Grade Level**

Grade	Comparison Group				Intervention Group			
	N	Pre-test	Post-test	Change	N	Pre-test	Post-test	Change
6th	121	72%	81%	+9%	91	81%	80%	-1%
7th – 8th	353	85%	85%	0%	283	84%	87%**	+3%
9th – 12th	969	82%	82%	0%	782	83%	85%***	+2% <sup>14,15</sup>

<sup>12</sup> The random sample of schools included three elementary and one high school in which curricula were delivered by trained CMSD teachers. Survey data were submitted by only one of these four sites.

\*\* Difference between pre- and post-test is statistically significant at  $p < .01$ .

<sup>13</sup> Difference between comparison and intervention groups is statistically significant at  $p < .01$ .

\*\*\* Difference between pre- and post-test is statistically significant at  $p < .001$ .

<sup>14</sup> There was a significant difference by grade with 10th graders having the greatest change and 9th graders having the least change.

<sup>15</sup> Difference between comparison and intervention groups is statistically significant at  $p < .001$ .



## Change in Skills

Students were asked to assess their skills related to responsible sexual behavior using survey questions about decision-making, saying no to sex and condom use negotiation. The survey questions were age-appropriate and varied by both grade level and the content of the curricula the students were taught. The scores of both comparison and intervention group students in fifth grade as well as ninth through twelfth grades on items measuring skills moved in the desired direction. Comparison group students in grades four, seven and eight showed small (but not significant) downward shifts in the students' skills assessments suggesting that over time, these students had less confidence in their abilities to talk to their parents about sex and say "no" to someone with whom they did not want to have sex. In contrast, fourth, fifth, and ninth through twelfth grade students in the intervention group, showed positive change in skill scores. The shift for ninth through twelfth grade students who received the intervention was statistically significant. Sixth graders alone showed more positive improvement in the comparison group than in the intervention group (see Table 7 below). Across all grade levels there were no observed gender differences in the intervention groups.

**Table 7. Changes in Skills by Condition and Grade Level**

Grade	Comparison Group				Intervention Group			
	N	Pre-test	Post-test	Change	N	Pre-test	Post-test	Change
4th	152	42%	34%	-8%	138	36%	37%	+1%
5th	156	77%	78%	+1%	136	78%	79%	+1%
6th	121	73%	82%***	+9% <sup>16</sup>	91	81%	81%	0% <sup>17</sup>
7th – 8th	353	77%	76%	-1%	283	77%	77%	0%
9th – 12th	969	88%	89%	+1%	782	89%	92%**	+3%

At post-test, many fourth grade students in the intervention group indicated that they still had difficulty with the one skill that they were asked about: only 37% of these students indicated that it would *not* be too difficult for them to ask their parent(s)/guardian(s) a question about sex.

## Change in Behavioral Intent

Items used to assess behavioral intent among fifth through twelfth graders included questions about delaying or refusing sex and intent to use condoms. The survey questions were age-appropriate and varied by both grade and the content of the curricula the students were taught. The behavioral intent scores for fifth grade students in both comparison and intervention groups moved in the desired direction. Comparison group scores among students in grades six through eight showed small (but not significant) downward shifts. However, among fifth through twelfth grade students who received the intervention, behavioral intent scores moved in the desired direction. The shift for ninth through twelfth grade students in the intervention group was statistically significant. The difference in change scores for sixth through twelfth grade comparison and intervention groups was statistically significant (see Table 8 on next page). No gender differences were detected within the intervention groups.

\*\* Difference between pre- and post-test is statistically significant at  $p < .01$ .

\*\*\* Difference between pre- and post-test is statistically significant at  $p < .001$ .

<sup>16</sup> There was a significant difference by gender with males having a greater change than females.

<sup>17</sup> Difference between comparison and intervention groups is statistically significant at  $p < .05$ .

**Table 8. Changes in Behavioral Intent by Condition and Grade Level**

Grade	Comparison Group				Intervention Group			
	N	Pre-test	Post-test	Change	N	Pre-test	Post-test	Change
5th	156	73%	77%	+4% <sup>18</sup>	136	76%	79%	+3%
6th	121	74%	68%	-6%	91	65%	73%	+8% <sup>19</sup>
7th – 8th	353	59%	53%*	-6% <sup>20</sup>	283	54%	57%	+3% <sup>19</sup>
9th – 12th	969	72%	72%	0%	782	73%	75%***	+2% <sup>21</sup>

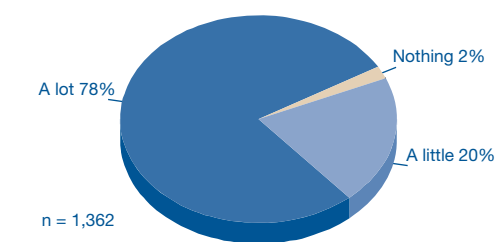
## Behavioral Trends

Given the brief nature of the intervention and the five-day interval between pre- and post-tests, measurement of behavior change was neither advisable nor feasible. However, the evaluation plan includes monitoring trend data collected through the District's biennial participation in the Center for Disease Control and Prevention's Youth Risk Behavior Survey (YRBS) over time. These data will be tracked to identify changes in students' self-reported behaviors (e.g., lifetime and current sexual intercourse and condom use).

## Student Satisfaction with the Program

Post-test instruments included several items intended to gauge student satisfaction with the intervention and to determine how much they felt they learned. The graph below presents students' responses to a question asking them how much they learned. Response choices were "A lot", "A little" and "Nothing". More than three quarters (78%) of students indicated that they learned a lot during the intervention. Responses are shown for each curriculum in Table 9 on next page.

**What students said they learned**



\* Difference between pre- and post-tests is statistically significant at  $p < .05$ .

\*\*\* Difference between pre- and post-tests is statistically significant at  $p < .001$ .

<sup>18</sup> There was a significant difference by gender with females having a greater change than males.

<sup>19</sup> Difference between comparison and intervention groups is statistically significant at  $p < .05$ .

<sup>20</sup> There was a significant difference by grade with 8th graders having a greater change than 7th graders.

<sup>21</sup> Difference between comparison and intervention groups is statistically significant at  $p < .01$ .

## STUDENT OUTCOMES

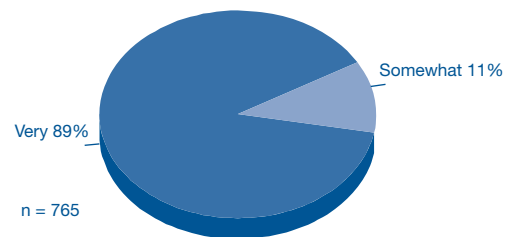
While the majority of students agreed that they learned a lot in the responsible sexual behavior sessions, students in ninth through twelfth grade who received the *Safer Choices* curriculum were more likely to report learning a lot during the intervention (84%) than students who received the *F.L.A.S.H.* (77%) or *Making Proud Choices* (65%) curricula (see Table 9).

**Table 9. How Much Students Said They Learned (by curriculum)**

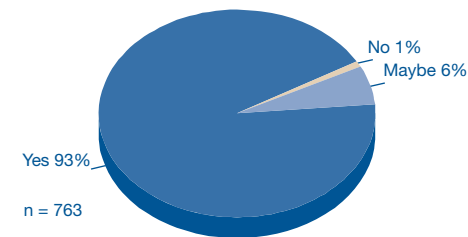
How much did you learn during either the FLASH, Making Proud Choices, or Safer Choices programs? (results by curriculum)			
Curriculum	Nothing	A little	A lot
FLASH (n = 342)	2%	21%	77%
Making Proud Choices (n = 274)	4%	31%	65%
Safer Choices (n = 746)	1%	15%	84%

High school students were also asked how helpful they thought the *Safer Choices* program was and whether they would recommend it to their peers. Their responses to these questions are displayed in the graphs below. Students gave the program high marks, with the majority indicating they thought it was very helpful (89%) and that they would recommend it to other students (93%).

**How helpful was the Safer Choices program?**



**Would you recommend the Safer Choices program for other students?**



### What Students Said They Learned

Facilitators who worked with students in grades K-3 were instructed to ask students a single question about what they learned during the last session of the curricula. Students in grades four through eight were also asked (on their surveys) what they thought were the most important things they learned in the responsible sexual behavior program. Their responses are summarized by curriculum. A complete listing is provided in Appendix C.

