

SEX EDUCATION DECISION MAKING
AT THE INDEPENDENT SCHOOL DISTRICT OF BOISE

by
Annabeth Elliott

A thesis
submitted in partial fulfillment
of the requirements for the degree of
Master of Science in Nursing
Boise State University

December 2010

© 2010

Annabeth Elliott

ALL RIGHTS RESERVED

BOISE STATE UNIVERSITY GRADUATE COLLEGE

DEFENSE COMMITTEE AND FINAL READING APPROVALS

of the thesis submitted by

Annabeth Elliott

Thesis Title: Sex Education Decision Making at the Independent School District of
Boise, Idaho

Date of Final Oral Examination: October 13, 2010

The following individuals read and discussed the thesis submitted by student Annabeth Elliott, and they also evaluated her presentation and response to questions during the final oral examination. They found that the student passed the final oral examination, and that the thesis was satisfactory for a master's degree and ready for any final modifications that they explicitly required.

Leonie Sutherland, Ph.D., R.N. Co-Chair, Supervisory Committee

Jeri L. Bigbee, Ph.D., R.N., F.N.P-B.C., F.A.A.N. Co-Chair, Supervisory Committee

Sandra Nadelson, Ph.D., R.N. Member, Supervisory Committee

The final reading approval of the thesis was granted by Leonie Sutherland, Ph.D., R.N. and Jeri L. Bigbee, Ph.D., R.N., F.N.P-B.C., F.A.A.N., Co-Chairs of the Supervisory Committee. The thesis was approved for the Graduate College by John R. Pelton, Ph.D., Dean of the Graduate College.

ACKNOWLEDGEMENTS

I learned a great deal conducting this case study and it would not have been possible without the guidance and support of my research committee at Boise State University. I am grateful to Leonie Sutherland, Ph.D., R.N, Jeri L. Bigbee, Ph.D., R.N., FNP-BC, FAAN, and Sandra Nadelson, RN, PhD for reading and rereading countless pages of drafts and offering advice. I appreciate the generous gift of their time, spent meeting with me and educating me about the research process.

I am deeply indebted to Kris Carter, DVM, MPVM, Career Epidemiology Field Officer for the U.S. Public Health Service, for the hours she spent sharing her expertise and mentoring my work on the sexual health community needs assessment. And thank you to Kathy Cohen, Family Planning, STD and HIV Program Manager, and Dieuwke Spencer, Chief of the Bureau of Clinical and Preventive Services, Public Health Division of the Idaho Department of Health and Welfare, for their flexibility, support and humor.

I am grateful to the administration of the Independent School District of Boise for allowing me to research their decision making process regarding sex education and to the Trustees, administrator, health teachers and school nurses who so graciously and openly shared their knowledge during the interviews. I also appreciate Karen Fox, Board Clerk, for providing documents and suggesting appropriate participants. In addition, I am indebted to the 16 key informants, who were interviewed for the community health needs assessment.

And lastly, I am so fortunate to have the most supportive and loving husband in the whole world. Thank you, Bill , for a steady supply of laughter, hugs, and stir fry! I am also blessed to have three wonderful, grown children. Thank you, Ricky, Joey, and Bethany, for being a pseudo focus group and expanding my understanding of teens' views on sexuality and for the stimulating and frank conversations during our Friday night family dinners. And above all, thank you, God, for giving me the strength and resources to pursue this education.

ABSTRACT

Sex Education Decision Making at the Independent School District of Boise

Annabeth Elliott

A needs assessment was conducted in Boise in 2008 to address pregnancy, abortion, and sexually transmitted diseases in teens. Key informants indicated students lacked knowledge about sexuality and agreed that comprehensive sex education was the best strategy for improving teen sexual health (Elliott, 2008). Because the Independent School District of Boise (ISDB) had an abstinence-only policy, the strategy could not be implemented until the policy was changed.

The purpose of this case study was to cultivate an in-depth understanding of the influences on sex education policy decisions at the ISDB and to add to the body of knowledge, which may facilitate the adoption of evidence-based sex education programs. A qualitative case study design was used to collect descriptive information about the ISDB comprehensive health education policy implemented in 2010. The Communities Coping with Change Model was used as the theoretical framework to guide data collection and analysis of the case (Kelly & Steed, 2004).

Unstructured, one-on-one interviews were conducted with two Board of Trustees and five ISDB employees. Archival records and documents were also reviewed. The data analysis revealed four primary categories of influence on sex education policy: conflict from the past, adherence to an abstinence-only sex education policy, the values of the

Boise community, and communication getting lost in the bureaucracy. Sex education policy development had been contentious in the past, influencing Trustees and staff to avoid conflict and strictly adhere to an abstinence-only philosophy. The Trustees and staff perceived a strong community value of sexual abstinence until marriage and that superseded providing comprehensive sex education. A bureaucratic organizational structure and competing priorities for education prevented a free flow of information between the ISDB Trustees, staff, and the community. The ISDB Trustees and staff were unaware of the current research on the growing problem of poor teen sexual health in Boise, evidence of effectiveness regarding sex education curricula or current research on parental support for comprehensive sex education. The community was unaware of the procedure for bringing sex education policy issues to ISDB Trustees and the vast majority of parents, teachers, and nurses had not participated in the process since 1986.

The findings of the case study suggested strong community support would be essential to persuading the ISDB Trustees to adopt an evidence-based sex education policy. Nurses, teachers, parents, and other community members must collaborate to present the ISDB Trustees with the full array of information they need to make an informed decision regarding sex education.

Keywords: Sex education, school, school board, decision making, influences, evidence-based, comprehensive sex education, abstinence-only, and policy.

TABLE OF CONTENTS

ACKNOWLEDEGMENTS	iii
ABSTRACT.....	v
LIST OF FIGURES	ix
CHAPTER ONE: RESEARCH PROBLEM	1
Statement of the Problem and Population to be Addressed	7
Population at Risk.....	7
Significance to Nursing.....	8
Conclusion	10
CHAPTER TWO: LITERATURE REVIEW AND CONCEPTUAL	
FRAMEWORK.....	12
Review and Critique of Relevant Literature	12
History of Sex Education	12
National, State, and Local Sex Education Content Standards	14
Abstinence-Only and Comprehensive Sex Education	16
Evidence of Effectiveness.....	17
Trends in Types of Sex Education Taught in the U.S.....	21
Student Preferences for Sex Education.....	23
Teachers' Viewpoints on Sex Education.....	24
Parental Support for Sex Education.....	25

Influences on School Decision Making	26
Conceptual Framework	33
Statement of Purpose	36
Research Question	37
Conceptual Definitions	37
Summary	39
CHAPTER THREE: METHODOLOGY	40
Research Design.....	40
Setting and Population	42
Sampling Method.....	44
Rationale for Theory Selection	46
Interviewee Recruitment	47
Background of Interviewees	48
Sexuality Education Responsibilities of High School Nurses	49
Sexuality Education Responsibilities of High School Health Teachers	49
Protection of Human Subjects	50
Data Collection Procedures.....	50
Community Characteristics and Contextual Information	50
Protection of Human Subjects	50
Data Collection Procedures.....	50

Community Characteristics and Contextual Information	50
Interviews.....	53
Data Analysis	54
Analysis of Document Review of Contextual Information	54
Analysis of Interviews	54
Analysis Summary	55
Researcher Bias.....	55
Summary	57
CHAPTER FOUR: RESULTS	59
Major Findings.....	60
Contextual Finding - Characteristics of the Boise Community	60
Current Health Textbook	61
Economic Findings	62
Religious Findings	63
Political Findings	64
Legal Findings	69
Social Findings.....	72
Findings According to the Research Questions	77
ISDB Policy Change	78
Process and Stakeholders Involved.....	78
Community Appraisal - Interviews.....	79

Categories Expressed in Interviews	80
Appraisal of the Change Event	92
Summary	93
CHAPTER FIVE: DISCUSSION AND CONCLUSIONS	94
Discussion According to the Research Questions	95
Process for Revising the Comprehensive Health Education Policy	95
Community Involvement	98
Nursing Involvement	100
Characteristics of Boise	101
Main Issues	102
Economic Recession	102
Problem-Solving Strategies	105
Adherence to the Policies.....	108
Communication - Getting Lost in the Bureaucracy	110
Conflict "This is a Tinderbox That We're Talking About Here"	111
Pulled Between Values and Reality	112
Implications and Recommendations	114
Implications for Nursing	119
Limitations	121
Recommendations for Further Research.....	123
Summary	124

REFERENCES	126
APPENDIX A	143
Idaho State Board of Education, Health Content Standards	
APPENDIX B	162
Social Security Administration, Section 510; Abstinence Only	
Requirements	
APPENDIX C	164
Interviewee Recruitment Script	
APPENDIX D	166
Document Summary Form	
APPENDIX E	168
Original Interview Questions	
APPENDIX F	170
Interview Summary Form	
APPENDIX G	172
New Comprehensive Health Education Policy and Former Sex Education	
and HIV Education Policy	
APPENDIX H	175
Calculations for the Approximate Number of High School Students	
with STD, Teen Pregnancy and Abortion, Independent School District	
of Boise, 2009	

APPENDIX I	177
List of Abbreviations	
APPENDIX J	179
John Wiley and Sons License, Terms and Conditions.....	179

LIST OF FIGURES

Figure 1.1.	2007 Teen Birth Rate by Selected Country	3
Figure 1.2.	Pregnancy, Abortion and STD in Persons aged 15-19. Idaho and Ada County Comparison, 2004-2008	4
Figure 2.1	Communities Coping with Change Model	34
Figure 3.1	U.S. Census Bureau, Boise Population by Race/Ethnicity, 2009	42
Figure 3.2	Independent School District of Boise (2009) Student Population by Race/Ethnicity	43
Figure 4.1	Type of Employment in Boise, 2009	63
Figure 4.2	Religious Affiliations of Church-Going Residents of Boise, 2000	64
Figure 4.3	The Hierarchy of Idaho Statutes	71
Figure 4.4	Percentage of Idaho Students Who Ever Had Sexual Intercourse, 2009.....	72
Figure 4.5	Idaho Teen Pregnancy Rates, Idaho and Districts 15-19 Year-Olds, 2008.....	73
Figure 4.6	The Approximate Number of High School Students with STD, Teen Pregnancy, and Abortion	75

CHAPTER ONE: RESEARCH PROBLEM

A recent survey indicates that 48 percent of Idaho teens are sexually active by their senior year of high school (Idaho State Department of Education, 2009).

