BEYOND EBIs

A Social-Emotional Decision-Making Approach to Adolescent Sexuality Education

WRITTEN BY

Della Wright, MPH, Dr. Denese Shervington, MD, MPH, Melanie Powers, MPH

ABOUT THE INSTITUTE OF WOMEN & ETHNIC STUDIES

Founded in 1993, IWES is a national non-profit health organization that creates initiatives to heal communities, especially those facing adversity. Through community-driven research programs, training, advocacy, and partnerships, IWES helps to build emotional and physical well-being, resilience and capacity among women, their families and communities of color, especially those which are disadvantaged.

IWES uses a Social Ecological Model (SEM), which recognizes that individual behavior is shaped by the intersection of multiple influences occurring at the interpersonal, community and societal levels. Through this in-depth, multi-dimensional approach, IWES creates culturally proficient programs, activities and research to address and advocate for the emotional and physical well-being, resilience, and capacity of women of color, their families and communities to heal and create sustainable change. IWES works in the following areas: Resilience; Emotional/Physical Well-Being; Youth Development; and Sexual Health.

CONTENTS

Adolescent Sexuality Education in the United States: 1980 - Present

Adolescent Sexuality Education (ASE) encompasses far more than sexual behavior and risk reduction; it includes complicated issues and discussions of identity formation, family history, goals for the future, and experiences of trauma. As standards for ASE have evolved, so too has language used to describe and analyze those standards. A current, widely accepted definition of comprehensive sexuality education (CSE) was developed by the Future of Sex Education (FoSE) project and describes CSE as "a planned, sequential K-12 curriculum that is part of a comprehensive school health education approach which addresses age-appropriate physical, mental, emotional and social dimensions of human sexuality" and allows students to "develop and demonstrate developmentally appropriate sexual health-related knowledge, attitudes, skills and practices" [1]. Additionally, FoSE states that CSE should be medically accurate and implemented by qualified, trained teachers. This definition articulates a standard of sexuality education that ought to be accessible to all youth; however, the vast majority of available curricula and programming do not meet this strict standard [1]. For this reason and for the purpose of producing a document that is usable across geographies and sectors, "adolescent sexuality education" (ASE) is used in place of "CSE" to describe quality sexuality education that includes the expanded topics of the FoSE definition, but that may not meet every other listed qualification, such as being implemented over longer periods of time. As researchers and practitioners shift long-term goals for adolescent sexual health education towards that which FoSE envisions, there persists a need to evaluate and improve existing programs and incorporate innovative strategies to better engage current youth, particularly those at greatest risk for the most damaging sexual health outcomes. Young people bring their whole lives into the classroom; new approaches must consider and include this and must permeate the field now.

The Reagan administration began funding abstinence-only programs in 1981 through the establishment of the Adolescent Family Life Act (AFLA), and this trend continued steadily and was solidified in 1996 when the Title V abstinence program was created as a part of welfare reform.

Though there are no universally agreed-upon national standards for school-based sexuality education in the United States, federal administrations have traditionally set the tone for the content, scope, and especially funding of sexuality education interventions. The Reagan administration began funding abstinence-only programs in 1981through the establishment of the Adolescent Family Life Act (AFLA), and this trend continued steadily and was solidified in 1996 when the Title V abstinence program was created as a part of welfare reform [2]. Both funding streams were allocated to programs that "[teach] that a mutually faithful, monogamous relationship in the context of marriage is the expected standard of sexual activity," and that sexual activity outside of those bounds "is likely to have harmful psychological and physical effects" [2]. In addition to these block grants

awarded to states, another funding stream, the Community-Based Abstinence Education program (CBAE), awarded grants directly to community-based organizations who upheld even more stringent standards of abstinence education, including an explicit ban on funded organizations providing any positive contraception information even without the use of CBAE funds [2].

Though hundreds of millions of dollars in funding were distributed to abstinence-only programs in the 1980s and 1990s, there were significant gaps in the research on the effectiveness of these programs, and the programs that were rigorously evaluated found no significant effects on sexual behavior [3].