### All About Life

Facilitators submitted student responses to the question, “What have you learned in these classes?” from 27 first through third grade classes in which the *All About Life* curriculum was delivered. In all but one of these classes students mentioned good touch/bad touch and/or not letting anyone touch their private parts. Children in nine of the classrooms said they learned not to talk to or trust strangers. Only children in one of the classrooms mentioned potential danger from family members. In reality, the majority of child sexual abuse is perpetrated by a family member or someone known to the child. This may be an area that requires more emphasis in the future.



Other common themes that were mentioned in a third or more of the classrooms included respect for self and others, following rules or laws, feelings and emotions, and differences within families.

### F.L.A.S.H.

*“Before you make a big decision, think about what’s going to happen if you do it.”*

Approximately 275 students who received the *F.L.A.S.H.* curriculum responded to the post-test item, “The most important thing I learned during the *F.L.A.S.H.* program is \_\_\_\_\_.” The largest proportion of the students (36%) identified information about HIV/AIDS as being most important. Nearly a quarter of the students (22%) said learning about safer sex and the importance of using protection was the most important thing they learned. Abstinence, reproductive health and anatomy, safety issues (good touch/bad touch) and decision-making skills were each named by about ten percent of the students.

### Making Proud Choices

*“If you are not ready to have sex you should not do it.”*

*“The safest sex is not having sex.”*

Nearly half (45%) of the 338 seventh and eighth grade students who answered the question about what they learned from *Making Proud Choices* mentioned learning about prevention of sexually transmitted diseases (STDs), HIV/AIDS and pregnancy. Nearly 20% said learning about abstinence or delaying sex was most important. Just over 10% cited information about HIV/AIDS and the negative consequences of having sex.



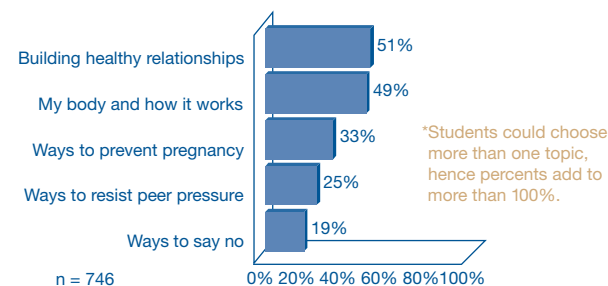
## STUDENT OUTCOMES



### Safer Choices

High school students were asked to choose (from a list provided) which topics they would like to learn more about. More than half of the students (51%) indicated they would like to know more about building healthy relationships. Nearly the same proportion (49%) said they want to learn more about their body and how it works.

Which of the following topics would you like to learn more about?\*



High school students were also asked how the program could be improved. Three hundred fifty-three students responded. More than a third (35%) said the program was good the way it is and had no suggestions for improvement. The next largest group of comments (12%) had to do with providing more time for the program with several students asking that it be offered as a course. The remainder of the comments had to do with requests to provide condoms in school, improve/update the curriculum's videos, use more interactive exercises and activities, provide more information and visual aids about STDs, bring in guest speakers, and to have fewer surveys.

*“Make the program longer or permanent in schools.”*



*“The program was very helpful and will help people to be more cautious and safe.”*



As noted previously, four evidence-based curricula were chosen for use in the District’s RSB initiative. Due to practical considerations, modifications were made to the way in which the curricula were delivered. In order to deliver each of the individual curricula to multiple grade levels, lessons were grouped and each grouping was delivered to a specific grade level. For example, *Safer Choices*, a two-volume, 20-session curriculum was divided into four segments of five sessions each. Ninth graders received the first five sessions, tenth graders the second five and so forth. In other words, students in any given grade received only segments of a whole curriculum. As a result of these modifications, the educational products used in this initiative vary substantially from the original products and may not yield the same results as those reported in the literature about the curricula.

The original implementation plan for Year 2 projected that a minimum of 85% of CMSD’s 48,514<sup>22</sup> students in grades K–12 would be reached by the initiative. External facilitators from six contracted agencies were expected to cover schools with 82% of the student body while the 14 trained CMSD health and physical education teachers were to deliver the curricula to the remaining 18% of students in the District. Because a delay in funding postponed agencies’ start-up, target numbers were later reduced by 15% such that 41,442 students were assigned to receive the curriculum.

According to data provided by CMSD and CCBH, a total of 26,326 CMSD students received programming during the 2007-2008 school year via curricula delivered by external CCBH subcontracted agencies, an external Cleveland Department of Public Health (CDPH) subcontracted agency, RSB liaisons and the internal health and physical education teachers. Thus the initiative reached 64% of the students assigned to receive the curriculum. Curriculum delivered by grade is as follows:

- 7,280 ninth through twelfth grade students (51% of enrolled students);
- 6,449 seventh through eighth grade students (80% of enrolled students);

- 5,424 fourth through sixth grade students (49% of enrolled students); and
- 7,173 kindergarten through third grade students (48% of enrolled students).

Facilitators from external agencies reached 75% of students in their assigned schools while CMSD health and PE teachers and an RSB liaison reached 11% of students in 14 assigned schools.

According to a report prepared by CCBH, factors that contributed to the lower than expected number of students reached included:

- late funding for contracted agencies which led to delayed start-up;
- cumbersome internal scheduling process;
- lack of a “back up plan” for classes with substitute teachers;
- scheduled school events that conflicted with RSB sessions; and
- scheduling difficulties due to holidays, vacations and Ohio Graduation Test (OGT) preparation and testing.

In addition, three of the trained CMSD health and PE teachers were unable to initiate implementation of the curriculum.

### Fidelity to the Curriculum

Three methods were used to assess the degree to which the curricula were delivered as intended. An observation form was created for trained evaluation and CCBH staff to use as they observed presentations of the four curricula. The form collected data about facilitator presentation (e.g., whether students were given an opportunity to ask questions, whether questions were accurately answered and whether all topics in the lesson were covered) and about student participation, engagement and understanding. External and internal facilitators were asked to complete a facilitator reflection form which collected data on their level of comfort with session topics, ability to cover all the session topics and answer student questions. They were also asked if they had enough time to get through the lesson and whether they modified the lesson in any way. Finally, classroom teachers in the set of sampled schools were asked to complete a brief survey at the end of the last session. The survey included questions about the facilitators’ curriculum delivery skills and student behavior as well as questions about the curriculum itself.

### Observer Feedback

Trained staff observed a convenience sample<sup>23</sup> of the lessons implemented across all grade levels by external agency facilitators<sup>24</sup>. One of the observers is on staff at PRA; the other observer is on staff at the CCBH. Observer forms were completed by the PRA staff person for 19 facilitators from six agencies and by the CCBH staff person for 14 facilitators from five agencies. Some facilitators were observed on multiple occasions.

In nearly all cases, observers reported that facilitators invited students to ask questions, provided accurate answers to the students’ questions and checked with students to make sure they understood the material. According to the observers, many facilitators were unable to cover all of the topics in the observed lesson. At times topics were not covered because facilitators ran out of time and/or had to spend more than a few minutes managing behavior problems with the students. On a few occasions observers indicated that students arrived late to class which also caused the lesson to be curtailed (*see Table 10 below*).

**Table 10. Summary of Observer Responses to Questions About Facilitator**

Did the facilitator...	Percent who said “yes”
Invite students to ask questions? (n = 87)	94%
Provide accurate answers to all of the students’ questions? (n = 81)	99%
Check with students to make sure they understood the material? (n = 84)	94%
Cover all topics in the lesson? (n = 84)	83%
Run out of time? (n = 74)	18%
Have to spend more than a few minutes managing behavior problems? (n = 83)	35%

During each lesson, the majority of students asked questions, participated in discussions when prompted, and did not seem to have difficulty understanding any of the topics in the lessons. The average amount of time students needed for the pre-test was 18 minutes with time ranging from five to 31 minutes. Students also needed an average of 18 minutes to complete the post-test with a range of 10 to 25 minutes.

<sup>23</sup> A convenience sample is one in which the researcher uses whatever individuals are available rather than selecting randomly from the entire population.