Alarming, Idaho teens also report a lack of knowledge about how to protect themselves against unintended pregnancy and Sexually Transmitted Disease (STD) (Northwest Research Group, 2007). In an attempt to reduce risky teen sexual behaviors through education, school administrators commonly choose between “abstinence-only” and “comprehensive” sex education curricula for students – an important decision when considering the cost of STDs, Human Immunodeficiency Virus (HIV), and unintended pregnancy to teens and society.

Unprotected teenage sex leads to substantial health, social, and economic problems. The physical complications of STDs include infertility, chronic pelvic pain, ectopic pregnancy, birth defects, and death (Centers for Disease Control and Prevention, 2009c). Infants born to teens are frequently of low birth weight, increasing their risk for chronic medical problems. Social problems occur because children of teens are twice as likely to be neglected, abused, or in foster care (Hoffman, 2006). The most common reasons young women drop-out of school is pregnancy and marriage. Teen parents make on average one-third less income, have higher rates of criminal activity, and are more frequently on public assistance than those who are not teen parents (Melville, 2006). Economically, teen pregnancy costs taxpayers an estimated \$9.1 billion per year

(Hoffman, 2006) and it is estimated over \$16.4 billion is spent on medical care for STDs annually (Centers for Disease Control and Prevention, 2009a).

Yet the national STD and HIV rates in teens have been rising over the last five years (Centers for Disease Control and Prevention, 2009c). And for the first time in 15 years, the United States (U.S.) birth rate in teens rose 3 percent, from 40.5 live births per 1,000 females, ages 15-19, in 2005 to 41.9 live births per 1,000 females, ages 15-19, in 2006. In addition, births among unmarried teens rose eight percent (Centers for Disease Control and Prevention, 2007b). The U.S. has the highest teen birth rate in the industrialized world; nearly ten times higher than Switzerland, over three times higher than Canada, and nearly two times higher than the United Kingdom. Figure 1.1 shows the teen birth rate by selected countries. Statistics from the National Campaign to Prevent Teen Pregnancy (2007).

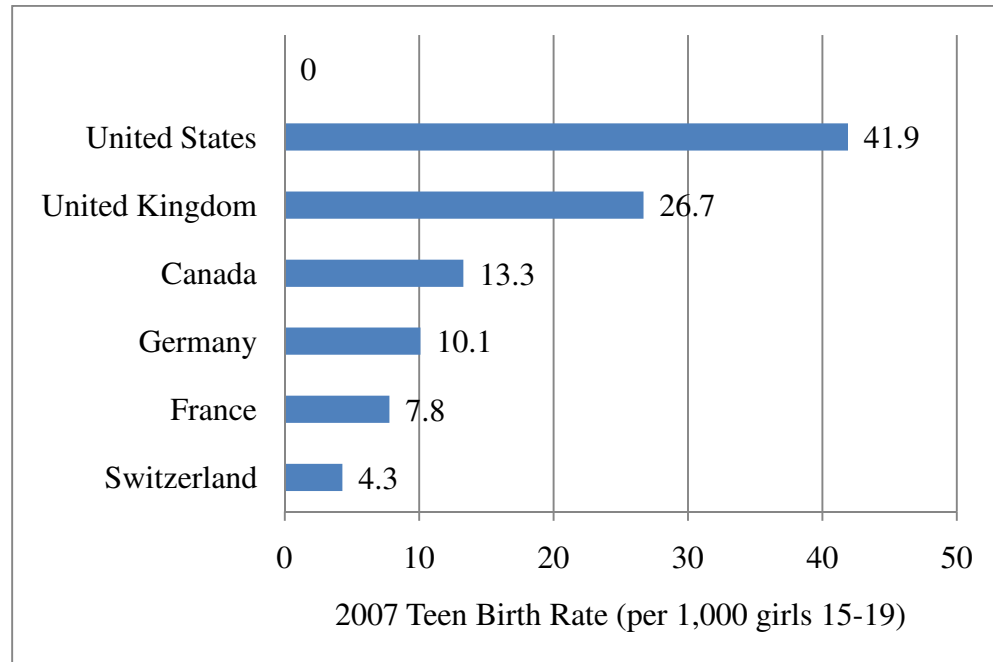


Figure 1.1. 2007 Teen Birth Rate by Selected Country

Like the U.S., the state of Idaho has seen substantial increases in STD and teen pregnancy. Figure 1.2 shows the rates of teen pregnancy, abortion, and STD in Idaho and Ada County from 2004–2008. STD rates in youth and adolescents increased 58 percent (Idaho Office of Epidemiology and Food Protection, 2010). The Idaho teen pregnancy rate increased nearly eight percent and the rate of teen abortions in Idaho increased 18 percent (Idaho Bureau of Vital Records and Health Statistics, 2010). In Ada County, where Boise is located, STD rates, in youth and adolescents, increased 76 percent (Idaho Office of Epidemiology and Food Protection, 2010), teen pregnancy increased 6.7

percent and teen abortion rates increased 13 percent, 57 percent higher than the rest of Idaho (Idaho Bureau of Vital Records and Health Statistics, 2010).

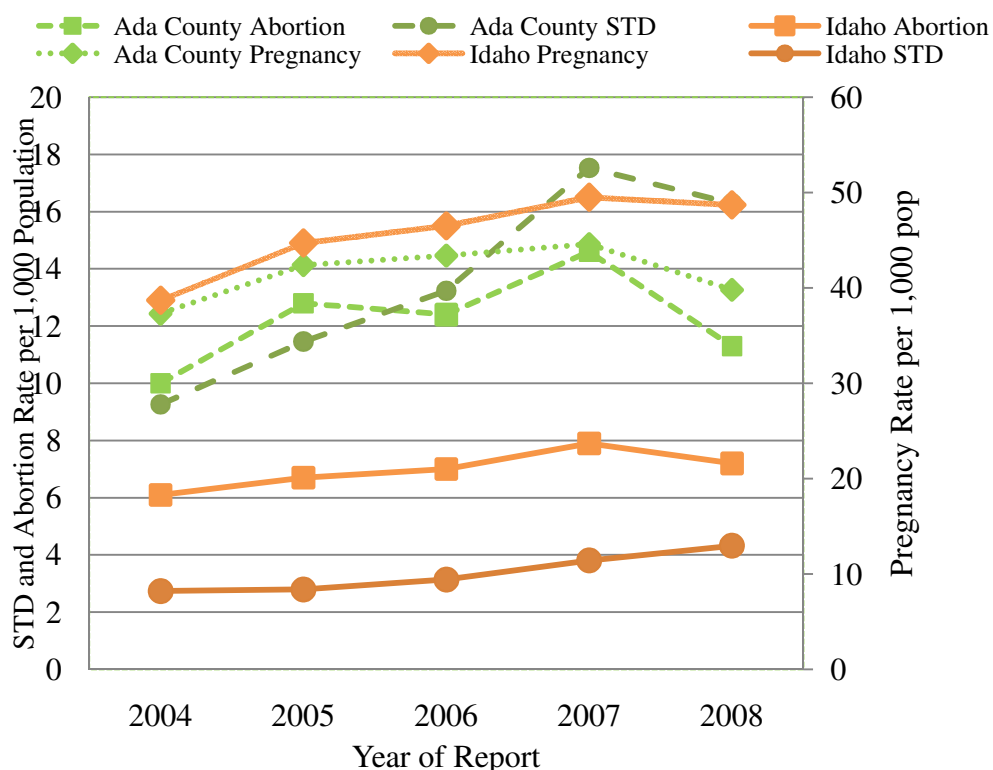


Figure 1.2. Pregnancy, Abortion, and STD in Persons aged 15-19. Idaho and Ada County Comparisons, 2004-2008

To identify ways to improve the sexual health of Ada County teens, a sexual health community needs assessment was conducted in Boise, Idaho in the fall of 2008, using Green and Krueter's Precede-Proceed Model, a health promotion framework useful for guiding health program assessments (2005). Fifteen key informants, who work in the field of sexual health, were interviewed to discover those things that mattered most to the community, what issues the community felt were most important to address, and what

resources were available to bring about change (Elliott, 2008). The assessment provided information about the issues contributing to the disturbing increases in STD rates, teen pregnancy, and abortion in Boise. Four main issues were identified as the most important factors contributing to poor sexual health. In parentheses behind the statement, the numerator indicates the number of key informants who made the statement and the denominator indicates the total number of key informants:

1. Students and parents (society in general) don't talk about sex (10/15).
2. Students had a difficult time accessing services due to time, cost, cultural issues, or lack of knowledge (9/15).
3. There was considerable misinformation and lack of knowledge in students, parents, and the community (8/15).
4. Students were engaged in a lot of risky sexual behavior (8/15).