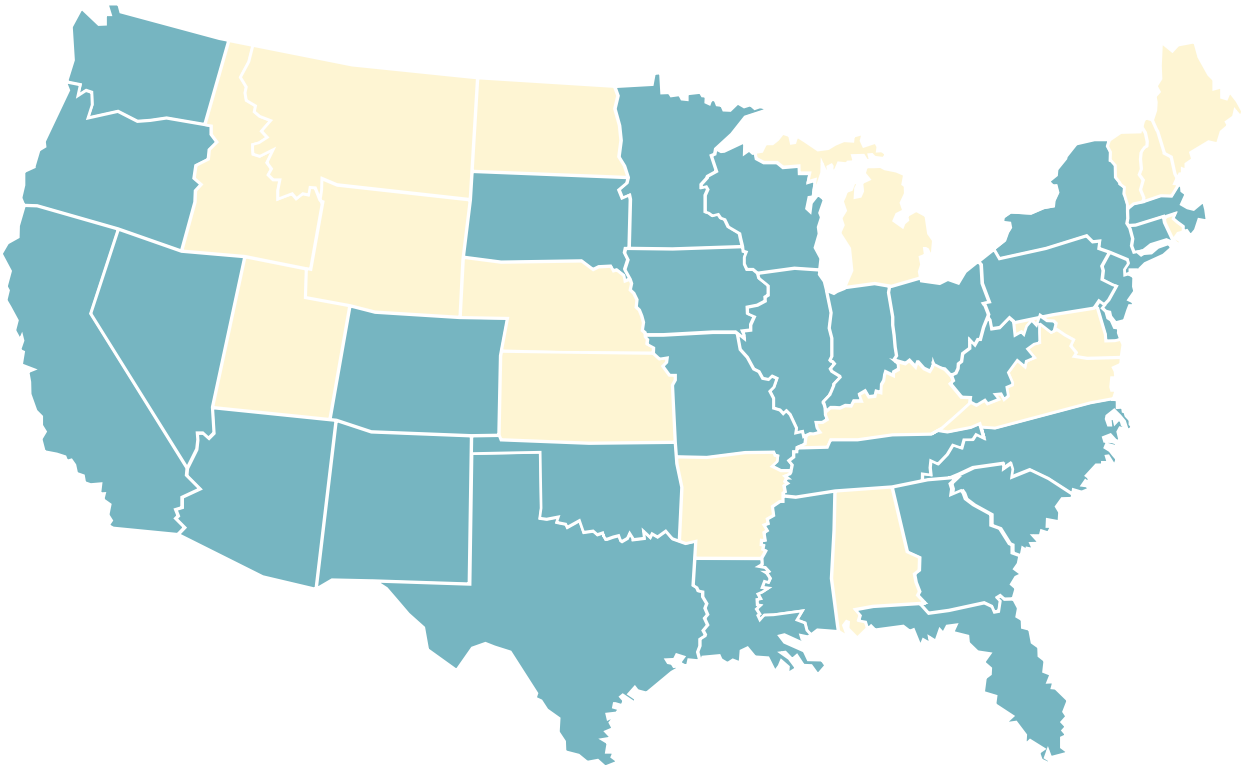
However, a rigorous evaluation of Title V-funded programs was published in 2008 and demonstrated no statistically significant impacts on abstinence, number of sexual partners, age of sexual onset, unprotected sex, pregnancy rates, or STI rates [4]. Additionally, an analysis of abstinence-only curricula funded under CBAE showed that over 80% of the curricula contained "false, misleading, or distorted information about reproductive health" and harmful gender stereotypes [5].

As a result of these findings and with the onset of the Obama administration, funding for abstinence-only programs was rolled back significantly and in 2010, the Office of Adolescent Health established a teen pregnancy prevention initiative that requires the use of curricula that are based in scientific evidence [6]. Beginning in 2009, the Office of Adolescent Health engaged Mathematica Policy Research to conduct an evidence review to identify studies of curricula that met Department of Health and Human Services (HHS) criteria of evidence. To be eligible for inclusion on the authorized list of programs for replication, a study must show positive impact that is statistically significant on at least one of several priority outcomes - sexual activity, contraceptive use, STIs, and pregnancy/birth [7]. Originally, 28 programs were identified as Evidence Based Interventions (EBIs) eligible for replication, and by 2016, the list had expanded to 37 [8].

Though the shift in policy towards evidence-based programming represents progress toward more effective sexuality education for youth, the evidence base is narrowly defined. A program that showed a significant positive impact in the 1990s might be eligible for inclusion, but may require significant updates and adaptations to remain relevant for today's youth. Although many of the listed EBIs are designed to work in specific communities (Black and Latino youth, girls between the ages of 18-19, etc.), significant variations exist even within those groups that make the "one size fits all" approach to curriculum delivery unlikely to produce the same effects from cohort to cohort. Rigorous evaluations are expensive and time-consuming, and this model of review and funding may leave out promising programs that cannot meet the burden of proof

required to be listed as eligible for replication. Additionally, the focus on individual-level behavior change as the only criteria for an effective intervention ignores the community and societal level constructs like poverty and systemic inequality that deeply affect adolescent sexual risk-taking and behavior. Ultimately, the landscape of adolescent sexuality education has been primarily informed by funding sources - a strategy which means that approaches will be reactionary and will change frequently with the political tide and federal administrations. Ideally, evaluation of innovative approaches and feedback from educators and researchers with on-the-ground expertise would inform funding streams. A reframing of adolescent sexual and reproductive health priorities, including an expanded definition of the evidence base, could lead to more effective adolescent sexuality education programming and policy.

Office of Adolescent Health Teen Pregnancy Prevention Grantees



States with TPP grantees (FY 2015 - 2019)

States without TPP grantees (FY 2015 - 2019)

An Intersectional Lens towards Adolescent Sexuality Education

Adolescent sexuality education can include information about abstinence, contraception, risk reduction, healthy relationships, and other topics that contribute to a more holistic view of adolescent sexuality, in contrast with abstinence-only programming. A systematic review of 19 CSE curricula found some consistent characteristics across the most effective programs - they had clear health goals (like preventing teen pregnancy or HIV infection), they focused on factors that affect risk behaviors like knowledge, values, norms, and self-efficacy, they created a safe environment for participation, they had trained and qualified facilitators, and they had support from the authorities involved in implementation [9]. Successful programs employ teaching methods that are participatory in order to involve students more actively, incorporate both skill-building and self-efficacy to use those skills, and generally last between twelve and twenty sessions [10]. Although effective programs may share these commonalities, it is important that curricula be flexible enough to meet the needs of diverse groups of youth. Adolescent development, especially around sexuality, is entwined with the lived experiences and identities of youth including their gender, race, sexuality, and exposure to trauma. As such, programs that seek to engage young people's identities may be more impactful than curricula that are designed to be "one size fits all."

Successful programs employ teaching methods that are participatory in order to involve students more actively, incorporate both skill-building and self-efficacy to use those skills, and generally last between twelve and twenty sessions.