<sup>24</sup> The evaluation plan called for observation of CMSD facilitators but due to tight scheduling, none of the 12 CMSD teachers that delivered the curricula were observed.

<sup>22</sup> This number reflects revised 2007-08 enrollment figures for the District.



**Table 11. Summary of Observer Responses to Questions About Student Behaviors**

Did the students...	Percent who said “yes”
Ask questions? (n = 86)	87%
Participate in discussions when prompted? (n = 87)	92%
Seem to have difficulty understanding any of the topics? (n = 87)	6%

**Facilitator Feedback**

Facilitators were asked to complete reflection forms regarding their experiences implementing the curricula with a sample of classrooms. Facilitator reflection forms were submitted by 14 facilitators from seven elementary and five high schools.

Few of the facilitators reported discomfort discussing lesson topics and in those cases in which discomfort was mentioned, it seemed to arise from the fact that some topics, such as stereotypes and gender roles, are hard to explain to young audiences. In general, facilitators reported no difficulty answering students’ questions, inviting students to ask questions, or checking with students to see if they understood the material being presented. Six of the facilitators reported that they did not have enough time to get through their lessons and therefore did not manage to cover all of the topics that were in the lesson for the day, which is consistent with what was reported by observers. On average these facilitators said they would have needed 30 additional minutes to complete the lesson that they were reporting about (with a range of 10 to 45 minutes).

Ten facilitators reported making modifications to the lesson for the day. This primarily involved combining lessons into one session or shortening the lesson to accommodate the pre- and/or post-tests.

Facilitators reported that the average length of time to complete the pre-test was 14 minutes and ranged from five to 35 minutes, while post-tests took an average of 12 minutes, ranging from five to 20 minutes. These estimates are similar to those reported by observers.

**Table 12. Facilitator Responses to Questions About Curriculum Delivery**

Did you...	Percent who said “yes”
Feel comfortable discussing all of the topics included in the lesson?	99%
Manage to cover all of the topics that are in today’s lesson?	84%
Get any questions from students for which you did not know the answer?	4%
Get any questions from students that you were uncomfortable answering?	1%
Invite students to ask questions?	99%
Check with students to see if they understood the material that you were presenting?	99%
Have enough time to get through the entire lesson?	85%
Make any modifications to the lesson plan for this session?	27%
Have any unanticipated problems or challenges during this session?	7%
Are there any changes that could be made which would make implementing this lesson easier for you?	5%
Do you feel as if you received all of the training that you need to effectively implement this lesson?	99%

Facilitators were asked to provide additional comments regarding the session. About half of the comments dealt with lack of time to complete all aspects of a given session. Elaborating on issues mentioned above, some of the facilitators attributed this problem to students’ late arrival to class, the volume of students’ questions and the need to administer pre- and post-tests for their inability to complete a session. In two cases, the facilitator recommended that sessions not be scheduled during the first period because students generally arrive late. Two other facilitators mentioned the need to improve communication with classroom teachers regarding scheduling and the purpose of the sessions.

**Classroom Teacher Feedback**

As indicated above, during the final session in each classroom within the random sample, facilitators asked the classroom teachers to complete a survey regarding their observations of the sessions. A total of 38 classroom teacher surveys were collected from two elementary and five high schools in the sample. The teachers who responded to these questions reported that they were present in the classroom either all (92%) or most (8%) of the time during which the sessions were presented. These classroom teachers gave high marks to the facilitators, the material presented to students, and students’ reactions to and behaviors during the sessions. Fewer than half of the classroom teachers reported that they would feel comfortable delivering the curriculum themselves – even with training. It should be noted, however, that these are not teachers that will be expected to deliver the curricula.

**Table 13. Classroom Teacher Observations**

Please indicate your level of agreement with the following statements:	Disagree/Strongly Disagree	Agree	Strongly Agree
The facilitator appeared comfortable presenting the curriculum.	0%	5%	95%
Students seemed to be attentive and interested during the sessions.	0%	18%	82%
Students asked questions during the sessions.	0%	21%	79%
The facilitator provided answers to all of the students’ questions.	0%	5%	95%
The facilitator checked with students to make sure they understood the material.	0%	11%	89%
The material was age-appropriate for the students in my classroom.	0%	3%	97%
The curriculum should continue to be incorporated into the classroom setting.	0%	13%	87%
Classroom order was maintained while the facilitator was in the classroom.	0%	16%	84%
The benefits of the program outweigh the burden of interrupting class time.	0%	18%	82%

*“It should be a permanent part of the curriculum – a portion of health, life-skills, vocational, gym or even a social studies class, but it seems a strange fit with English.”*

While many of the teachers indicated they had no suggestions for improving the program, the most frequently mentioned suggestion was to lengthen or expand the program. Several teachers also asked that the sessions be started earlier in the school year. Other suggestions included separating the class by gender and including more information about abstinence.

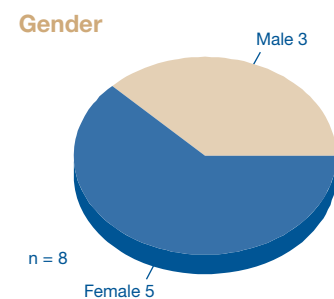
## PROGRAM IMPLEMENTATION

### Teacher Training

During Year 1 of the initiative, 14 CMSD health and physical education teachers were trained to deliver one or more of the responsible sexual behavior curricula. These teachers were expected to deliver the curricula to students in their respective schools during the 2007-08 school year. The goal for Year 2 was to train an additional 20 CMSD teachers who would be expected to teach the sessions in 2008-09. This is part of a longer term sustainability plan to transition delivery of the curricula from primarily external agencies to delivery by CMSD PE and health teachers. The evaluation plan called for assessing the effectiveness of teacher training and included surveying teachers regarding their training experience. Due to a number of factors including issues related to teacher contracts, no teachers were trained in Year 2. The following section provides a summary of surveys completed by CMSD health and PE teachers who were trained in Year 1 to deliver the curricula during Year 2.

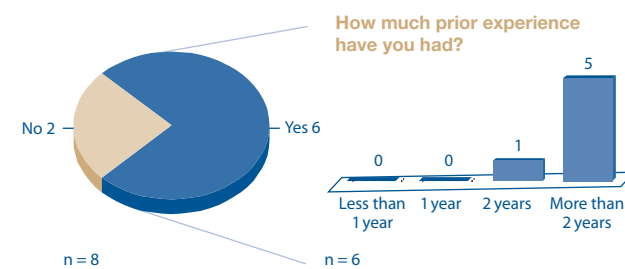
### Surveys of Trained CMSD Health and PE Teachers

A subset of the students who received the sexuality education intervention received it from trained CMSD health and PE teachers rather than from contracted agency facilitators. These teachers were asked to complete a survey during the last day of curriculum delivery that included a range of questions about their training as well as their experiences implementing the curricula.

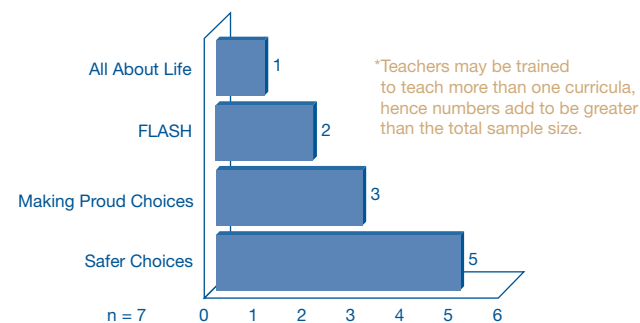


A total of eight surveys<sup>25</sup> were collected from the 14 trained CMSD sexuality education teachers. Five of these teachers were female and three were male<sup>26</sup>. They were most likely to have been trained to teach *Safer Choices*, the curriculum taught in grades 9 – 12.

### Have you had any prior experience teaching sexuality education?



### Which responsible sexuality curricula were you trained to teach?\*



The teachers responded to a series of six questions related to the training they received on the curricula last year. Their answers ranged from “poor” to “excellent” and answers were coded as follows:

- 1 = poor
- 2 = fair
- 3 = good
- 4 = excellent

An average score was determined for each statement by adding up the responses for all teachers who responded to the statement and dividing by the total number who responded. Additionally, an overall mean score was computed for all six questions by totaling the scores given for each and dividing by the number of questions to which they responded. Higher average scores are more desirable.