The key informants identified the following strategies to improve sexual health:

1. Need to start comprehensive sex education early and build knowledge of relationships and what is appropriate throughout the school years (13/15).
2. Need for increased amount of instructional time in the classroom for sex education and have it integrated into other coursework if there isn't time in health class (13/15).
3. Students need to be empowered with knowledge to inform healthy decisions regarding their sexuality (12/15).
4. Need for open parental communication with teens about sexuality so teens have someone to talk to and process sexual issues with (12/15).

Using secondary research and Green & Krueter's ranking worksheets that took into account resource limitations, the political climate, parental preferences, current public policy, and how realistic it is to change community norms (2005), it was determined the most feasible intervention would be to provide comprehensive sex education in schools.

The findings of the community needs assessment indicated Boise health providers were aware of research indicating that effective sex education curricula improve a teen's knowledge and help them postpone sexual activity. Knowledge helps teens who are already sexually active reduce the number of partners and prevent pregnancy and disease (Kirby, 2007; Manlove, Romano-Papillo, & Ikramullah, 2004). Therefore, evidence-based sex education curricula are a powerful piece of the overall activities needed to reduce pregnancy and STD in teens. In order to reduce the high cost of unprotected teen sex, school decision makers may want to choose a curriculum that has been shown to achieve the desired outcomes.

Numerous research studies found that 80 percent of parents around the U.S., across political and religious lines, want comprehensive sex education taught to their children (Ito, Gizlice, Owen, Foust, & Leone, 2006). In the Behavioral Risk Factor Surveillance System (BRFSS), only 7.3 percent of Idahoans surveyed said there should be no comprehensive sex education taught in schools and in Central Health District, where Boise is located, only 5.4 percent of adults said there should be no comprehensive sex education in the school (Idaho Bureau of Vital Records and Health Statistics, 2009). With support from parents, health care providers (Duberstein Lindberg, Santelli, &

Singh, 2006; Elliott, 2008), and the scientific research community, why aren't schools adopting comprehensive sex education curricula?

In order to implement the recommendations of the key informants interviewed for the sexual health community needs assessment, more information was needed about how policy decisions are made in the Independent School District of Boise (ISDB) and what influences those decisions. Therefore, this case study analyzes the complex set of factors that influence Boise school district decision makers when considering issues regarding sex education.

Statement of the Problem and Population to Be Addressed

Decisions regarding the sex education coursework taught in public schools are complex and involve social, economic, political, and ethical components. The school nurses or sex education teachers may not understand the myriad of influences at play; yet, knowledge of these factors is needed to successfully influence decision makers and implement evidence-based programming (Blinn-Pike, 2008; Cates, 2008; Darroch, Landry, & Singh, 2000; Hayter, Piercy, Massey, & Gregory, 2008; Hess & Leal, 1999; Landry, Kaeser, & Richards, 1999; Macgillivray, 2004; Newton & Sackney, 2005; Opfer & Denmark, 2001).

Population at Risk

The Centers for Disease Control and Prevention (CDC) defines "youth" as 10-14-year-olds and "adolescents" as 15-19-year-olds (Centers for Disease Control and

Prevention, 2009b). For this case study, youth and adolescents will be included because the ages of these two groups combined encompass the timeframe formal sex education is taught in the public school system. Youth are not immune from the adverse health consequences of unprotected sex; in the U.S. in 2008, over 18,000 youth were reported with Chlamydia, gonorrhea, or syphilis and in 2004, 16,000 “youth” became pregnant (Centers for Disease Control and Prevention, 2009b).

Studies show that cumulatively, 30 percent of teen girls will get pregnant at least once by the time they reach 20 years of age and one-third will have an STD by the time they reach 24 years of age (Kirby, 2007). Additionally, the majority of STD cases are reported in adolescents, with an estimated one in four female teens suffering from herpes, Human Papilloma Virus (HPV), Chlamydia, or gonorrhea (Forhan, 2008). Lastly, in the U.S. in 2008, 4.5% of newly diagnosed HIV cases were reported in teens 13-19-years-old (Centers for Disease Control and Prevention, 2010b). These health consequences of unprotected sex in teens indicate a need for increased teen knowledge of how to prevent STDs and unintended pregnancy (Santelli et al., 2006). A very effective way to educate a large number of teens is through the public school system.

Significance to Nursing

Nurses have traditionally been part of planning and providing sex education in the schools, effectively engaging parents and the community in the collaboration (Harrison, 2005). A statewide survey of over 400 schools in Florida found that eleven percent of sex education classes are taught by school nurses and 79 percent of health teachers use

registered nurses as guest speakers (Dodge et al., 2008). In addition, research shows that parents and teachers support sex education delivered by a nurse (Cotton et al., 2000; Piercy & Hayter, 2009). An analysis by Jones found school nurses play an important role in facilitating evidence-based practice (2008). The position statement from the National Association of School Nurses supports the establishment of evidence-based school programs for the prevention of teen pregnancy and affirms that the school nurse has a role to assist with the “selection, development and presentation of effective reproductive health education programs” (2004, pp. 1, para. 10). Consequently, this case study on sex education decision making adds to a body of knowledge that may facilitate the adoption of evidence-based sex education programs in public schools.

Nurses comprise 24 percent of public health department staff in the U.S., the largest category (Leap, 2006). Nurse practitioners, midwives, registered nurses, and licensed practical nurses typically run the STD and family planning clinics at the health departments, providing free or low cost confidential services to many teens (U.S. Department of Health and Social Services, 2005). These nurses are highly aware of the need for effective sex education in public schools and the positive impact education has on sexual health (Elliott, 2008).

Providing population-based services and program management is another role of nursing in public health departments and frequently these positions are the hardest to fill with qualified candidates (U.S. Department of Health and Social Services, 2005).

According to *Revitalizing the Health Professions for the Twenty-First Century*, the public health system needs to substantially retrain nurses with the skills and competencies

needed to operate in a new context (Pew Health Professions Commission, 1995). Some of the skills include community assessments, policy development, coalition building, and leadership training (U.S. Department of Health and Social Services, 2005). This case study will provide nurses in public health with information needed to lead a collaborative effort in their community to develop sex education policy and influence public school decision makers to implement accurate, evidence-based, sex education in the public schools.

Furthermore, school nurses are expected to support sex and relationship education in public schools. Many administrators and teachers depend on doctors and nurses to provide specific, up-to-date information about sex education, sexual health, and contraception (King & Eckstein, 2005). Knowing the process for sex education decision making can help nurses predict what, when, and how to deliver evidenced-based, accurate sexual health information to decision makers, so it can be utilized.

Conclusion

Substantial health, social, and economic problems resulting from unintended pregnancy and STD, which predominantly affect teens, have risen in Idaho over the last five years. Public schools are faced with the complex and controversial task of choosing effective programs of study to educate teens about healthy sexuality and parents must be involved in the process. An understanding of the complex influences at play is needed for nurses to successfully influence decision makers and implement evidence-based

programming (Blinn-Pike, 2008; Cates, 2008; Darroch et al., 2000; Hayter et al., 2008; Hess & Leal, 1999; Landry et al., 1999; Macgillivray, 2004; Newton & Sackney, 2005; Opfer & Denmark, 2001). The next chapter will discuss the relevant scholarly literature which has been published about decision making and sex education curricula and the factors which influence these decisions.

CHAPTER TWO: LITERATURE REVIEW AND CONCEPTUAL FRAMEWORK

Review and Critique of Relevant Literature

This literature review includes a brief history of sex education in the U.S., a description of the population targeted for sex education, the grade levels students are typically taught sex education, and the content mandated by Idaho law as the minimum requirement for public schools. The components of the two most common types of sex education taught in the U.S. today, abstinence-only and comprehensive sex education, are described and the evaluation research published on those curricula are analyzed and compared. Next, the prevalence of abstinence-only and comprehensive sex education across schools in the U.S. is discussed and how the popularity of the two curricula has changed over the last 20 years. Then, research findings on students, parents, teachers, and the healthcare community's preferences and viewpoints on sex education are summarized. Lastly, the political, social, economic, and ethical factors that may influence decisions regarding sex education in the public schools are examined, including an assessment of who is commonly responsible for decision making within school systems.

History of Sex Education

Sex education in the U.S. started in the 1800s, when the Women's Christian Temperance Union asked students to take premarital sexual abstinence pledges as vows of purity. This was followed by the social hygiene movement, which was created in 1914 by the American Social Hygiene Association (ASHA) with funding from anti-prostitution

activist, John D. Rockefeller. ASHA worked to instill morals in the public; thereby, reducing prostitution and disease. Educators believed public schools were the ideal place to guide young people who were awakening sexually but were not yet in marital arrangements. Physicians taught lessons about anatomy, reproduction, morality, and STD. It was believed sex education would dispel the ignorance that existed because of the “conspiracy of silence” (Boyer, 2001, p. 1) regarding sexuality and disease. By the 1920s approximately 25 percent of public schools had sex education, which was funded by the Chamberlin-Kahn Act of 1918 (Boyer, 2001).

The first opposition to sex education in U.S. public schools arose in the late 1960’s and was spearheaded by the John Birch Society and the Christian Crusade. These groups believed sex education should be taught in the home and that discussion of sexuality promoted sexual exploration in students. These groups challenged the status quo and by 1969 had successfully convinced 17 state legislatures to restrict sex education in public schools. Sex education has been controversial since; however, in the 1980s, comprehensive sex education was re-implemented in many schools to mitigate the effects of the deadly HIV epidemic (Haffner & deMauro, 1996).