In the past decade, support for specific inclusion of a gender and rights-based perspective in CSE programs has grown. This is due to the well-established link between harmful gender norms/inequitable relationships and risk behaviors as well as negative sexual and reproductive health outcomes [11-15]. The United Nations Population Fund (UNFPA) specifically instructs that curricula have "a basis in the core universal values of human rights" as a key component of its guidance for CSE, and emphasizes the need for gender to be explicitly addressed as both a stand-alone topic and a key influencer of communication, assertiveness, and other relationship skills [16]. One study that reviewed evaluation research for sexuality education curricula showed that many conventional CSE programs without lessons on gender and power related to societal oppression demonstrate some change in behavioral outcomes, but most are not able to show significant impact on pregnancy or STIs [17]. In contrast, several programs that addressed gender and power had significant effects on STI and unwanted pregnancy rates [17]. Common characteristics of effective programs with a gender and power analysis include explicit attention to gender's role in relationships (including specific activities, content, and vocabulary for facilitators), development of critical thinking through media and culture analysis, personal reflection through discussions or journaling, and an emphasis on

valuing oneself and fostering pride and agency within participants [18]. Because of the strong associations between inequitable relationships/gender roles and negative health outcomes for adolescents and adults alike, a gender and power analysis is an integral component of a CSE program.

There are eight states in the U.S. that restrict the teaching of LGBTQ-related content in schools, but only four states that require that sex education be inclusive of LGBTQ youth.

The proliferation of abstinence-only programming in the United States has set the scene for a damaging climate for LGBTQ youth. These programs stigmatize sexual contact that happens outside the boundaries of heterosexual marriage, and imply that lifelong abstinence is the only acceptable course of action for LGBTQ youth [19]. Even in more comprehensive EBIs, there is an explicit focus on pregnancy prevention, and heterosexual contact and a male/female gender binary is framed as the norm. This may cause young people who do not fall into these categories to tune out or to feel isolated, as if the program is not for them – thus, they will not derive the same health and development benefits that studies have documented for heterosexual cisgender youth. Considering the robust evidence base that LGBTQ youth have high rates of risky sexual behavior, it is particularly important to create interventions that meet their needs [20]. However, significant barriers exist to implementing CSE that is LGBTQ inclusive. There are eight states in the U.S. that restrict the teaching of LGBTQ-related content in schools (so-called "no promo homo laws"), but only four states that require that sex education be inclusive of LGBTQ youth [21]. Even when programming is designed to be LGBTQ inclusive, curricula often ignore the needs and existence of transgender and gender non-conforming (GNC) youth, focusing only on LGB youth and their specific risk factors [22]. These conditions have a profound impact on LGBTQ young people – less than five percent of middle and high school students surveyed by the Gay, Lesbian & Straight Education Network (GLSEN) reported having positive discussions of LGBTQ-related topics in their health classes, and LGBTQ students who reported having an abstinence-only sex education program were more likely to miss school because they felt unsafe/uncomfortable [23]. Transgender and GNC youth are at increased risk of negative health outcomes, including a higher probability of having depression and other mental health issues [24]. Transgender and GNC youth are also much more likely to be homeless, and a national survey found that 45% of transgender and GNC people between the ages of 18 and 24 reported at least one suicide attempt [25-26]. Though equitable education for LGBTQ youth is an ethical imperative, the lack of inclusivity in curricula does a disservice to all youth regardless of their sexual and gender identities.

A web-based survey conducted with over 175 African American youth showed that over 12% of youth surveyed identified as heterosexual, although they self-reported engaging in sexual activity with members of their same sex [27]. This finding is consistent with data from the New York Youth Risk Behavioral Survey, which found that almost 40% of youth with same-sex partners identified as heterosexual [20]. Considering these data, interventions that are targeted toward a specific sexual identity may not be as effective as interventions that use neutral language, provide non-stigmatizing information about safer sex practices for all sexual behaviors, and affirm all sexualities and gender identities as valid and normal.

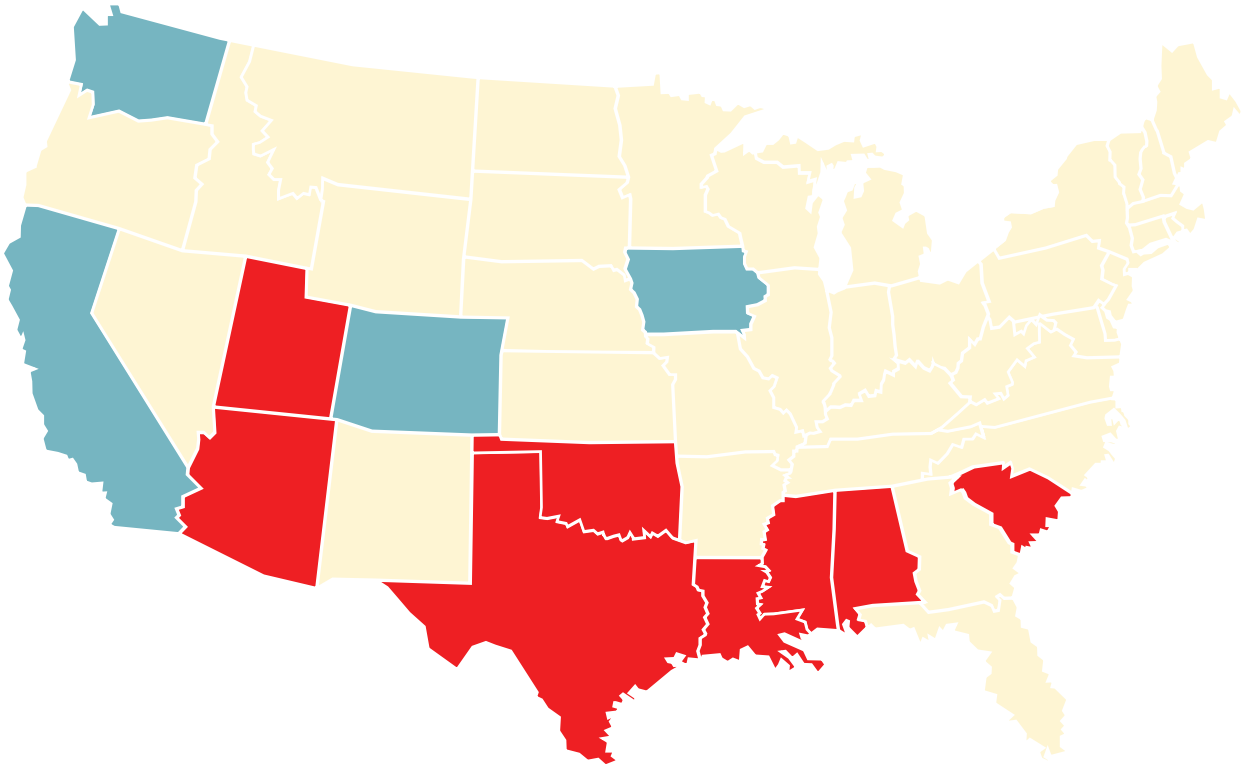
Considering that young people of color are at disproportionate risk of the negative health outcomes that are usually of interest for sexuality education - teen pregnancy, STIs, HIV - interventions should be tailored specifically to their needs.