The overall mean score (2.96) shows that teachers rated the training they received as a whole to be good. Teachers gave the highest ratings (3.25) to both the clarity of the training objectives and the organization of the presentation. The lowest ratings (2.75) were given to the adequacy of time to cover curriculum material, the opportunity to practice delivering curriculum material, as well as how well the training prepared them to deliver the curricula, indicating that the teachers may benefit from more intensive training.



Table 14. Teacher Rating of Training Received in 2007

How would you rate the responsible sexuality training you received last year? (n = 8)	Poor (1)	Fair (2)	Good (3)	Excellent (4)	Mean Score
Clarity of training objectives	0	0	6	2	3.25
Organization of presentation	0	0	6	2	3.25
Responsiveness to your training needs	0	1	6	1	3.00
Adequacy of time to cover curriculum material	1	1	5	1	2.75
Opportunity to practice delivering curriculum material	1	3	1	3	2.75
Overall quality of training to prepare you to deliver the sexuality education curricula	1	1	5	1	2.75
<b>Overall Mean Score</b>					<b>2.96</b>

<sup>25</sup> Since there were fewer than 20 surveys collected, N's are reported for this section instead of percentages.

<sup>26</sup> Race data were only collected for trained CMSD health and PE teachers, not for external facilitators. Thus, the decision was made not to report this information for anyone, since it is not available for everyone.



Teachers responded to a series of 11 questions that related to their ability to teach certain topics. Survey items represented a general overview of topics covered in the four curricula. Again using a 4-point scale for which 1 = poor, 2 = fair, 3 = good, and 4 = excellent, teachers gave the highest ratings (3.25) to their ability to teach male reproductive anatomy, pregnancy prevention, prevention of HIV/STDs, and puberty. The lowest rating (2.57) was assigned to their ability to teach about resources in the community.

**Table 15. Teacher Rating of Ability to Present Specific Topics**

Please rate your ability to teach the following topics. (n = 8)	Poor (1)	Fair (2)	Good (3)	Excellent (4)	Mean Score
Male reproductive anatomy	0	1	4	3	3.25
Pregnancy prevention	0	1	4	3	3.25
Prevention of HIV/STDs	0	1	4	3	3.25
Puberty	0	1	4	3	3.25
Decision-making skills	0	1	5	2	3.13
Female reproductive anatomy	0	2	3	3	3.13
Dating	0	1	6	1	3.00
Gender roles	0	1	6	1	3.00
Sexual abuse prevention	0	1	7	0	2.88
Sexual orientation	0	2	6	0	2.75
Resources in the community (e.g., HIV or STD testing) (n=7)	0	3	4	0	2.57
<b>Overall Mean Score</b>					<b>3.05</b>

A series of ten questions were posed to determine teachers' comfort level in discussing certain topics with students. Using a 3-point scale, response options ranged from 1 ("not at all comfortable") to 3 ("very comfortable"). An average item score was determined for each statement by adding up the responses for all teachers who responded to the statement and dividing by the total number who responded. Additionally, an overall average score was computed for all ten questions by totaling the scores given for each and dividing by the number of questions they responded to. Higher average scores are more desirable.

Teachers were most comfortable discussing how HIV/STDs are transmitted, delaying sex, and puberty. The lowest rating (1.75) was given for their comfort level in discussing sexual intercourse.

**Table 16. Teachers' Comfort Level Presenting Specific Topics**

How comfortable are you in discussing the following topics with students? (n = 8)	Not at all comfortable (1)	Somewhat comfortable (2)	Very comfortable (3)	Mean Score
How HIV/STDs are transmitted	0	2	6	2.75
Delaying sex	0	2	6	2.75
Puberty	0	2	6	2.75
Female reproductive anatomy	0	3	5	2.63
Dating	0	4	4	2.50
Sexual abuse/inappropriate touch	0	4	4	2.50
Male reproductive anatomy	0	4	4	2.50
Condom use	1	4	3	2.25
Sexual orientation/homosexuality	0	7	1	2.13
Sexual intercourse	2	6	0	1.75
<b>Overall Mean Score</b>				<b>2.45</b>

Finally, teachers were asked to indicate their level of agreement with three statements about sexuality education. A 4-point scale was used whereby 1 = strongly disagree, 2 = disagree, 3 = agree, and 4 = strongly agree. An average score was determined for each statement by totaling the responses for all teachers who responded to the statement and dividing by the total number who responded. Additionally, an overall mean score was computed for all three questions by totaling the scores given for each and dividing by the number of questions to which they responded. Higher average scores are more desirable. Overall, the teachers agreed with all three statements, giving the highest rating (3.38) to the statement that sexuality education should continue to be incorporated into the classroom setting. The lowest rating (3.00) was assigned to the teachers' comfort levels in delivering sexuality education in the classroom.

**Table 17. Teacher Agreement with Statements About Sexuality Education**

Please indicate your level of agreement with the following statements. (n = 8)	Strongly Disagree (1)	Disagree (2)	Agree (3)	Strongly Agree (4)	Mean Score
Sexuality education should continue to be incorporated into the classroom setting.	1	1	0	6	3.38
The benefits of offering sexuality education outweigh the burden of interrupting class time.	1	1	2	4	3.13
In general, I feel comfortable delivering sexuality education in the classroom.	1	1	3	3	3.00
<b>Overall Mean Score</b>					<b>3.17</b>

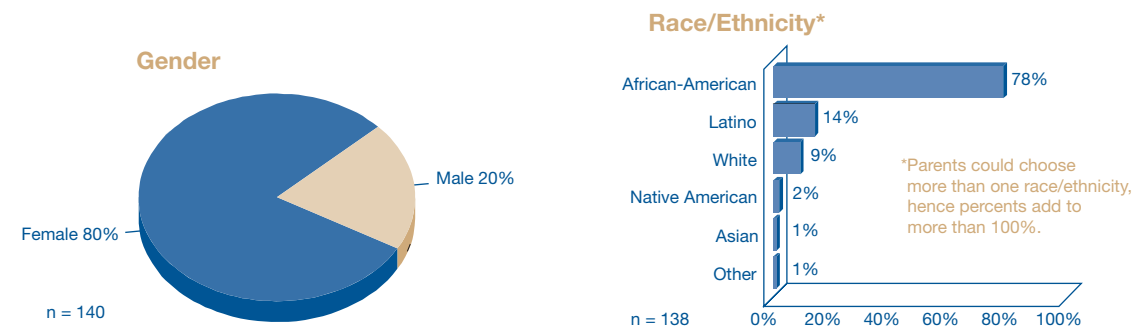
The survey also allowed the teachers to provide additional comments or suggestions about their training, the curricula or their experience teaching the responsible sexual behavior education sessions. All eight teachers offered comments. Four teachers requested updates or additional information on community resources and services, new treatments, and changing attitudes. One teacher asked for a list of things that should not be discussed in the classroom while two teachers indicated that they required more in-depth training to be adequately prepared to teach the upper level curricula.

## PARENTS' PERCEPTIONS

Between March and May, 2008 PRA staff attended several CMSD events in order to distribute surveys to parents to assess their knowledge of and views about the Responsible Sexual Behavior initiative. A total of 141 surveys were collected from parents of children in kindergarten through grade six and 120 surveys were completed by parents of children in grades seven through twelve. In reviewing the findings from these surveys, the reader should keep in mind that the data were from a convenience sample of parents and therefore, may not be representative of the views of all parents in the District.

### Surveys of Parents of Children in Grades K-6

A total of 141 surveys were collected from parents of children in kindergarten through grade 6. The majority of parents of kindergarten through sixth grade students who completed the survey were female (80%) and African-American (78%).



Nearly three-quarters (73%) of parents of children in grades K through 6 reported that they knew they could choose whether or not their children received sex education in the classroom. However during the current school year, just over one-third (36%) reported receiving a letter from the school regarding sex education being taught in the classroom, 30% reported that their child's school offered sex education in the classroom, and about one-quarter (26%) reported that their children learned about sex education in the classroom (see Table 18 on next page). It is of note that CMSD policy is for parents to receive a letter explaining the initiative prior to the curricula being implemented in the classroom and allowing parents to opt their children out. The discrepancy between this policy and the percentage of parents reporting having received a letter from the school could be due to temporal factors (e.g., some parent surveys may have been distributed before the sexuality education was implemented), due to some children neglecting to give the opt-out letters to their parents, or to parents not remembering having received the letters. Additionally, as reported earlier not all schools received the curriculum, so parents from those schools would not have received a letter about the initiative.