In 1996, Beverly LaHaye organized over 30,000 Concerned Women for America (CWA) to write letters to Congress complaining that comprehensive sex education programs, including HIV education, encouraged immoral sexual behaviors and to demand federal dollars not be used to advance the homosexual agenda or promote immorality. CWA credits this effort with influencing White House legislation (Concerned Women for America, 2009). Coincidentally, in 1996, the federal government

provided public schools with over \$1 billion for abstinence-only education (Lindau, Tetteh, Kasza, & Gilliam, 2008). This funding shift gave momentum to abstinence-only education and in 1999 nearly one-fourth of schools taught abstinence as the only way to prevent pregnancy and STD. Teachers in these schools were not allowed to teach students about contraceptive methods or condom use, unless it was discussion of failure rates. Their school policies also prohibited answering student questions about topics other than abstinence (Darroch et al., 2000; Landry et al., 1999). These policies may have contributed to a decrease in the proportion of students receiving formal instruction about birth control. The proportion of males receiving instruction about birth control decreased from 81 percent in 1988 to 66 percent in 1999, and for females, from 87 percent in 1988 to 70 percent in 1999 (Duberstein Lindberg et al., 2006). So, at different times throughout history, public education has been an instrument to increase awareness in those at risk for STDs (namely young people) and promote public health.

National, State, and Local Sex Education Content Standards

The Idaho health education standards mandate the health content schools must teach in Idaho (Appendix A). There are eight core concepts and the two concepts relating most to sex education are Prevention and Control of Disease, and Growth, Development and Family Life. The Idaho content standards are legislated and were revised in 2010 (Idaho State Department of Education, 2010b).

There are national health education standards and many states align their health education standards with them; however, the national standards are general and

overarching and do not directly mention sexuality (Joint Committee on National Health Education Standards, 2007). The Idaho sex education health content standards are also general and allow the teacher discretion to decide what is taught. The vagueness of the national and state standards makes it difficult to know precisely what sex education content students receive and there is often a wide variation in what is taught, even within school districts (Darroch et al., 2000; Dodge et al., 2008; Lindau et al., 2008).

Nationwide, 35 states have health education standards that mention HIV, STD, and sexuality (Bogden, 2006). Sexuality is mentioned in the CDC's Health Education Curricula Analysis Tool (HECAT), which helps teachers link the principles in the national standards into activities and curricula to increase student knowledge and skill (Centers for Disease Control and Prevention, 2007a). One of the reasons the Idaho State Board of Education recently revised their health education standards was to align Idaho's content standards with HECAT and the national standards (P. Stewart, personal communication, November 10, 2008).

All Independent School District of Boise (ISDB) policies must be consistent with the U.S. and Idaho laws concerning public education and must be within the content standards established by the Idaho Legislature and State Board of Education (Independent School District of Boise, 2010a) Similar to much of the nation, ISDB schools teach sex education to high school students during health class, which is taught for 50 minutes daily, for 2 weeks, during the junior year (T. Carles, personal communication, March 31, 2009).

Abstinence-Only and Comprehensive Sex Education

Sex education in U.S. schools today is derived from two main philosophies, abstinence-only and comprehensive sex education. According to Merriam-Webster's Dictionary, "abstinence" is the abstention from sexual intercourse (2009). Abstaining from sex is taught as a strategy to reduce unintended pregnancy and STD/HIV in teens in all sex education curricula; however, when abstinence is the only method taught, it is referred to as "abstinence-only" education. Abstinence-only curricula do not discuss condoms and birth control unless it is to mention failure rates (Darroch et al., 2000; Fineberg, 2008).

Sex education that includes complete information about abstinence, condoms and contraceptives is called comprehensive sex education. Other topics that may be covered include abstinence until marriage, abstinence until older, HIV / STD prevention, dealing with pressure, the emotional consequences of sex, how to talk to your partner about birth control and STD, reproductive system basics, STD testing, where to access contraceptive and STD services, abortion, rape and sexual assault, how to use other forms of birth control, how to use condoms, homosexuality, sexual orientation, and emergency contraception. Abstinence-plus is another term used to define sex education programs that stress a strong abstinence component, but include discussion of condoms and birth control (Darroch et al., 2000).

To qualify for federal funding for abstinence programs through Section 510 of the Social Security Administration, delegates must meet stringent requirements (U.S.A. Social Security Administration, 2007). Appendix B contains a complete list of the

requirements. Another condition of Section 510 funding is the school must agree not to use any other financial resources to teach students about contraceptives or condoms (Santelli et al., 2006).

Evidence of Effectiveness

Evidence-based decision making occurs when individuals or organizations choose to implement interventions that show the best outcomes, according to reliable and rigorously conducted research. Cochran systematic reviews are considered the best evidence of effectiveness, followed by other systematic reviews and meta-analysis (University of Washington, 2007). When analyzing sex education curricula, evaluation experts assess the strength of effectiveness of a program by systematically reviewing multiple curricula using established methodology and inclusion criteria to reveal an overall pattern of results. Inclusion criteria typically consist of current curricula evaluated with randomized control trials, adequate sample sizes, and sufficient follow-up time (Fineberg, 2008).

Two Cochran reviews performed in 2007 found that abstinence-only programs failed to reduce STD, unintended pregnancy, age of sexual initiation, incidence of unprotected sex, or number of sexual partners (Underhill, Montgomery, & Operario, 2007b; Underhill, Montgomery, & Operario, 2007a). Recent meta-analyses of abstinence-only curricula also found the programs failed to delay sexual activity, reduce the number of sex partners, or increase the use of condoms or contraception (Kirby, 2007; Manlove et al., 2004; Young & Penhollow, 2006). The findings of the meta-analyses and

Cochran reviews were consistent with a very rigorous, multi-year evaluation of sex education programs performed by Mathematica Policy Research. The study, which was commissioned by the U.S. Congress in 1996, found no evidence of effectiveness in abstinence-only programs (Trenholm et al., 2007).

However, one well designed abstinence-only intervention was recently conducted among young, urban African American teens in sixth and seventh grade. The intervention did produce positive program effects (Jemmott, Jemmott, & Fong, 2010). Even after 24 months of follow-up, the abstinence-only intervention group was shown to have significantly delayed sexual initiation when compared to control groups. One control group received general health promotion messages, the second control group received safe sex messages without abstinence as a strategy, and the third control group received comprehensive sex education with abstinence as a strategy. The abstinence intervention did not meet the federal criteria for abstinence-only education because it did not advocate delaying 'sex until marriage,' but instead promoted 'sex until later.' The theory-based intervention was also not moralistic and did not discuss the inadequacy of condoms. This study was done so recently that it has not been included in any systematic reviews, but the findings indicate objective, theory-based, abstinence-only education may be the most appropriate intervention in certain age groups (Jemmott et al., 2010).

Many comprehensive sex education programs have been rigorously evaluated. The Cochran systematic review found 23 of 39 programs reduced at least one risk behavior, such as abstinence from sexual intercourse, use of condoms, or unprotected sex (Underhill et al., 2007a). A meta-analysis by Kirby included 48 comprehensive sex

education and STD/HIV prevention programs. The analysis found 47 percent of the programs had positive impacts, such as postponing the first experience of sexual intercourse and increasing condom use. Also, 44 percent of the programs showed an increase in the use of contraceptives (Kirby, 2007). Of the 15 sex education programs with experimental designs included in Manlove's meta-analysis, seven delayed age at first sex (47 percent) and four increased the use of contraceptives (27 percent) (2004). The evaluations showed comprehensive sex education was associated with a reduction in risk behaviors, such as frequency of sex, number of sex partners, and increased condom use.

The majority of sex education programs, whether abstinence-only or comprehensive sex education, evaluated program impacts by comparing the participants' self-reported risk behavior, diagnosis of STD, or incidence of unplanned pregnancy with that of the control group (Fineberg, 2008). Self-reported outcomes are not as accurate as objective biological measures and threaten the validity of the findings because of possible recall error or partiality due to the participants' gratitude or resentment towards the program because of the way it was conducted (Grembowski, 2001). Furthermore, it is difficult to compare program effects of abstinence-only and comprehensive sex education programs due to variability in the multiple research methods, choice of outcomes, evaluation methods, and the differences in populations and program settings (Fineberg, 2008). These factors limit the ability to draw definitive conclusions.

Conclusions are further limited because very few evaluations of the impact of abstinence programs have been conducted. One explanation for this, given by Phyllis

Schlafly, is that some parents believe it is inappropriate to ask students personal questions about sexual activity, condoms, and/or birth control use. Schlafly believes the programs are effective and funding is better spent on providing additional abstinence education programs than on performing evaluations (Eagle Forum, 2000). Even though Schlafly cannot speak for the research scholars who conducted abstinence-only curricula evaluations, she is well known as a powerful voice for a very vocal, but small, segment of the population.

Even with comprehensive sex education, the behavior change detected in the reviews was not dramatic. It is estimated the interventions lowered sexual risk behaviors by about one-third (Kirby, 2007). Furthermore, the Cochran reviews did not find a lower incidence of STD or HIV among participants of comprehensive sex education programs than in the control groups (Underhill et al., 2007a). When further considering the program effects of abstinence-only curricula, the Cochran reviews and two other studies suggest that some abstinence-only curricula had adverse program effects. It is possible that teaching only the failure rates of condoms and birth control actually deters students from using condoms and contraceptives and contributes to unintended pregnancy and STD (Bruckner & Bearman, 2005; Strayhorn & Strayhorn, 2009; Underhill et al., 2007b).

Undoubtedly, the evidence from the multiple, rigorous reviews helped sway the scientific and healthcare communities in support of comprehensive sex education (Duberstein Lindberg et al., 2006; Santelli et al., 2006). Furthermore, the lack of evidence supporting abstinence-only education may have influenced school decision makers because over one-half of states initially receiving abstinence-only grant awards, including

Idaho, turned back Section 510 funding (Siecus, 2008). But more goes into decision making than scientific evidence; therefore, this thesis will continue to examine other influences on sex education decision making.