Though many EBIs and CSE curricula are designed specifically for youth of color, African-American youth are still more likely to receive abstinence-only education than any other group [28]. Considering that young people of color are at disproportionate risk of the negative health outcomes that are usually of interest for sexuality education – teen pregnancy, STIs, HIV – interventions should be tailored specifically to their needs [29-31]. However, even when this is the stated intention of a program, messages included in CSE curricula often include assumptions and stereotypes about youth of color as being sexually irresponsible and belonging or seeking to belong to "improper" relationships and family structures, and fail to address the structural disparities that may impact youth sexual behavior and risk-taking [32]. For example, young people of color are more likely to grow up poor, attend under-funded schools, and have less access to healthcare than white youth – all of which are factors that affect sexual decision-making, access to resources, and cultural context [32].

Additionally, few curricula include historical context, though the history of sexual and reproductive health and education services is very different for people of color in the United States. Many CSE curricula emphasize the benefits of long-acting reversible contraception (LARC), and while they may be highly effective birth control options, communities of color who have a history of reproductive oppression through forced sterilization, fertility control, and government experimentation may be wary of utilizing such methods [33]. Providing context and acknowledging historical traumas may engage youth more effectively and allow them to make informed decisions. Ultimately, interventions that do not address the lived experiences of youth of color will not be effective in serving them. It is also important to recognize that "youth of color" are not a homogeneous group, and that a curriculum that was effective for African-American youth

in Baltimore will produce different effects when used with African-American youth in rural Mississippi or with Latino youth in California. CSE programs that allow for customization based on setting and experience would allow for more engaging and effective conversations across race and ethnicity. The construction of an ASE model that allows for an intersectional understanding of youth identities is likely to produce results for youth that go beyond disease prevention and move toward holistic development.

State Laws Regarding Sex Education & LGBTQ Content



States with "No Promo Homo" laws

States that require sex ed be inclusive of LGBTQ youth

States without laws about sex ed and LGBTQ youth

Adolescent Sexuality Education Implementation - What Works

The evolution of ASE theory and practice has created space for the inclusion of a broader swath of themes within programming and curricula. At present, the primary themes addressed within ASE (anatomy/physiology, reproduction, HIV/STIs, contraception, safer sex practices, etc.) remain relatively consistent; however, the context of youth's lives and experiences are inherently ever-changing. Adults and youth alike make sexual behavior decisions based on their knowledge, beliefs and abilities and do so within a broader context that includes romantic, peer and familial relationships, sociocultural norms and traditions, and community and economic circumstances [34]. To effectively engage youth, sexuality education must be inclusive of their experiences and reality, allow space for participants to inform program implementation, and create opportunities for reflection. Participant discussion supports material comprehension and retention and is one of many methods employed to increase program interactivity [35]. A few steps beyond prompted, facilitator-led discussion lies additional, and potentially even more effective and critical strategies – trauma-informed and healing prescriptive practices, storytelling, and the development of critical analysis skills through the use and creation of media.

Considering the relationships between sexuality and trauma, it is critical that sex education is delivered through a trauma-sensitive healing-informed lens.

Youth who have been impacted by trauma experience learning environments differently as the result of those traumas – particularly when the learning material involves sexuality and sexual development. The Centers for Disease Control (CDC) estimate that 15.2% of girls and 6.4% of boys are sexually molested before the age of eighteen [36]. Studies show that due to poor psychological functioning and mental health as a result of the abuse – evidenced by low self-esteem and self-worth, poor impulse control, substance abuse, impaired interpersonal judgment and self-efficacy, and depression – many of these youth initiate early sexual activity [37]. Individuals who experience childhood sexual abuse are also at a much greater risk of developing post-traumatic stress disorder [38-39]. Sexual abuse puts youth at risk for re-victimization or reenactment, described in the psychodynamic literature as being secondary to 'repetitive compulsion,' a psychic process whereby an individual tries to achieve mastery over the traumatic situation. Their attempts to transform their helplessness into control, i.e. transform an event that was passively endured into one that was actively mastered, result in self-defeating and maladaptive behaviors [40]. Exposure to violence in childhood is also associated with increased sexual risk, and studies have shown that high levels of interpersonal stress are associated with lower and inconsistent condom use [41-42]. For African American girls who experience the trauma of poverty, systematic oppression and racism, sexuality is sometimes used in a risky way as a bargaining tool for acceptance, value, and even love [43]. These negative outcomes are persistent, regardless of the type of trauma one has experienced. The Adverse Childhood Experiences (ACE) study found that adults who