Table 18. Young Children's Parents' Knowledge About the RSB Initiative

During the current school year... (n = 141)	Yes	No	I Don't Know
My child's school offered sex education in the classroom.	30%	32%	38%
I received a letter from the school with information about sex education taught in the classroom.	36%	53%	11%
I know that I can choose whether or not I want my child to learn about sex education in the classroom at school.	73%	13%	14%
My child learned about sex education in the classroom.	26%	48%	26%

Additional analyses used data from parents who were aware that their children's schools offered sex education in the classroom. More than one-half (56%) of these parents reported that their children asked them a question about something they learned during their sex education lessons and about 70% had a discussion with their children about sex or a related topic because of what they learned.

Table 19. Percent of Parents That Discussed Sexuality with Their Children (K-6)

During the current school year... (n = 43)	Yes	No	I Don't Know
My child asked me a question about something they learned during sex education in the classroom.	56%	42%	2%
I had a discussion with my child about sex or a related topic like puberty or protection from sex abuse because of what they learned in the classroom.	70%	28%	2%

Most parents thought that their children should receive education about all of the topics listed on the survey (see Table 20 below). They were most likely to think their children should receive information about respect for body/self and resisting peer pressure. They were least likely to believe their children should receive information about sexual growth and development (puberty).

Table 20. Parent Attitudes About Curriculum Topics

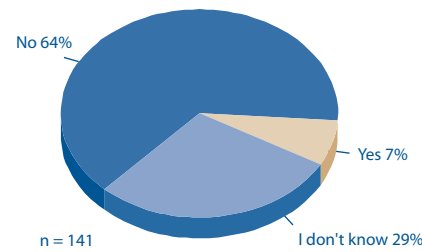
Do you think your child (or children) should receive information about the following sex education topics in school? (n = 141)	Yes	No	I Don't Know
Respect for body/self	86%	9%	5%
Resisting peer pressure	86%	9%	5%
Healthy relationships	85%	10%	5%
Discussions about families and gender roles	85%	9%	6%
Knowledge of HIV/AIDS	82%	10%	8%
Sexual abuse prevention	82%	9%	9%
Sexual growth and development (puberty)	77%	15%	8%

# PARENTS' PERCEPTIONS

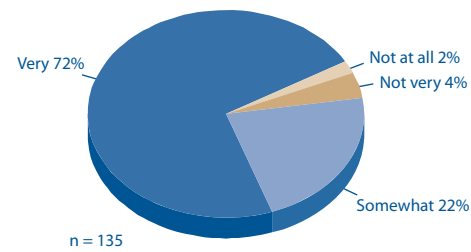


Very few parents (7%) of children in grades K through 6 reported that they were aware of any changes made to policies/procedures about sex education in school. However, 94% of parents thought that it was somewhat important or very important for schools to be involved in sex education.

**Are you aware of any changes made to policies/procedures about sex education in school?**



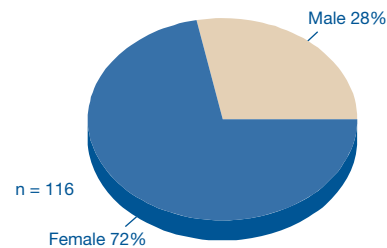
**How important is it for schools to be involved in sex education?**



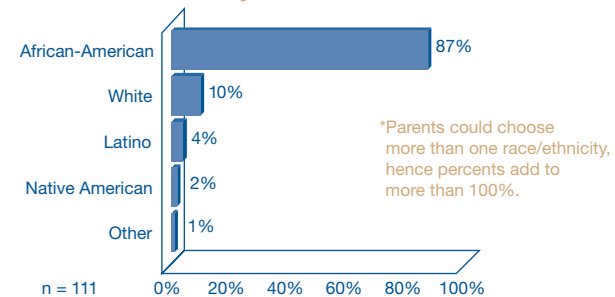
## Parents of Children in Grades 7-12

A total of 120 surveys were collected from parents of children in grades seven through twelve. The majority of these parents were female (72%) and African-American (87%).

**Gender**



**Race/Ethnicity\***



Just under half of the parents (46%) knew that their children's schools offered sex education in the classroom and only 42% believed that their children received such education. Although the majority (69%) of the parents were aware that they could choose whether or not they want their children to learn about sex education in the classroom only 34% reported receiving a letter from the school with information about sex education being taught in the classroom. As described in the previous section, schools are instructed to send opt-out letters home with all students before the RSB sessions began. The reasons described in the previous section for a smaller than expected percentage of K-6 parents reporting having received an opt-out letter apply to parents of children in grades 7-12.

**Table 21. Older Children's Parents' Knowledge of the RSB Initiative**

During the current school year... (n = 120)	Yes	No	I Don't Know
My child's school offered sex education in the classroom.	46%	22%	32%
I received a letter from the school with information about sex education taught in the classroom.	34%	53%	13%
I know that I can choose whether or not I want my child to learn about sex education in the classroom at school.	69%	13%	18%
My child learned about sex education in the classroom.	42%	30%	28%

Additional analyses used data from parents who were aware that their children's schools offered sex education in the classroom. The results indicated that a relatively high proportion of parents reported that they had a discussion with their children related to sex because of something they learned in the classroom (91%) or that their children asked them a question related to what they learned in sex education (74%).

**Table 22. Percent of Parents That Discussed Sexuality with Their Children (7-12)**

During the current school year... (n = 55)	Yes	No	I Don't Know
My child asked me a question about something they learned during sex education in the classroom.	74%	22%	4%
I had a discussion with my child about sex or a related topic like puberty or protection from sex abuse because of what they learned in the classroom.	91%	7%	2%



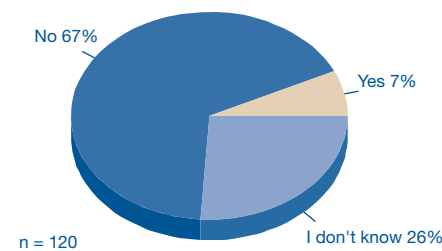
## PARENTS' PERCEPTIONS

Most parents of seventh through twelfth grade students thought that their children should receive information about all of the topics listed on the survey which match the topics included in the curriculum used for grades 9 – 12 (see Table 23 below). They were most likely to think that their children should receive information about healthy relationships (91%).

**Table 23. Parents' Attitudes About Curriculum Topics**

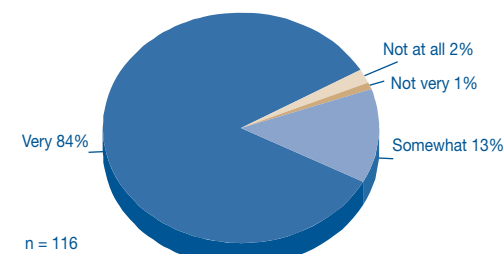
Do you think your child (or children) should receive information about the following sex education topics in school? (n = 120)	Yes	No	I Don't Know
Healthy relationships	91%	3%	6%
Discussions about families and gender roles	89%	3%	8%
Ways to avoid high risk sexual behaviors (don't have sex at an early age, or with multiple partners, or when using drugs or alcohol, don't have unprotected sex)	89%	5%	6%
Prevention of sexually transmitted diseases including HIV/AIDS	89%	4%	7%
Pregnancy prevention	88%	5%	7%
Sexual growth and development (puberty)	86%	6%	8%
Proper use of condoms and other methods of birth control	83%	8%	9%

### Are you aware of any changes made to policies/procedures about sex education in school?



Very few (7%) parents were aware of any changes made to policies/procedures about sex education in school. However, the overwhelming majority (97%) of parents of seventh through twelfth grade students believed it was very important or somewhat important for schools to be involved in offering sex education. These results are similar to answers provided by parents of children in K-6 who also largely reported that they were unaware of any changes made to policies/procedures about sex education in school (64%) but felt that it was very important (72%) or somewhat important (22%) for schools to be involved in sex education.