Trends in Types of Sex Education Taught in the U.S.

The first government supported abstinence-only programs began in 1981 with the Adolescent Family Life Act. The U.S. Government expanded support for abstinence-only programming in 1996 and since then over \$1 billion dollars in Section 510 and Title V funding have been distributed (Lindau et al., 2008). This ample funding source and the Section 510 restrictions on teaching sex education other than abstinence-only (Santelli et al., 2006) may have influenced school decision makers to adopt abstinence-only education because twice the number of schools taught abstinence-only in 1999 compared to 1988. There was also a 37 percent decrease in the number of schools who taught comprehensive sex education during the same time period. In addition, the proportion of students taught about birth control in 1999 was 13 percent lower than in 1988 (Darroch et al., 2000; Landry et al., 1999). As mentioned previously, most abstinence-only programs only mention condoms or birth control to discuss failure rates or side effects. One must wonder if abstinence-only education changed students' beliefs about condom and birth control efficacy, making teens less likely to use them. In 2005, for the first time in fifteen years, the percentage of students reporting condom and birth control use decreased and this decline continued in 2009 (Centers for Disease Control and Prevention, 2010c)

The American Civil Liberties Union (ACLU), representing taxpayers including clergy and religious organizations, filed a lawsuit in 1988 against the federal government for funding “The Chastity Act,” alleging the abstinence-only education program violated the First Amendment right to separation of church and state by promoting narrow religious beliefs (Young & Bailey, 1998). The lawsuit, which was settled out of court in 1993, also alleged the content was medically inaccurate. Then, again in 2004, an investigation by the U.S. House of Representatives found that 80 percent of abstinence-only curricula contained false, misleading, or distorted statements about the efficacy of condoms and birth control, the risk of abortion, and the cultural roles of males and females (2004). Critics of abstinence-only education also claim it does not prepare students with knowledge of birth control or safer sex practices for when they become sexually active – information that will be needed because the vast majority of people are sexually active before and after marriage. This includes students who pledge to abstain from sexual intercourse until marriage; 88 percent of “virginity pledgers” have vaginal intercourse before marriage, compared to 99 percent of non-pledgers. Pledgers were also significantly less likely to use birth control, condoms, or be tested for STDs (Bruckner & Bearman, 2005).

Some students are already sexually active by the time they are taught sex education in school and if they choose to remain sexually active, abstinence-only curricula does not provide them with information about how to prevent pregnancy or STDs. Furthermore, Section 510 abstinence-only Requirement D states that “mutually faithful monogamous relationship in the context of marriage is the expected standard of

human sexual activity” and Requirement E states that “sexual activity outside of the context of marriage is likely to have harmful psychological and physical effects” (U.S.A. Social Security Administration, 2007, p. 401). These requirements do little to protect the estimated 2.7% of young men and 4.5% of young women who identify as gay, lesbian, bisexual, transgender, or questioning, since gay marriage is illegal in most states (Jorm, Korten, Rodgers, Jacomb, & Christensen, 2002).

Student Preferences for Sex Education

Research suggests that many students desire comprehensive sex education. When students were asked, the majority indicated they would like more sex education (Cates, 2008), including birth control methods (Gawlinski, 2007) and where to get contraceptives (Kaiser Family Foundation, 2000; Pittman & Gahungu, 2006). Students and teachers think sex education would be more beneficial if it was taught in earlier grades and 54 percent of students believe what is taught is not relevant to issues in the lives of teens today (Kaiser Family Foundation, 2000). In Cates’ study, students reported not having role models for how to have a healthy sexual relationship, including religious leaders, who teens disrespected and viewed as hypocritical. In addition, Cates found parents, teachers, and health care providers often fail to seize upon opportunities to teach teens about sex (Cates, 2008). When delivering sex education interventions, peer education, which is taught by teens, is often effective and preferred by students (Kaiser Family Foundation, 2000; Kirby, 2007).

Teachers' Viewpoints on Sex Education

Teachers and administrators agree there is a great deal of variation in the content of sex education coursework when there is not a prescribed curriculum. Nearly one-fourth of teachers reported they autonomously choose the sex education content they teach (Kaiser Family Foundation, 2000). Furthermore, the curriculum a teacher uses has a significant influence on what topics are included. Fifty two percent of Illinois teachers surveyed reported the available curriculum and materials had a great deal of influence on what they taught for sex education, followed by their school (38 percent), school district (35 percent), personal values (32 percent), community values (19 percent), state laws (17 percent), and parental input (9 percent) (Lindau et al., 2008).

Research also indicates the teachers' skill and comfort level discussing sexuality influences the quality of sex education. In general, teachers lack knowledge of sexuality and most have not received adequate training about how to teach sex education (Gawlinski, 2007; Kaiser Family Foundation, 2000; Lindau et al., 2008; Piercy & Hayter, 2009). Teachers admit to feeling uncomfortable talking about sex (Gawlinski, 2007) and feel constrained about what they can say (Cates, 2008; Darroch et al., 2000). Lectures are primarily used to relay the information to students, even though small group discussions and peer education have been shown to be more effective (Donovan, 1998). Moreover, teachers report time constraints in the classroom make it difficult to deliver quality, comprehensive sex education programming (Lindau et al., 2008). Teachers are also afraid of being terminated if parents or school administrators deem their sex education coursework is inappropriate (Darroch et al., 2000; Macgillivray, 2004; Piercy & Hayter,

2009) and most teachers do not choose to jeopardize their career for sex education, which they think is of secondary importance (Donovan, 1998).

All of these issues in the classroom may contribute to the lack of interest many teens exhibit towards sex education in public schools. Alarming, 59 percent of teachers report the biggest barrier to teaching sex education is not conservative parents or school administration, but the students themselves. Teachers report barriers such as student apathy and misinformation (Darroch et al., 2000). According to teachers, students do not take the topic seriously because of an attitude of invincibility and lack of awareness of their risk (Darroch et al., 2000; Elliott, 2008), which is consistent with the typical maturation process of teens (American Medical Association, 2001).

Parental Support for Sex Education

Idaho Statute 33-1610 mandates that school districts involve parents in planning, developing, evaluating, or revising any new sex education program (Idaho Legislature, 2009a). So how are parents involved and what philosophy of sex education do the majority of parents support? Numerous research studies demonstrate that 80 percent of parents, across political and religious lines, want comprehensive sex education taught to their children (Bleakley, Hennessy, & Fishbein, 2006; Cates, 2008; Eisenberg, Bernat, Bearinger, & Resnick, 2008; Howard-Barr & Moore, 2007; Ito et al., 2006; Kaiser Family Foundation, 2002).

A common theme that emerged in the literature was that parents, teachers, health care providers and students are inhibited when discussing sex (Cates, 2008; Elliott, 2008;

Gawlinski, 2007). Many parents want their children educated about sexuality and how to prevent pregnancy and STD, but are uncomfortable teaching them, so they support comprehensive sex education in school.

Influences on School Decision Making

Influences on school decision making regarding sex education include political, economic, social, and ethical factors (Kaiser Family Foundation, 2000). When principals rated how much influence these factors had on them, 57 percent said the teachers input was very important, followed by the principal's own values (54 percent), parents (23 percent), other community members (15 percent), religious leaders (11 percent), and local politicians (6 percent) (Kaiser Family Foundation, 2000). Therefore, the literature was reviewed to reveal more about these influences on sex education decision making.

Political Influences

According to a national survey conducted by the Kaiser Family Foundation, three-fourths of school principals reported state and local laws influence the sex education content in their school. Eighty-eight percent of principals also report their school district and local government had some influence over what was taught (Kaiser Family Foundation, 2000). This finding was validated in a national representative sample of school superintendents, 48 percent of whom said state directives determined what could be taught (Landry et al., 1999).

No doubt decision makers want to protect themselves against allegations they teach inappropriate sex education, such as accusations that comprehensive sex education encourages teenage sexual activity, contains pornography, and condones sex at a young age with multiple partners (Haffner & deMauro, 1996; Martin, Rector, & Pardue, 2004). School board members are elected and typically there is only a five percent voter turn-out for school board elections (Allen & Plank, 2005). Therefore, a highly organized group driving voter turn-out has been known to impact the election (Shields, 1996). This may influence school board members to operate under self-interest rather than for the public good. Fear of high profile, controversial decisions often causes school board members to circumvent the decisions made by the community-based teams in order to soothe parental complaints and keep the peace with special interests (Donovan, 1998; Geraci, 1996; Opfer & Denmark, 2001). This leaves the door open for the vocal minority to impose their will on the majority (Neutens, 1992). Many special interest groups have strong social networks and can quickly mobilize hundreds of constituents to send emails, supporting or complaining about a curriculum to school decision makers (T. Carles, personal communication, March 31, 2009).

The most recent research also indicates that school board members spend more time gathering information and analyzing the facts when making important decisions. School board members considered “important issues” as those having a high level of public interest, capable of affecting the next school board election. When making decisions regarding “important issues,” school board members prefer to discuss matters with (in order of highest preference) the school superintendent, the people involved,

consultants or content experts, and lastly parents, students, teachers, and the other school board members (Brown, 1985). Another study determined the sources of information school board members typically accessed to make controversial decisions. Thirty-three percent researched the issue on the Internet, 21 percent read school publications, 17 percent utilized email, 16 percent accessed information at school board conferences and 9 percent were informed at school administration seminars (Brown et al., 2004).