reported four or more ACEs were more likely to report multiple sex partners, higher rates of attempted suicide and histories of substance abuse than those who reported lower ACE scores [44]. Considering the relationships between sexuality and trauma, it is critical that sex education is delivered through a trauma-sensitive, healing-informed lens. The Substance Abuse and Mental Health Services Administration's (SAMHSA's) principles of trauma-informed approaches (providing safety; optimizing trustworthiness and transparency; encouraging peer support and collaboration; allowing for empowerment – voice and choice; and integrating cultural, historical and gender issues) can provide guidance for ensuring this delivery [45]. Such an approach validates young people's lived experiences and gives them the opportunity to explore their emotional landscape and learn how to recognize and manage stressors. Additionally, youth should be screened for traumatic stress conditions, allowing for referrals to the appropriate levels of care and services for those who screen positive. Trauma is not static – children often experience multiple and changing exposures to trauma, and the thoughtful incorporation of trauma-informed and healing prescriptive approaches are critical to sexuality education instruction.

Youth-led storytelling and creation also provides a valuable opportunity for sexuality education facilitators to innocuously assess the group, including participant trauma, lived experiences and relevant issue areas and subsequently tailor programming and resource referral to the identified needs and developmental stages of those specific youth.

In recognition of the diversity of experience in any sexuality education classroom, the needs of the youth in the room should be assessed and linked to curriculum topics and discussions. In states like Louisiana where laws prevent surveying to determine student sexual risk behavior or attitudes in schools, nontraditional assessment methods are a valuable alternative. One useful technique that should be incorporated into ASE programming is that of story-telling, or narrative intervention. Narrative intervention in a public health context involves the sharing of stories with a health theme and guides participants to situate their own life experience in relation to those stories [46]. A narrative approach can be especially impactful in the arena of sexuality education, because it allows young people to contextualize what they learn within their own complex experiences [47]. Youth-led storytelling and creation also provides a valuable opportunity for sexuality education facilitators to innocuously assess the group, including participant trauma, lived experiences and relevant issue areas and subsequently tailor programming and resource referral to the identified needs and developmental stages of those specific youth. Story-creation is an attractive tactic that both assists with group appraisal and promotes youth engagement and investment. Youth-driven story creation also enables participants to set priorities and inform the implementation of programming while

engaging with lessons and activities closely and genuinely. A story-telling facilitator's role is to assist participants in the framing of stories from their own lives, and to position those experiences into a larger community context [48]. Storytelling in the ASE context can be operationalized in several ways. For example, facilitators may ask overarching questions about participants' experiences and knowledge about relationships, and guide a discussion based on the themes that emerge. This technique elicits relevant information more organically from participants, and allows facilitators to incorporate didactic sexual health information as questions arise and to situate that important information within the context of the participants' lived experiences. However, storytelling can also be incorporated in more structured activities, like allowing participants to create back stories for fictional characters that are referenced and highlighted throughout the duration of the program. The personality traits and experiences assigned to the characters likely reflect student experiences and illuminate present and pressing issues in their lives which can then be appropriately addressed and included in program implementation. Ultimately, storytelling as an ASE technique has promise because it integrates the participants' experiences into the program in real time. Since no two youth, much less groups of youth, lead the same lives or have identical needs, it is imperative that sexuality education curricula are crafted to be adaptable and that facilitators possess the confidence and skillset necessary to identify and institute appropriate adaptations. Flexibility and real-time tailoring are necessary to truly meet the needs of all youth when there is inherently such great variance.

Media integration creates opportunities to efficiently deliver material, reinforce messaging, and appeal to youth who are often not receptive to standard teaching techniques.

Media exposure and analysis is another useful strategy long-employed by the Institute of Women and Ethnic Studies (IWES) and other organizations in the implementation of various sexuality education programs. For eleven years, IWES staff implemented an evidence-based intervention, Community PROMISE, with media adaptations that continuously evolved in response to changing youth needs and advancing media. The inclusion of media analysis and creation allowed participants to critically analyze depictions of gender and power, relationships, HIV stigma and sexuality in the media and to draw connections between their exposures to media and the themes in their own lives. These adaptations were critical to ensuring the program resonated with the youth population. Further, the inclusion of media as a teaching tool and dissemination method updated otherwise outdated strategies to fit within social context and utilize current methods for sharing and absorbing information. In a pilot study that examined the emotional education component of a sexuality education intervention, researchers utilized videos to facilitate the emotional education and competence portion. Authors

chose to use videos because, as they noted, individuals are likely to watch videos when seeking emotional education in their daily life. The videos in this study featured examples of positive interpersonal connection, created associations between these feelings and protective behaviors, and presented relatable examples of "cool" youth participating in protective behaviors [35]. Media integration creates opportunities to efficiently deliver material, reinforce messaging, and appeal to youth who are often not receptive to standard teaching techniques. Beyond the value that media utilization adds to the implementation of sexuality education, it also provides opportunities to create tools tailored to a program's specific youth population. Scenarios USA, a progressive sexuality education program, integrates an analysis of gender and human rights and encourages youth thinking and writing critically about their own personal relationships and the influence of societal gender norms and power dynamics [49]. These activities support the development of youth agency and at the culmination of each cohort, students transform these creative writings into a fictionalized script or other project. They are then invited to submit their final product to be considered for film production. These youth-created videos are used in future iterations of implementation, ensuring that the program is continuously adapting to the current youth population in addition to including their voices [47]. Media pieces can be used to amplify youth voices, reach a broader audience and enhance sexuality education instruction; as the role of video and other forms of media in standard daily life continues expanding, their presence in sexuality education modalities must increase congruently.