### How important is it for schools to be involved in sex education?



## STAKEHOLDER PERCEPTIONS

Six focus groups<sup>27</sup> and eight individual interviews were conducted with external agency facilitators, CMSD health and PE teachers who were trained to deliver the curricula, CMSD and CCBH staff and administrators, CMSD Board members, public health officials, and members of the Mayor's staff. The purpose of these interviews was to gauge support for the Responsible Sexual Behavior initiative and obtain stakeholder feedback on various aspects of its implementation. The interviews yielded information about curriculum content and delivery, administrative support and buy-in, progress toward full implementation, and challenges encountered during Year 2 of program implementation. An attempt was made to hear from a representative group of stakeholders and the interviews yielded a great deal of consensus around key topics. However, the findings presented here should not be generalized beyond the group of people who shared their thoughts and opinions with us. It is also noteworthy that the focus group conducted with trained CMSD health and PE teachers had only four participants. This is a very small number of participants so any conclusions made from their responses should be made with caution. (Focus group and interview guides are included in Appendix A.)

### Curriculum Content and Delivery

While trained CMSD health and PE teachers and external agency facilitators alike reported that they were able to engage most students in the material presented, there was concern voiced by external facilitators that some of the selected curricula may not be the most appropriate for CMSD students. The most common concerns centered on the fact that some of the curricula contain material that is outdated or to some degree lack cultural relevance. In these cases, it appears that teachers and agency facilitators alike try to adapt the material by incorporating more current references.

“...the FLASH program, it was talking about John Ritter and I thought – you know, my kids aren't going to know who John Ritter is. You know I grew up on the cusp of Three's Company, so I kind of had to modify it for who I was going to refer to [in that exercise]. But it was a little bit outdated with that.”

Some of the facilitators interviewed felt the *Safer Choices*, *Making Proud Choices* and *F.L.A.S.H.* curricula were not well-suited to an inner-city Cleveland student population and recommended incorporation of supplemental material such as videos and role-play scenarios more culturally appropriate for the CMSD student body.

“One example is the video that is set in an all white suburb, demographically it is just completely different so that turned the kids off right away and it wasn't getting anything done... the kids would spend the entire video talking about the kids overall instead of actually listening to the video.”

“Our Cleveland inner city kids at 4th grade know a lot more information than we're giving them... they hear it on the streets and they hear it from friends... we're talking about friendships, gender roles, self-esteem and a little bit about puberty... unfortunately we do have some 4th graders out there that are engaging in some type of sexual activity.”

<sup>27</sup> Three focus groups were conducted with 15 external agency facilitators; one focus group was conducted with four CMSD trained health and PE teachers; one focus group was conducted with three CCBH staff; and one focus group was conducted with two CMSD staff.

## STAKEHOLDER PERCEPTIONS

*“You can’t take a curriculum based for the suburbs and bring it into Cleveland and think it’s going to work without tailoring it or even updating it... when we go into [school in the suburb] the fifth graders look like fifth graders, they haven’t hit puberty yet... but these kids have had their periods since 4th grade and we’re telling them about puberty in fifth grade so we’re a little bit too late. And then the kids next year are pregnant or they have an STD, we didn’t give them what they needed to keep them safe.”*

Trained CMSD health and PE teachers were most positive about the clear organization and structure of the four curricula and the minimal advance preparation required to deliver the content.

*“I liked that it was very laid out. You knew every day when you walked in what was to be expected. And as a PE teacher who was doing this on the side, it was very helpful. There wasn’t a lot for me to go out and do and say ok I’ve got to get this and that. It was already put together for me. So that was good.”*

However, a frequent complaint among agency facilitators was that the two curricula for older students (*Making Proud Choices* and *Safer Choices*) are too lecture-based. For all grade levels, agency facilitators asked for supplemental material with interactive experiences and, for older students, material that was geared to providing students opportunities to practice negotiation and refusal skills.

*“The little ones were very engaged because any time you let them color, they love it. I just wish we had more and larger pictures that I could have shared with them because they really enjoy hearing stories and things like that. Then the older ones, I think if there were more activities for them, that would help bring across the points that we’re trying to get them to understand... this lecture style just does not work.”*

*“They really like to do the STD poster activity but it depends on what you do with it. If it’s just the poster, that’s one thing but if you give them more creative opportunity with it they really get into it. I’ve had students make comic strips about an STD, do a whole page of graffiti about the STD... I’ve had a kid get up in the middle of class and rap about genital warts... and that’s what works better than us just getting up there [and lecturing].”*

Although the curricula selected for this initiative are evidence-based, from the standpoint of fidelity to curriculum design, concern was voiced that most are not being delivered as originally intended. Primarily due to practical considerations, the curricula have been adapted to span several grade levels so that students in any given grade get only parts of a whole curriculum. In addition, some material is covered in more than one grade. Some facilitators complained that such repetition reduced student engagement, though as was noted previously, students themselves gave positive ratings to the curricula.

*“In fifth and sixth grade we show the same exact videos... I heard a lot of complaints like ‘We watched this movie last year’, ‘I already know what’s going to happen’, ‘I don’t care to see this again’. They are seeing the same stuff over and over.”*

*“There’s not enough differentiation between the grades in *All About Life* in K through 3, it’s the exact same thing for each grade.”*

*“I had a question box and almost every sixth grade class I taught in I always get a note that says ‘I thought we learned this last year’ or ‘This was boring to me because I’ve learned this before’. So they are somewhat more disengaged because they’ve heard and seen everything before.”*

The *Safer Choices* curriculum which is taught in grades 9 – 12 was viewed as problematic on several levels. Several facilitators cited the lack of a comprehensive approach to anatomy and others cited the lack of information about internet predators, sexual assault, power differentials within relationships and gender-biased content.

*“The way this [anatomy] is presented is to just say that this is this and that is that and then just kind of give a quick overview. I don’t think it is really comprehensive enough unless there is an understanding why each part is there and how they work together it just doesn’t make sense.”*

*“It’s very hetero focused... the amount of homophobia in this school is really problematic... they hear the word gay or homosexual and they just go crazy... at the same time you have gay people in the room too so it’s difficult... I really think tolerance is important, there’s just nothing about tolerance.”*

*“I felt really uncomfortable doing the *Saying No* session. It seems like you’re sending a mixed message if you tell them that no always means no and then you’re talking about how there are different ways to say no and these are the best or most effective ways to say no and you’re not talking about respect and how prevalent sexual assault is... there’s no way to formally introduce sexual assault and it just really sends a negative message.”*

### Training

Although teachers and most agency facilitators stated that they were familiar with their assigned curricula, there were calls for training that involved more than a review of the curricula. Teachers reported some discomfort talking about aspects of reproductive anatomy with young children while some agency facilitators said they needed training in dealing with subjects such as internet relationships and Ohio rape laws. There were also reports that some of the agency facilitators did not have a good grasp of the material



while others were not well equipped to maintain order in the classroom. Finally, facilitators also requested guidance and provided recommendations for dealing with “taboo” subjects that arise from student questions.

*“Some of the other agencies coming in teaching *FLASH* for the first time were not comfortable doing the reproductive system and stuff because they didn’t have a lot of information about it. They got a package saying ‘Here, read this and let us know if you have any questions.’”*

*“I think it needs to be stressed to the administration of the school and the classroom teachers that we’re not going to be able to discipline children and implement the program at the same time.”*

*“I struggled with using the words ‘penis’ and ‘vagina’ with my kindergartners and first graders. To me that’s not something I should be teaching them but I know that was part of it. So that one, I had to struggle personally with. And I’m not sure if I’d want someone else teaching my child that information so there I kind of questioned and thought I’m not sure if this is appropriate. But that was the one thing. Everything else was fine.”*

## STAKEHOLDER PERCEPTIONS

*“There’s no guidelines for covering difficult questions that you get that are outside of the curriculum so that everybody knows how to answer it... like abortion, not taking a stand on it but just say ‘It’s the termination of a pregnancy’ and leave it as that or anal sex... what’s the best way to answer it so that we’re not just left hanging?... I think they need that too.”*

### Scheduling Logistics

Nearly all the facilitators said that scheduling sessions this year was problematic. The current year’s efforts to ease the scheduling burden for contracted agencies by assigning the task to CMSD liaisons was viewed by most people to be unsuccessful and external agency facilitators asked that they be allowed to do their own scheduling in the future. For external facilitators, having to deal with a third party to coordinate their schedules with those of their assigned schools and the evaluation process made centralized scheduling cumbersome and inefficient. CMSD teachers also indicated some level of frustration with scheduling and voiced a preference for scheduling sessions earlier in the school year.