However, not all decisions are made by school boards. Nearly 20 percent of school districts have advisory boards made up of teachers, parents, community members, and religious leaders who are charged with making school district wide recommendations regarding sex education (Kaiser Family Foundation, 2000). However, research shows that school boards will frequently not abide by the advisory committee's recommendations in order to retain consistency among schools or satisfy complaints of special interest groups (Donovan, 1998; Geraci, 1996).

The sources decision makers use to gather information may affect the type of data received because some are based on academic evidence and others are not. In an effort to diffuse effective interventions into society, the CDC contracted with the Academy of Education and Development to create a website (www.effectiveinterventions.org), which lists sexual health curricula that have been thoroughly evaluated and are science-based (2009).

Social Influences

An older, but significant, research study found that the values and past experiences of the members affected school board decision making (Brown, 1985). A case study of sex education decision making in California described how a school board member, from a conservative district, opened the door for HIV education because of her personal experiences with her brother, who had HIV (Macgillivray, 2004). In addition the communication patterns and emotional nature of board members, their shared social life, culturally shared assumptions, and interpretations all affect decision making (Newton & Sackney, 2005). Even the demographic composition of the school board affects sex education decision making. A study of urban schools found schools with policies containing comprehensive sex education had a higher proportion of women on the school board than schools without comprehensive sex education. It is unknown if the same holds true for rural schools.

The demographics of a community, including the size, average education level of residents, the rural or urban designation, and the degree of diversity, may impact the type of sex education taught. For instance, urban communities with a higher proportion of Hispanic residents, more years of education, and more public support for comprehensive sex education are associated with increased incidence of comprehensive sex education. The same study also found school districts with policies supporting abstinence-only sex education had populations with more residents who had less than a high school education (Hess & Leal, 1999).

Research on decision making shows people prefer the status quo and have a bias for deferring decisions and taking no action. When weighing the potential benefits and risks of a choice, decision makers weigh the risk of loss heavier than the potential gain (Anderson, 2003). These tendencies may explain why nearly 50 percent of schools considered changing their sex education curriculum and 66 percent of those schools sex education policies remained unchanged (Kaiser Family Foundation, 2000).

Communities with active coalitions, made up of representatives from churches, universities, teachers, parents, and students, have been successful at creating a policy for comprehensive sex education that includes sexual orientation issues. In addition, community groups with leadership that inspires members to work together in a sustained way, to achieve their goals, have also been associated with comprehensive sex education (Macgillivray, 2004),

Surveys showed rural school principals believe decisions made in rural areas regarding sex education are under greater scrutiny than in urban areas. The school principals presume that living in a small town increases community participation because everybody knows everybody's business. One principal said he attended church with most of the townspeople and there was an expectation that he adhere to the values of the church when choosing the sex education curriculum. There is also the fear that going beyond the values of abstinence-only education may cost teachers or administrators their jobs. Furthermore, many residents in rural communities believe country living shields teens from risks associated with STD and HIV. Many principals were concerned this

“myth” lures parents into a state of complacency and makes discussions about sex and STD / HIV prevention seem less imperative (Blinn-Pike, 2008, p. 82).

Economic Influences

The affluence of the community also affects the type of sex education taught in local schools. A study of urban communities found an association between higher income levels and the prevalence of comprehensive sex education. Additionally, a larger proportion of enrollment in private schools was associated with comprehensive sex education (Hess & Leal, 1999). Education and enrollment in private schools was strongly correlated with higher income levels; therefore, the preference for comprehensive sex education may be a function of socioeconomic status.

When making a decision to change sex education curriculum, school administrators consider the financial outlay for new teacher manuals, student textbooks, handouts, and materials. Furthermore, schools providing teacher training on the new curriculum will incur costs for travel, registration, and lodging for teachers to attend the training. These costs may prohibit schools from changing their sex education curriculum, especially when budgets are tight. Furthermore, additional funding from Section 510 federal grants may influence sex education; however, only 31 percent of school administrators reported that funding influenced what was taught in their area (Kaiser Family Foundation, 2000). Lastly, the possible economic impact to teachers and school administrators cannot be omitted. Fear of being fired for offering sex education may

convince some school personnel to protect their livelihood by choosing the sex education curriculum least likely to be viewed as offensive (Donovan, 1998; Hayter et al., 2008).

Ethical Influences

Supporters of abstinence-only sex education view sex outside of marriage as immoral and reject providing information about how to use condoms because it sends a “mixed message.” In addition, they claim teens who abstain from sex are less likely to be depressed, commit suicide, or live in poverty (Avert, 2008). On the other hand, supporters of comprehensive sex education believe it is a basic human right to have access to information about matters affecting teens and the decisions they make. These supporters assert sex education provides young people with the means to protect themselves against abuse and exploitation, unintended pregnancies, STDs, and HIV (Office of the United Nations, 1998). The United Nations goal is to be sensitive to all religions, but not base sex education on any set of specific religious values.

With these two differing moral arguments, it is clear sex education is an ethical dilemma. Therefore, several authors have developed ethical models to guide decision making regarding sex education. The models work by assigning strength and weight to the values and ethical principles on each side of the argument. Two separate ethical analyses selected beneficence as the most critical principle because not teaching students methods to prevent HIV could result in death (Brown & Simpson, 2000; Bruess & Greenberg, 2008); however, each school could use the model as a logical tool for helping them to make their own decisions based on local values.

Understanding the issues that school decision makers consider important is key to influencing decision making (Brown et al., 2004). This case study will examine the new comprehensive health education policy implemented at the ISDB and how political, social, economic, and ethical factors influenced the decision.

Conceptual Framework

There is a paucity of research regarding decision making at the community level; most models are focused on individual level decision making and very few communal models or frameworks for evaluating community decision making exist. Kelly and Steed's conceptual model of Communities Coping with Change (2004) is used to guide this case study because it explains change at the community level and can be applied to decision making regarding sex education. The components of the Communities Coping with Change (CCC) model illustrate the multidimensional influences that bring about change or maintain the status quo, such as the economic, social, and political climate of the community (Kelly & Steed, 2004). These influences are similar to those found in the literature review. The CCC model should provide an effective structure to thoroughly explore the decision making process at the ISDB. Figure 2.1 depicts the CCC Model (Kelly & Steed, 2004, p. 204).

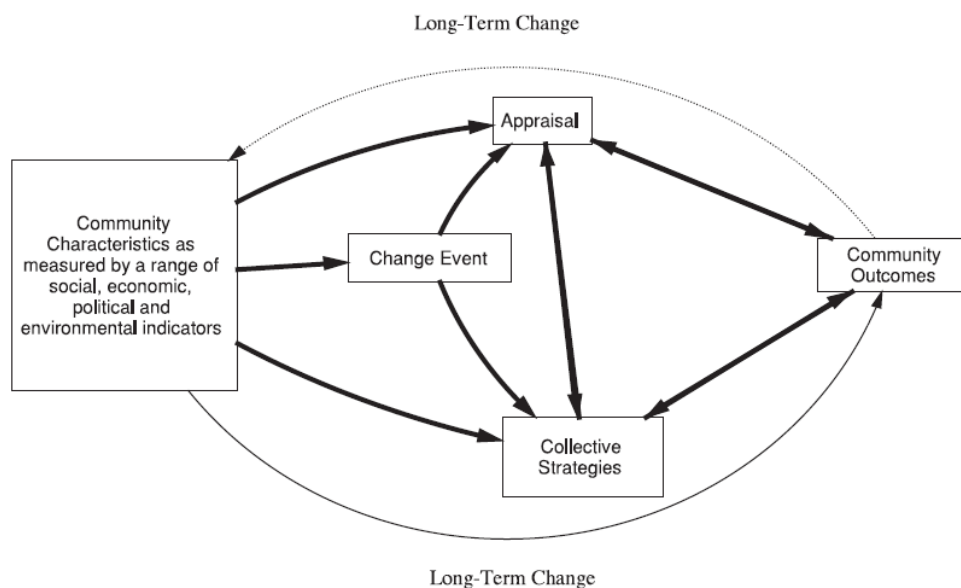


Figure 2.1. Communities Coping with Change Model

Kelly and Steed (2004) use the CCC model to explain how the characteristics of the community, including diversity, average income, education, unemployment rate, industry, size, proximity to a city, leadership, influence of local governments, level of participation, community competence, sense of community, and collective self-efficacy influence the problems that brought about the need for the decision (change event) and the final outcomes. According to the model, the way the community at large interacts with those in power (decision makers) to prioritize problematic issues, weigh alternatives, and implement solutions also influences quality of life.

In the CCC model, the way a community copes with problems is referred to as the "collective strategy." Kelly and Steed use Checkoway's typology of six collective

strategies for change, which consists of mass mobilization, social action, citizen participation, public advocacy, popular education, and local-services development (2004). For this case study, the collective strategies the ISDB utilized when revising the comprehensive health education policy will be examined and the response to those strategies will be analyzed. Kelly and Steed assume that communities will use the same strategies to make decisions they used in the past and the strategies will be congruent with the communities' primary characteristics and bound by community resources (2004). Thus, the analysis provided insight into the patterns of decision making and community involvement that are likely to reemerge in the ISDB in the future. This information may be used by nurses to determine the most practical ways to intervene in the decision making process.

Lastly, Kelly and Steed (2004) adapted Lazarus and Folkman's work done in 1984 on the psychological stress response in individuals, as a guide for how communities appraise an event. Individuals appraise an issue as irrelevant, threatening, or positive, while at the same time evaluating the resources available to cope with the issue (as cited in Kelly & Steed, 2004). The appraisal is also influenced by the individual's perception of the situation, whether it is novel, predictable, uncertain, controversial, or controllable. The interplay of these factors influences the process and how the outcome unfolds. Based on the community's appraisal, the issue will generally be dealt with as a problem to be managed or the community will react emotionally. Social support is often the solution for emotion-focused coping strategies (Kelly & Steed, 2004).