Ideally, youth development skill-building and sexual health information would exist in the same program in order to provide young people with the holistic knowledge necessary to make healthy choices and to support their development.

The ASE field has largely moved towards a more inclusive and holistic examination of youth sexual health and the many internal and external variables that contribute to decision-making. This evolution, though slow, is reflected in the language used by leading public health institutions and government agencies, and in research and publications. The CDC has shifted from a focus on EBIs as the gold standard to advocating for what they term "Exemplary Sexual Health Education," which seems to indicate an acknowledgment that EBIs alone are not sufficient [50]. Unfortunately, language and intention often do not indicate truly holistic sexuality education programs that support youth development while providing critical sexual health information. Programs often boast a "youth development approach" to sexual health education, yet remain focused only on pregnancy and disease prevention both in terms of curriculum content and outcomes of interest. Research documents the relationship between sexual risk-taking behavior and various general youth development outcomes, including emotional capacity, leadership skills, connectivity, and communication skills, but far too few programs consider these as components equally valuable to didactic sexual health information [51]. Ideally, youth

development skill-building and sexual health information would exist in the same program in order to provide young people with the holistic knowledge necessary to make healthy choices and to support their development. Emotion is one of the most integral pieces of assessing risk and executing decisions and can often be a more reliable predictor of behavior than social-cognitive factors, particularly with regard to sexual risk behaviors and especially among youth [35]. Learning to take inventory, name feelings and emotions and process them in a manner that supports healthy decision making must be included in ASE programming. In order to include this critical element, facilitators must be trained to assess and address manifestations of trauma and adjust instruction in real-time. This extends far beyond group management techniques or mastery of any one curriculum.

WHAT WORKS

1. **Engage Effectively**
   Be inclusive of youth experiences and reality. Allow space for participants to inform program implementation. Create opportunities for reflection.

2. **Understand & Assess Trauma**
   It is critical that sex education is delivered through a trauma-informed lens. Youth should be screened for traumatic stress conditions.

3. **Incorporate Storytelling**
   A narrative approach allows young people to contextualize what they learn within their own complex experiences. It also provides an opportunity for facilitators to assess the group.

4. **Integrate Media**
   Media creates opportunities to efficiently deliver material, reinforce messaging and appeal to youth who are often not receptive to standard teaching techniques.

5. **Address the Whole Child**
   Youth development skill-building provides young people with the holistic knowledge necessary to make healthy choices and to support their development.

Conclusion & Recommendations

The evidence base is clear that the context within which adolescents develop their identities has a strong impact on their experiences with sexuality education. In order to truly support adolescent development, ASE programs should increase participants' awareness of their emotional landscape and how to manage stress, teach social problem-solving skills, increase young people's ability to establish positive relationships, and make responsible decisions and handle challenging situations constructively. The social determinants of health ("the environments in which people are born, live, learn, work, play, worship, and age") are intimately connected with adolescent development, and should also be considered when constructing an appropriate sexuality education model [52]. Race, gender, sexuality, disability, poverty and experiences of trauma shape the way young people relate to and experience sexuality education. The standardized curriculum-based model has the potential to flatten those experiences in order to maintain fidelity. Instead of creating new standardized curricula and working to validate their effects, a model that allows for flexibility will engage young people most effectively. In order to achieve that goal, organizations working in the field need to emphasize several elements in their programming.

LEARNING OBJECTIVES

In order to incorporate the level of flexibility that this ASE model requires, programming cannot rely on the use of a manualized curriculum to be delivered in the same way with each group of youth. In order to address individual needs, cultural contexts and learning styles, programs should be based on a set of agreed-upon learning objectives and evaluate the ways in which individual facilitators plan activities in order to achieve mastery of those objectives. For example, organizations could build learning objectives on work done by collectives like the Future of Sex Education (FoSE), who have developed standards of sexuality education that span grade level spectrums [1]. Standards like these establish goals and expectations that ensure youth learn the core concepts of ASE, while leaving it up to skilled facilitators to employ methods like storytelling and media creation in order to effectively engage each group of students.

SKILLED FACILITATORS

By moving to a model in which there is no "script" for implementation, the role of the facilitator of adolescent sexuality education shifts closer to that of a classroom teacher (and in many cases facilitators may be teachers). Facilitators must be skilled in creating and maintaining a classroom environment that supports the absorption and retention of human sexuality, contraception, reproductive anatomy, disease prevention and other critical sexual health topics and also encourages feelings of safety and trust and promotes honest discussion and critical thinking. They must be skilled and trained in addressing the complex issues that arise during the course of ASE programming, particularly when storytelling and personal narrative is included. An ASE facilitator must have a mastery of sexual health topics and the capacity to connect with and engage students while appropriately responding to their needs. Youth populations that are most represented in poor sexual health outcome data and at greatest risk for disease transmission and unintended pregnancy require facilitators with an especially sophisticated skillset and programming that is even more adaptable and sensitive to their unique needs and experiences. Effective facilitators equipped with interactive activities that solicit youth perspective and input can improve upon existing evidence-based curricula and avoid some potentially harmful effects of rigid programs (e.g. overly cautionary or demonizing messaging about sexual activity in a classroom containing students who are sexually active whether by choice or not) [50]. This requires significant investment in training, professional development and intentional hiring. Programs should prioritize hiring facilitators with demonstrated experience in facilitating group discussion and who consistently demonstrate empathy and respect for young people with different backgrounds and lived experiences, as well as an awareness of human developmental needs. In order to infuse trauma-informed and healing prescriptive practices into pedagogy, recognize young people who have experienced trauma and manage classrooms in which discussions of difficult-to-navigate topics are par for the course, a facilitator must have strong skills and rapport with youth. Hiring this caliber of facilitator would necessitate a shift in compensation and training for many organizations.