*“And a lot of times I get a schedule and it’s like a Monday, Tuesday, Thursday, and Friday and I’m like, ‘I told you I can’t do Mondays and Fridays’ so we end up... and the teachers get frustrated because it interferes with their schedules. Which, I can’t help that because I have already, sometimes have made prior arrangements to do something else.”*

*“I didn’t really start until like March because they needed to schedule it. And they had to come in and find out when I was going to teach and all of that, you know. And I said, ‘It’s kind of late.’”*

### Administrative Support and Buy-In

The Responsible Sexual Behavior initiative appears to be well supported by top-level administrators and other key stakeholders such as local government officials, CCBH administrators and staff and CMSD board

members. It is perceived by all parties interviewed as a “cutting-edge” initiative that is responsive to and grounded in the needs of CMSD students.

*“We know that there are teens in general and urban teens in particular that really need ‘high quality - research based’ education about responsible sexual behavior. And we know that it needs to start early as we’re doing and continue from an awareness to an informational age at the middle grades to those kinds of, you know, giving the high school teenagers an opportunity to say “no” – those kinds of strategies at the high schools. I think it’s clearly necessary... Clearly this is something that all children need a quality curriculum for.”*

*“I think that the program is cutting edge. I think that it’s cutting edge that even a mayor of the city would even take the risk... Most elected officials won’t touch the subject much less when you’re talking about young people and the fact that he supports this and is making sure that the program was age-appropriate. Our partners with the AIDS Collaborative and the other health partners, they were very effective in ensuring that the curriculum was age-appropriate.”*

*“When it’s staffed each year there’s a nice building block and awareness for students. They tend to develop a deeper understanding and ask deeper questions... than where you don’t have a K through 12 integrated program it’s usually... you come into a school or it might be the Health class that you take that year and you’re going to do the unit on this but there’s no connection. I mean waiting until tenth grade to do that unit or waiting until ninth grade to do that unit is way too late. And the students benefit from it and I’m fully supportive of that.”*

*“I think it’s extremely exciting that we realized in our research that Cleveland was one of few cities, very few cities around the country that are doing this. I think that’s something, to be, obviously for the community and all the partners to be proud of.”*



There was also strong consensus that the effort was strengthened by the high degree of collaboration and support among a broad range of public and private entities in the planning, funding and ongoing monitoring of the initiative.

*“And there’s not like there’s any question that there is [collaboration] but in the funders’ being there they’re also saying, ‘What else do you need from us? How else can we help?’ The funders are there to ensure that it is in fact being executed, giving more suggestions on sustainability, and also asking, ‘How else can we help?’ I’ve really seen them as very, very positive partners in this process and thank goodness for them.”*

*“There is political support for this at each level of government, municipal government in the city and county in Cleveland. We have that support.”*

*“Obviously [support came] from the city side and from the school side as well. And the funding for the program came from the Cuyahoga County Commissioners*

*initially and now from other sources as well, but yeah, there’s pretty wide spread support for this.”*

However, stakeholders did identify several barriers that may pose a challenge to ongoing support, particularly within the school district. Several respondents felt that more focused internal and external communication about the initiative was needed to ensure ongoing support.

*“I think they [school board] need to know what the program is, if there is a mission or vision, who’s involved, how the program came about. Maybe just to refresh their memories because there was something when the program first started, but I don’t think there has been any updates.”*

*“I don’t think there has been much public reporting of the progress or of the program in general. I don’t think it’s something that’s been provided on a proactive basis.”*

“...And I think one of the things that we need to re-institute and kind of re-mix up again a little bit is at least some type of quarterly communication on all high priority initiatives that could go to cabinet.”

“We’ve got to have some additional training I think for the principals to really truly understand what is the intent and the goal of the program.”

A need to focus particular attention on principals and teachers was voiced by both internal and external facilitators. Although facilitators believe there is general awareness and acceptance of the initiative among principals and teachers, it does not always result in a level of cooperation. A lack of communication and a host of competing concerns were factors cited as contributing to what was perceived as a lack of support among some principals and teachers.

“There seems to be a lot of room for the individual principals to kind of assert their views into the situation, almost like they weren’t told this is a CMSD initiative... so it seemed like principals were able to push back if they just personally didn’t feel comfortable with what was happening.”

“Our building level administrators are aware that there is a program and that we are working to implement it but probably do not have the ability to talk knowledgeably about the curriculum and the implementation... We have 120 building principals, I would say some do and some don’t [support the program] just because there’s so many things on their plates.”

“The teachers acted like they didn’t know why I was there or where I was from... they don’t even know what the whole objective of Cleveland with the K to 12 is, they’re still asking ‘What are you doing?’... It’s alarming when you go in there and they don’t even know what the plan of the district is. They need more education on what the whole process is, what they’re trying to do.”

“If we could get “higher-ups” to keep saying it and keeping it in front of them. Just to make it so that when we go in we can get it on the schedule.”

### Challenges to Full Implementation

Although this year’s inability to train additional CMSD health and PE teachers was viewed as unfortunate, most people interviewed who were aware of the issue saw it as a minor setback and unlikely to deter funders or those involved in implementation. Rather, it was recognized that implementation plans needed to take into account issues such as teachers’ contracts and careful monitoring of existing resources.

“One consideration is we want to adhere to the teachers’ contract and the guidelines of that. And if that means creating a ‘memorandum of understanding’ then that’s what we need to do. So that the teachers – because they are not receiving any additional money in order to teach this. And frankly this health component is a part of standards, national state standards. So we’re going to actually speak to that particular component. And frankly the teachers embrace it. It’s just a matter of ‘here’s the curriculum and here’s how we need you to deliver it.’ But we realize that we have to recognize that there is a contract and we want to adhere to that.”

“We have struggled some with funding but I don’t believe that it’s because the political leaders don’t see the value. I think it’s just a matter of using the resources we have.”

Aside from contractual issues, key stakeholders including CMSD teachers believe there are both advantages and disadvantages to the plan to move to full in-house delivery of the curricula by CMSD health and PE teachers that should be taken into consideration. Advantages of using teachers to deliver the RSB curricula include cost savings, an existing relationship with students and reduced scheduling barriers within the classroom.

“These are the people on the ground [teachers] that students may have another type of connection with and build a rapport with and build trust with that if they are having issues outside of the school they would probably approach these teachers for advice.”

Although the existing relationship with students was seen as an advantage by some, others viewed this relationship as a disadvantage.

“I know the goal is to transition so that the teachers end up doing it themselves but I just don’t see how that’s going to be effective... the teacher might have a relationship with their parents or they might go to the same church or whatever... even if you don’t want to bring in an outside agency you could have one person at a school that was dedicated to do that. I think that would be more helpful than having a classroom teacher that you see all week.”<sup>28</sup>

The primary disadvantages of using teachers to deliver the curriculum is the low teacher comfort level with the subject matter, conflicting moral values, and lack of expertise in teaching sexuality education. In addition, trained CMSD health and PE teachers supported inclusion of outside agency facilitators citing their status as “experts” as being recognized by students. However, they also cautioned that outside facilitators are more likely to experience classroom management problems.

“A vast majority of the teachers I encountered said ‘Thank goodness someone else is coming in because if we were here the students wouldn’t ask us these questions... we wouldn’t feel comfortable being honest with them.’”

“I think it’s good to have outside resources and individuals outside of just the school to come in and talk about various subjects. I mean anytime you can bring in a speaker that has, somewhat expertise in a particular topic that they talk about I think it enlightens the kid quite a bit.”

Other barriers to full implementation that were cited include training resources, adequate funding, contractual barriers with teachers and the ability of teachers to master and/or deliver two or three different curricula to an entire school population.