The CCC model is based on social science theory and has been used in natural resource management to facilitate effective collaborative decision making when there are value-laden issues, diverse viewpoints, and multiple stakeholders involved. Although the model has not been widely used in population health nursing, or rigorously tested, it proved to be a viable theoretical model to guide the collection of factors that described the decision making process at the ISDB. CCC theory has not been rigorously tested but it is not critical because the purpose of a case study was to describe a situation of interest, making a theory that definitively predicts relationships between variables unnecessary (Creswell, 1998). Fortunately, the CCC model was a useful framework for data collection because it contained the elements identified in the literature review.

To summarize, the CCC model was used to examine the characteristics of the ISDB community, how sex education decisions were historically handled, contextual factors that influenced the Board's perceptions, and what collective strategies were used to problem solve and arrive at a solution. The evaluation of the outcomes (increased knowledge, reduced unintended pregnancies, and STDs) are beyond the scope of this case study and was not included.

Statement of Purpose

With knowledge of the decision making process, nurses can effectively assist school decision-makers to implement evidence-based, sex education curricula. Therefore, the purpose of this case study is to describe the influences at play regarding the decision making process related to sex education in the ISDB.

Research Question

The research questions are:

- When the last decision regarding sex education curricula was made at the ISDB, what was the process?
- Who was involved and how? Were school nurses involved? Were health department nurses involved?
- What were the characteristics of the Boise community?
- What were the main issues and the context influencing policy?
- What problem solving strategies were used to arrive at a decision?

Conceptual Definitions

In this section, the constructs of the CCC are defined. The first term to be defined is "change event." A change event arises in the community as a result of a situation or problem that needs to be addressed to make the community safer, healthier, or more economically viable. Policy decisions are considered change events and are typically political in nature. The community generally views the impact of policy decisions as uncertain and the issues are usually accompanied by a high degree of ambiguity (Kelly & Steed, 2004)

The next construct to be defined is "appraisal." Appraisal is the perceptions of the community about the change event, which may be perceived as irrelevant, threatening, or positive. The community also may perceive the context of the situation as novel, predictable, uncertain, controversial, or controllable. The appraisal affects the way the

community will cope with the change event, typically communities will view the change event as a problem to be solved or an emotional issue (Kelly & Steed, 2004).

As mentioned previously, Kelly and Steed use Checkoway's typology of six collective strategies for change to describe a community's collective strategy. A collective strategy is the way a community copes with the change event and may consist of mass mobilization, social action, citizen participation, public advocacy, popular education, and local-services development (2004). Each collective strategy is briefly defined below.

Mass mobilization occurs when community members visibly coordinate their efforts to increase public awareness and knowledge about the change event. Social action aims to create community groups with strong leaders to inspire and coordinate the members. Citizen participation occurs when members of the public are involved in decision making and planning boards of governmental or community groups. The purpose of public advocacy is to ensure that members of concerned groups are able to express their viewpoints to those in power. Popular education occurs when the community is informed about the issue of concern. And lastly, local-services development occurs when community members resolve their own problems by providing their own services (Kelly & Steed, 2004). The components of the CCC model chosen for this case study provided an effective framework to examine the characteristics of the ISDB community, how sex education decisions were historically handled, and contextual factors that influenced the community's perceptions.

Summary

Chapter Two provided a brief background on sex education in the U.S. and a literature review, which summarized and evaluated the research findings on comprehensive sex education and abstinence-only sex education curricula. The central viewpoints and preferences of students, parents, teachers, and the healthcare community about sex education were reviewed, along with the political, social, economic, and ethical factors that have been shown to influence decisions regarding sex education in public schools. Given those influences and the research purpose, the CCC model was used as the theoretical framework to guide this case study. A description of CCC and definitions of the components of CCC were also covered. In the next chapter, the methodology used for the case study is presented.

CHAPTER THREE: METHODOLOGY

The literature explored in Chapter Two on sex education indicated many factors influence decision makers, including, but not limited to, politics, school policy, parental support, teacher preference, community values, existing curriculum, and local, state, and national laws. The Communities Coping with Change (CCC) model identifies the multidimensional influences that bring about a change in the community or maintain the status quo. Components of the CCC model that identify the influences include community characteristics, appraisal, and collective strategies and these components were utilized as the theoretical framework to guide data collection in this case.

Thus, a research design was needed that allowed for the collection of the wide variety of data employed in the CCC model, and utilized a straightforward analysis of the data. This chapter describes the case study design was selected for this research, and the rationale for choosing it. In addition, the procedures used to collect and analyze the data, ensure rigor and protect human subjects, are presented.

Research Design

According to Creswell (1998), the strength of a case study design is the ability to analyze multiple sources of information to describe an event in great detail, including the context and setting of the case. The case study also includes a contextual description that encompasses the physical setting, as well as the social, historical, and economic

landscape of the case; therefore, the design is appropriate to collect and analyze the complex set of factors influencing sex education decision making at the ISDB.

(Creswell, 1998). This type of information completes the CCC Model, further ensuring the case study is a pertinent design for this research. Furthermore, Yin's assertion that case study research is often useful for matters of public policy and education adds credence to the choice of a case study design (2003).

A case can be a collection of people (Creswell, 1998), in this case the community of Boise, including the staff and administration at ISDB. In addition, the event studied should be finite, confined by a pre-determined duration of time and specific geographic location (Creswell, 1998). Therefore, this case study was confined to the decision of the ISDB Board of Trustees to adopt the new comprehensive health education policy in April of 2010.

The ISDB was chosen as the case for this study because it is located in the city of Boise, the largest population center in Idaho. The highest teen abortion rates in Idaho are reported in Boise, along with the most teen cases of STD and HIV. Because of the large population in Boise, policy decisions made about sex education have the potential to greatly impact the sexual health of Idaho because more teens could either receive evidence-based sex education programming or not. The ISDB has the second largest enrollment in the state with Meridian School District having the largest. ISDB and Meridian School District are classified as the only two very large districts in the state and each have 10,000 more students than the third largest district (Idaho Legislature, 2009b).

ISDB is also a convenience sample, because it is located in the same city as the research facility, Boise State University (BSU).

Setting and Population

Boise, Idaho is located in the northwestern U.S., and in 2009, the U.S. Census estimated it had 205,707 inhabitants living within 1,645 square miles. Boise is the capitol of Idaho and has the largest population of any Idaho city. It is estimated that the population of Boise grows by 2.07% each year. The U.S. Census Bureau's estimate of race and ethnicity for 2009 for the population of Boise was 89.4% White, 6.3% Hispanic, 2.3% Asian, 1.3% Black and less than 1% American Indian. The racial and ethnic composition of Boise is shown in Figure 3.1.

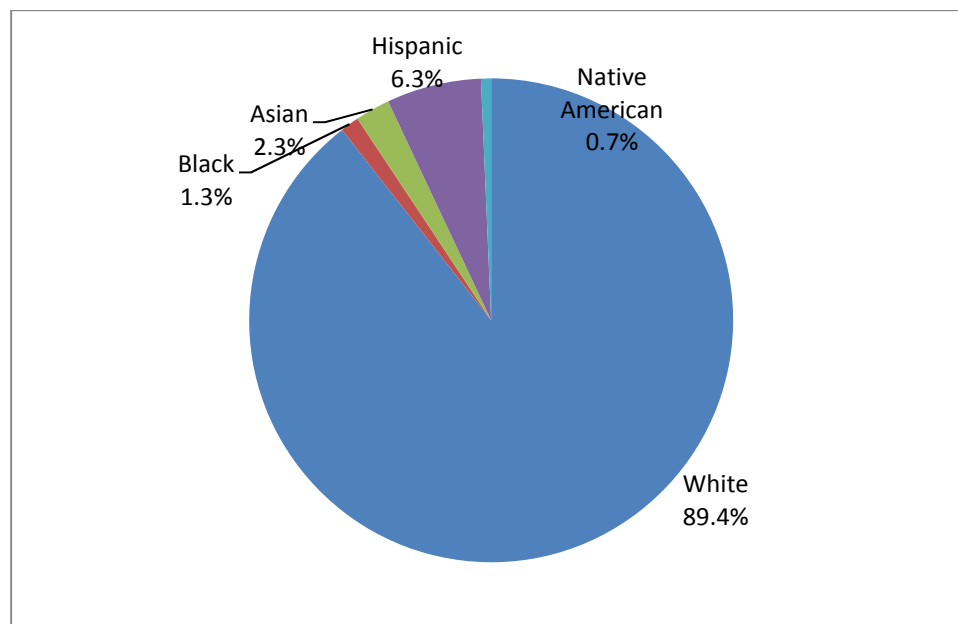


Figure 3.1. U.S. Census Bureau, Boise Population by Race/Ethnicity, 2009

An estimated 7.2 percent of Boise's population is between 15-19 years-of-age (U.S. Census Bureau, 2009) and may attend high school and receive sex education coursework. The ISDB is the institution responsible for providing sex education in public schools to students in Boise. There are five ISDB high schools and eight junior high schools. In 2009, ISDB had an enrollment of 25,251 students, including 5,648 junior high students and 6,026 senior high students. (The total number of high school and junior high school students comprises 5.7% of Boise population.) ISDB enrollment has been dropping since 1997 when there were 27,070 students (Independent School District of Boise, 2010e). This is largely due to a population shift to the west end of the valley, which resides in the Meridian School District. In 2009, the racial / ethnic composition of the student body of ISDB was 85% White, 8% Hispanic, 4% Asian, 2% Black, and 1% Native American (Figure 3.2).