EVALUATION & OBJECTIVES

As an industry predominately financed through federal and foundation funding and driven by a need to justify the use of those funds, the focus in evaluating impact and outcomes of adolescent sexuality education has continued to center around specific and limited problem areas. Money is granted to improve quantifiable sexual health outcomes, like disease incidence and pregnancy rates. Although reduction in negative health outcomes is one of the ultimate goals of ASE, the many structural factors that contribute to societal issues like teen pregnancy and HIV incidence are unlikely to respond to interventions targeted at individuals. Focusing on additional proximal outcomes, including the aforementioned youth development outcomes like leadership, self-efficacy and self-worth that have been inexorably linked to risky sexual health behavior, would assist in expanding the evidence base for innovative and flexible programs that are more holistic in nature. Additionally, it is important to expand the definition of the "evidence base." In recognition of the fact that randomized control trials and other rigorous methods are extremely resource-intensive and lengthy, creative and mixed-methods evaluations are imperative to document successes and challenges of new programs. Techniques could include content analysis of stories and media generated by participants, written facilitator reflections, and youth self-assessments of their changes in emotional capacity, leadership skills, connectivity and communication skills.

REFERENCES

1. Future of Sex Education Initiative. *National sexuality education standards: core content and skills, K-12.* The Journal of School Health, 2012.

2. Howell, M. *The history of federal abstinence-only funding.* Washington: Advocates for Youth, 2007.

3. Kirby, D. (2002). Effective approaches to reducing adolescent unprotected sex, pregnancy, and childbearing. *Journal of Sex Research 39.1,* 51-57.

4. Trenholm, C., Devaney, B., Fortson, K., Clark, M., Quat, L., & Wheeler, J. (2008). Impacts of abstinence education on teen and sexual activity, risk of pregnancy, and risk of sexually transmitted diseases. *Journal of Policy Analysis and Management 27.2,* 255-76.

5. Special Investigations Division. *The content of federally funded abstinence-only education programs.* U.S. House of Representatives Committee on Government Reform - Minority Staff, 2004.

6. Office of Adolescent Health. *HHS Office of Adolescent Health's teen pregnancy prevention program.* Department of Health and Human Services, 2014.

7. Mathematica Policy Research. *Identifying programs that impact teen pregnancy, sexually transmitted infections, and associated sexual risk behaviors: review protocol.* Department of Health and Human Services, 2010.

8. Department of Health and Human Services. "Teen pregnancy prevention evidence review." 2016.

9. Kirby, D. *Emerging answers 2007: research findings on programs to reduce teen pregnancy and sexually transmitted diseases.* National Campaign to Prevent Teen and Unplanned Pregnancy, 2007.

10. UNESCO. *International technical guidance on sexuality education: An evidence-informed approach for schools, teachers and health educators.* Paris: UNESCO, 2009.

11. Fladseth, K., Gafos, M., Newell, M.L., & McGrath, N. (2015). The impact of gender norms on condom use among HIV-positive adults in KwaZulu-Natal, South Africa. *PLoS ONE 10.4.*

12. Hillier, L., Harrison, L., & Warr, D. (1998). "When you carry condoms all the boys think you want it': negotiating competing discourses about safe sex. *Journal of Adolescence 21.1,* 15-29.

13. Impett, E.A., Schooler, D., & Tolman, D.L. (2006). To be seen and not heard: femininity ideology and adolescent girls' sexual health. *Archives of Sexual Behavior 35.2,* 129-42.

14. Santana, M.C., Raj, A., Decker, M.R., La Marche, A., & Silverman, J.G. (2006). Masculine gender roles associated with increased sexual risk and intimate partner violence perpetration among young adult men. *Journal of Urban Health 83.4,* 575-85.

15. Raiford, J.L., Seth, P., & Diclemente, R.J. (2013). What girls won't do for love: Human Immunodeficiency Virus/sexually transmitted infections risk among young African-American women driven by a relationship imperative. *Journal of Adolescent Health 52.5,* 566-71.

16. UNFPA. *UNFPA operational guidance for comprehensive sexuality education: a focus on human rights and gender.* New York: United Nations Population Fund, 2014. 1-72.

17. Haberland, N. & Rogow, D. (2015). Sexuality education: emerging trends in evidence and practice. *Journal of Adolescent Health 56.1.*

18. Haberland, N.A. (2015). The care for addressing gender and power in sexuality and HIV education: a comprehensive review of evaluation studies. *IPSRH International Perspectives on Sexual and Reproductive Health 41.01,* 31-42.

19. Santelli, J., Ott, M.A., Lyon, M., Rogers, J., Summers, D., & Schleifer, R. (2006). Abstinence and abstinence-only education: a review of U.S. policies and programs. *Journal of Adolescent Health 38.1*, 72-81.

20. Pathela, P., & Schillinger, J.A. (2010), Sexual behaviors and sexual violence: adolescents with opposite-, same-, or both-sex partners. *Pediatrics 126.5,* 879-86.

21. Gill, A.M. *2014 State equality index*. Washington: Human Rights Campaign Foundation, 2015.

22. McGarry, R. (2013). "Build a curriculum that includes everyone." *Phil Delta Kappan 94.5,* 27-31.

23. Kosciw, J.G., Greytak, E.A., Palmer, N.A., & Boesen, M.J. *The 2013 national school climate survey: the experiences of lesbian, gay, bisexual and transgender youth in our nation's schools.* New York: GLSEN, 2014. 1-139.

24. Reisner, S.L., Vetters, R., Leclerc, M., Zaslow, S., Wolfrum, S., Shumer, D., & Mimiaga, M.J. (2015). Mental health of transgender youth in care at an adolescent urban community health center: a matched retrospective cohort study. *Journal of Adolescent Health 56.3*, 274-279.