“Having the resources to bring enough training with the fidelity necessary into 120 buildings... and with the very limited people that we have under the funding cuts, we don’t have the ability to monitor that in an effective way... whereas in the original plan we would transition more and more of the teachers and use those outside agencies as the facilitators, monitors, the coaches and as the adult trainers until we were assured of the fidelity and then withdraw those resources because we had the confidence.”

“The biggest problem I had, you know as you said funding. I don’t know how the monies are used but for our 600 students that I have at the school. I don’t teach the whole school Phys Ed and Health. I don’t. We don’t have a Health teacher there. That’s the biggest problem. And the time allotment was not good for me. You know you have to teach 6 to 8 classes and that was a difficult time allotment for me.”

“If we have to continue to do it on this limited scale I’m concerned about our ability to bring it to scale because it just doesn’t get enough impact at one time.”

<sup>28</sup> It is of note that the implementation plan involves having the curricula taught by trained CMSD health and PE teachers and not by classroom teachers.

## CONCLUSIONS AND RECOMMENDATIONS

The evaluation of Year 2 of the K-12 Responsible Sexual Behavior initiative revealed a number of positive findings. First and foremost are the significant increases in student knowledge at all grade levels as well as significant improvement in attitudes, skills and behavioral intent among high school students. The initiative appears to have broad and robust support among constituent groups including students, parents, teachers, local government officials and school and county health department administrators and staff. These positive findings were in spite of setbacks including delayed funding, inability to train a new cadre of CMSD health and PE teachers and lower than expected rates of curriculum delivery.

The following recommendations for Year 3 implementation were derived from a number of sources including focus groups with facilitators, CCBH and CMSD staff and CMSD teachers as well as from review of other evaluation resources. They are offered as an aid to planning and preparation for implementation during the 2008-09 school year. It is of note that the plan for the 2008-2009 year is for all of the students, with the exception of 9th and 10th graders, to receive the curricula from trained CMSD health and PE teachers. Thus, some of the recommendations with respect to the logistics of working with outside facilitators may not be applicable.

### Logistics

- Allow agencies/teachers to arrange their own scheduling for curriculum delivery.

Probably unsurprisingly, nearly all persons interviewed made the above recommendation. The current year's efforts to ease the scheduling burden for contracted agencies by assigning the task to CMSD staff was viewed by most people to be unsuccessful. Challenges, including the large number of schedules between and within agencies that needed to be coordinated with school calendars as well as with the evaluation process, made the process of centralized scheduling cumbersome and inefficient. It appears that contracted agencies and teachers prefer to do their own scheduling in the future.

- Begin curriculum delivery earlier in the school year.

The majority of those representing teacher and facilitator agency groups indicated that they would prefer to begin curriculum delivery earlier in the school year. There was recognition that beginning any earlier than October would probably not be practical given the normal bustle of activity associated with the beginning of a school year and the need to allow for adequate time to communicate with school administrators. However, nearly everyone felt that implementation moved too slowly during the 2007-08 school year and resulted in a failure to deliver the curricula to all of the expected classrooms.

- Work for increased communication to principals and teachers to get buy-in and encourage teacher cooperation.

This recommendation emerged primarily from contracted agency representatives but was also voiced

by CMSD teachers and staff. There was a sense that due to competing concerns, the Responsible Sexual Behavior initiative was, if not *off* their radar screens, not on the top of the list of priorities among principals and others responsible for classroom activities and schedules. Early and frequent communication to school administration stressing the importance of the initiative was urged.

- Allow facilitators/teachers more time to deliver the curricula.

Observer forms and facilitator reflection forms indicated that facilitators/teachers ran out of time and/or failed to cover all of the topics in a given lesson about 15-20% of the time. This may be due, in part, to the fact that facilitators were asked to deliver pre-tests and post-tests during their first and last sessions. In some cases, however, the lack of time appeared to be due to classes starting late, cancelled sessions and scheduling conflicts. Students also indicated that they wanted more sessions. Consideration should be given to increasing the number of sessions particularly if the call for supplemental materials is heeded.

### Training

- Provide more structured training for delivery of curriculum.
- Provide specific training about how to deal with sensitive topics.

Although teachers and most agency facilitators stated they were familiar with their assigned curricula, there were calls for training that involved more than a review of the curricula. There were reports that some of the agency facilitators did not have a good grasp of the material while others were not well equipped to maintain order in the classroom. Trained CMSD health and PE teachers gave high marks overall to their comfort with curricula material and ability to deliver the information. However, there were some topics that they indicated having some difficulty

dealing with in the classroom. Teachers reported some discomfort talking about aspects of reproductive anatomy with young children, discussing sexual intercourse with older students, and addressing controversial topics that arose during curriculum delivery. Some agency facilitators said they needed training in dealing with subjects such as internet relationships and Ohio rape laws. Consideration should be given to modifying curriculum training to include discussion of classroom management, dealing with difficult questions and opportunities for delivery practice should be provided.

### Curricula

- Consider adopting more culturally appropriate curricula or replace existing videos and scenarios with more relevant materials.

While teachers and agency facilitators alike reported that they were able to engage most students in the material presented, there was concern voiced that some of the selected curricula were outdated or unsuited to an inner-city Cleveland student population.

- Update/revise curricula to include more interactive material (role plays, skills practice, etc.) and more current topics such as cyber relationships and relational power dynamics.

A frequent complaint among agency facilitators was that the two curricula for older students (*Making Proud Choices* and *Safer Choices*) are too lecture-based. Facilitators asked for supplemental material with interactive experiences more geared to providing students opportunities to practice negotiation and refusal skills. Some of the material (including instructional videos) was also considered outdated – using television or other popular culture references that have no relevance for today's students. In these cases, it appears that teachers and agency facilitators alike try to adapt the material by incorporating more current references. Other concerns regarding the curricula centered on the lack of information about

## CONCLUSIONS AND RECOMMENDATIONS

internet predators, power differentials within relationships and gender-biased content.

- Place additional emphasis on components of the curricula that address attitudes/beliefs and skills.

After receiving the intervention, students in each of the grade levels demonstrated a significant increase in knowledge related to sexuality education. Further, the change experienced by students in the intervention group was significantly higher than the change experienced by the comparison group. Some changes in attitudes and behavioral intent were seen, but not in every grade level. This may indicate that students need additional support in these areas or that these sections of the curricula need to be emphasized during program delivery.

- Continue to monitor the impact of using a modified version of these curricula.

Although the curricula selected for this initiative are evidence-based, from the standpoint of fidelity to curriculum design, there is concern that most are not being delivered as originally intended. Primarily due to practical considerations, the curricula have been adapted to span several grade levels so that students in any given grade get only parts of a whole curriculum. Over time this may not present a problem but in the short run, it is difficult to determine if this approach to curriculum delivery is effective.

### Full Implementation

- Explore Health and PE teachers' concerns about sole reliance on internal facilitators

Teachers noted that the use of outside agencies to present information about topics such as sexuality or alcohol and drugs has some advantages in that students may be more willing to accept information coming from outside the classroom. Several people interviewed also cited more pragmatic reasons for

maintaining contracts with outside agencies – there simply may not be enough time in CMSD health and PE teachers' schedules to master and deliver two or three different curricula to an entire school population. Teacher re-assignment and issues related to teacher contracts were also mentioned as reasons to consider use of outside resources.

### Evaluation

- Begin evaluation earlier in the school year.

The evaluation for the 2007-2008 school year did not begin until second semester. This presented challenges for the evaluation staff, outside facilitators, trained CMSD teachers, and schools. Most importantly, the late start date made it impossible to draw a true random sample for the evaluation. Other repercussions included creating additional obstacles for the scheduling system and reducing the time available for evaluators and stakeholders to complete evaluation related tasks.

- Incorporate the evaluation process into teacher training.

As implementation moves toward greater participation of CMSD teachers in the delivery of the four curricula, it is imperative that teachers become familiar with the goals and processes of the initiative's evaluation. During Year 2, teachers received evaluation materials and instructions; however, only one of three teachers that delivered the curricula in sampled schools complied with at least some of the evaluation requirements. For many reasons, including the late evaluation start-up and scheduling issues, CMSD teachers did not meet the evaluation team and did not have an opportunity to ask questions about or provide input into the process. This may have affected their buy-in of the evaluation and reduced their willingness to participate. Inclusion of the evaluation team as part of the training for internal and external facilitators is strongly recommended.

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