25. National Healthcare for the Homeless Council. *Gender minority & homelessness: transgender population.* In Focus 3.1, 2014.

26. Haas, A.P., Rodgers, P.L., & Herman, J.L. *Suicide attempts among transgender and gender non-conforming adults: findings of the national transgender discrimination survey.* American Foundation for Suicide Prevention & The Williams Institute, 2014.

27. Institute of Women & Ethnic Studies. *Unpublished data - youth sexual health survey.* 2012.

28. Kuehnel, S.S. (2009). "Abstinence-only education fails African American youth." *Washington University Law Review 86.5,* 1241-271.

29. Office of Adolescent Health. "Trends and teen pregnancy and childbearing." 04 May 2016.

30. Centers for Disease Control and Prevention. *Sexually transmitted disease surveillance 2014.* Atlanta: Surveillance and Data Management Branch, 2015. 1-149.

31. Centers for Disease Control and Prevention. "HIV among youth." 2016.

32. Schalet, A.T., Santellis, J.S., Russell, S.T., Halpern, C.T., Miller, S.A., Pickering, S.S., Goldberg, S.K., & Hoening, J.M. (2014). Invited commentary: broadening the evidence for adolescent sexual and reproductive health and education in the United States. *Journal of Youth and Adolescence 43.10,* 1595-610.

33. Committee on Women, Population and the Environment (2007). Sex, lies, & birth control: what you need to know about your birth control campaign In SisterSong Women of Color Reproductive Health Collective and the Pro-Choice Public Education Project (Ed.), *Reproductive Justice Briefing Book: A Primer on Reproductive Justice and Social Change.*

34. Chandra-Mouli V., Lane C., Wong S. (2015). What does not work in adolescent sexual and reproductive health: a review of evidence on interventions commonly accepted as best practices. *Global Health Science and Practice 3.3,* 333-340.

35. Ferrer, R.A., Fisher, J.D., Buck, R., & Amico, K.R. (2011). Pilot test of an emotional education intervention component for sexual risk reduction. *Health Psychology 30.5,* 656-660.

36. Centers for Disease Control and Prevention. *Behavioral risk factor surveillance system survey ACE module data, 2010.* Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2015.

37. Nurcombe, B. (200). Child sexual abuse I: psychopathology. *Australian and New Zealand Journal of Psychiatry 34*, 85-91.

38. Wolfe, V.V., Gentile, C., & Wolfe, D.A. (2989). The impact of sexual abuse on children: a PTSD formulation. *Behavior Therapy 20,* 215-228.

39. McClear, S.V., Deblinger, E.B., Esther, B., et al. (1992). Sexually abused children at high risk for post-traumatic stress disorder. *Journal of the American Academy of Child and Adolescent Psychiatry 31,* 875-879.

40. Gleiser, K. (2003). Psychoanalytic perspectives on traumatic repetition. *Journal of Trauma & Dissociation 4.2*, 27-47.

41. Wilson, H., Donenberg, G., & Emerson, E. (2014). Childhood violence exposure and the development of sexual risk in low-income African American girls. *Journal of Behavioral Medicine 37.6,* 1091-1101.

42. Hulland, E.N., Brown, J.L., Swartendruber, A.L., Sales, J.M., Rose, E.S., & Diclemente, R.J. (2015). The association between stress, coping, and sexual risk behaviors over 24 months among African-American female adolescents. *Psychology, Health & Medicine 20.4,* 443-456.

43. Collins, M.L., Baiardi, J.M., Tate, N.H., & Rouen, P.A. (2015). Exploration of social, environmental, and familial influences on the sexual health practices of urban African American adolescents. *Western Journal of Nursing Research 37.11,* 1441-1457.

44. Felitti, V.J., Anda, R.F., Nordenberg, D., Williamson, D.F., Spitz, A.M., Edwards, V.E., Koss, M.P., & Marks, J.S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. *American Journal of Preventive Medicine 14.4,* 245-258.

45. Substance Abuse and Mental Health Services Administration. *TIP 57: Trauma-informed care in behavioral health services.* SAMHSA, 2009.

46. Petraglia, J. (2007). Narrative intervention in behavior and public health. *Journal of Health Communication: International Perspectives 12.5,* 493-505.

47. Casemore, B., Sandlos, K., & Gilbert, J. (2011). On taking an interpretive risk in sex education. *Teachers College Record.*

48. Guse, K., Spagat, A., Hill, A., Lira, A., Heathcock, S., & Gilliam, M. (2013). Digital storytelling: a novel methodology for sexual health promotion. *American Journal of Sexuality Education 8.4,* 213-227.

49. Rogow, D. (Ed.) (2014). Health equality school engagement: scenarios USE reinvents sex education. *Quality/Calidad/Qualité,* 21. Retrieved April 2, 2016, from http://www.popcouncil.org/uploads/pdfs/qcq/QCQ21.pdf

50. Scribner-O'Pray, E. (2014). Beyond evidence-based interventions for teen pregnancy prevention in NorthStar Youth Worker Fellowship (Ed.), *Moving Youth Work Practice Forward: Reflections on Autonomy and Authority. http://web.augsburg.edu/sabo/NorthStarWorkingpapers2013-2014/pdf*

51. Gavin, L.E., Catalano, R.F., & Markham, C.M. (2010). Positive Youth Development as a strategy to promote adolescent sexual and reproductive health. *Journal of Adolescent Health, 46.3.*

52. Healthy People 2020. "Social determinants of health." Retrieved from http://www.popcouncil.org/uploads/pdfs/qcq/QCQ21.pdf