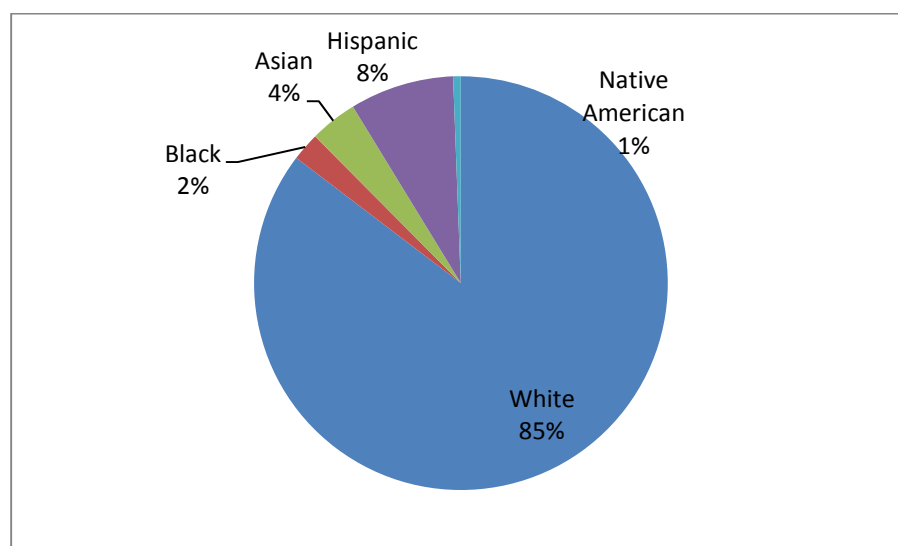


Figure 3.2. Independent School District of Boise (2009) Student Population by Race/Ethnicity

The ISDB has employed school nurses since 1918 and supports student success through health services. A full-time registered nurse is employed at each of the ISDB secondary schools. The school nurse's mission is to promote optimal health, prevent disease, and provide health education (Independent School District of Boise, 2010d). The school nurses teach grade school puberty and sex education classes. High school nurses provide one-on-one counseling to students who seek help for any health related issue, including sexual health.

The ISDB Board of Trustees is responsible for setting the policy that guides public education in Boise; thus, decisions regarding sex education are made by the Boise School Board of Trustees. The Superintendent of Schools advises the Board and works with the ISDB staff to execute the policies of the Board. All policies created by the Board must be consistent with the laws covering public education in the State of Idaho and the United States. The Board must also follow the guidelines established by the Idaho Legislature and the State Board of Education (Independent School District of Boise, 2010a).

Sampling Method

Community characteristics provide the context for this case study and can be understood by looking at current policies, demographics, social, economic, political, and historical indicators. The researcher gathered significant amounts of electronic information. This included demographic data from the U.S. Census Bureau and city of Boise. Other information from the Youth Risk Behavior Survey (YRBS) System was

collected regarding teen sexual activity and parent-child communication about HIV prevention. Data regarding teen pregnancy and abortion rates came from the Idaho State Bureau of Records and Vital Health Statistics, and STD morbidity data was available online from the Idaho State Office of Epidemiology and Food Protection.

Face-to-face interviews were also conducted to fulfill the appraisal component of the CCC Model. To appraise the community's perception of the problem of rising unintended pregnancy, abortion, and STD rates in Boise, interviews were conducted with:

- Two ISDB Trustees
- Two health teachers
- Two high school nurses
- One ISDB mid-level administrator

To examine the relationship dynamics and the decision-making process of the Trustees, it would have been optimal to observe a Board Meeting while the Trustees created and approved the new comprehensive health education policy (Morse & Field, 1995); however, the ISDB had just finished revising the policy when data collection for this case study began, so direct observation was not possible. In addition, when making the 2010 revision to the sex education policy, the ISDB did not convene an advisory committee or notify parents of the upcoming decision. Therefore, analysis of committee work on the comprehensive health education decision was also not a part of this case study.

Rationale for Theory Selection

The research questions guided the types of information collected and focused the direction of the analysis (Burns & Grove, 2005). The questions centered on increasing the understanding of

- the process of ISDB decision making
- the main issues and context underlying the sex education issue
- the characteristics of the Boise community
- the strategies ISDB has used in the past when dealing with sex education issues

The Community Coping with Change Model (CCC) was chosen for the theoretical framework to guide this research because, according to the model, the way a community interacts with decision makers to prioritize problematic issues, weigh alternatives and implement solutions influences the quality of life and health in the community. In addition, the key elements of the research questions are components of the CCC Model (2004). The components of the CCC include the change event, community characteristics, appraisal and outcomes. The community characteristics include a range of demographic, social, economic, political, and historical indicators and provide a rich description of the context underlying the sex education issue. Since the review of the literature showed the characteristics of a community influence sex education decisions, it was fitting to choose a model which examines community characteristics and analyzes how members of specific political, social and demographic groups typically reacted to problems and issues in the past.

To understand the strategies the ISDB has used for addressing sex education issues in the past, an appraisal of ISDB staff was performed. Appraisal is another component of the CCC model that predicts how the community's perception of the situation also influences change within a community. Whether the problem is perceived as novel, predictable, uncertain, controversial, or controllable will influence how the community copes with the problem at hand (Kelly & Steed, 2004). The perceptions of teens' sexual health issues by the Boise community was appraised by conducting face-to-face interviews and incorporating secondary research via a sexual health community needs assessment, which was conducted in Ada County in 2008 (Elliott, 2008). To collect the information needed to implement the CCC, model a case study design was utilized to analyze multiple sources of information to describe the context and setting of the case in great detail (Creswell, 1998).

Interviewee Recruitment

Purposeful sampling was used to recruit participants who were involved in the case. The ISDB Board Clerk recommended one trustee and a mid-level administrator for interviews because they were the driving force behind the recent creation of the new comprehensive health education policy. Another administrator was recruited because of being listed on the ISDB website as a source for sex education information for parents who had questions. The administrator was also recommended by others who were interviewed.

The interviews were requested by telephone and/or email. The recruitment script is located in Appendix C. The researcher made up to three phone calls and sent up to three emails before terminating the request for participation. Both Trustees agreed to participate and one of the administrators agreed to be interviewed. The second mid-level administrator, who was listed on the ISDB website as a resource for secondary sex education was contacted by telephone and email multiple times, but never responded and was not interviewed.

Twelve frontline workers, including high school nurses and secondary health teachers, were contacted by telephone or email and four agreed to be interviewed. The researcher made up to two phone calls and sent up to two emails before terminating the request for participation. Interview solicitations were made during the last week of school and summer vacation, which could have contributed to the difficulty the researcher had finding frontline workers to participate in the study.

Background of Interviewees

Both the Trustees were educators and have had multiple years of experience on the ISDB board. Both Trustees viewed policy as one of their specialties. One held a doctoral degree and the other a Masters degree. The administrator was an advanced practice nurse and has had long-term experience with the ISDB, as well. One of the health teachers had been teaching as a secondary health teacher at the ISDB for over 20 years and was in a position of leadership at his school. The other had taught health for several years at ISDB and had experience teaching health in other school districts. The

school nurses both had over 20 years of experience at ISDB, one with many years experience at the elementary level. The following two sections discuss some of the responsibilities of high school nurses and health teachers in the ISDB.

Sexuality Education Responsibilities of High School Nurses

School nurses employed by the ISDB are registered nurses (RN) and teach the sex education classes in elementary school. The sex education taught in elementary school includes puberty, growth and development, fertilization, blood borne pathogens, and transmission of disease. In high school, nurses do not teach the sex education classes; however, they may provide one-on-one counseling for girls who think they are pregnant. The RNs commonly refer students to the Central District Health Department (CDHD), Planned Parenthood, or Birthright for birth control or pregnancy and STD testing. The nurse is prohibited from providing condoms, pregnancy tests, or education on birth control. The school nurses are also a resource for health teachers who teach sex education in secondary school.

Sexuality Education Responsibilities of High School Health Teachers

The secondary health teachers in the ISDB teach reproduction, conception through birth, teen dating, abstinence, the menstrual cycle, STD, and HIV. The teachers deliberately foster a respectful and open classroom culture. Most of the health teachers in the ISDB bring in a guest speaker, an RN from CDHD, to teach the students about STD and HIV. In addition to abstinence, the CDHD RN is allowed to discuss condoms and

barrier methods as strategies to prevent STD and HIV. The health teacher may refer students to CDHD for services or consult with the school nurse or the CDHD RN if students have questions beyond the health teacher's level of expertise or comfort.

Protection of Human Subjects

Institutional Review Board (IRB) approval for the case study and for the community health needs assessment was obtained from BSU prior to data collection. All participants were informed of the purpose and voluntary nature of the study and provided signed consent. Minimal identifiers were collected, specifically approximate age, gender, and race/ethnicity. With the consent of the participants, six of the interviews were audio recorded. Notes were taken during the interview that was not recorded. The researcher and thesis committee members are the only individuals with access to the recorded data. All data collected for this case study is confidential and is stored in a locked file cabinet in office NN 428 of the Norco Building at Boise State University, School of Nursing. The data will be stored for three years and then destroyed.

Data Collection Procedures

Community Characteristics and Contextual Information

Data were collected from March 2010 through September 2010 and the most current available data were utilized. Contextual information was collected online or by visiting the ISDB and included:

Documents, books, and electronic information:

- Current sex education policy in ISDB
- Current sex education curriculum
- Minutes from school board meetings
- Agenda from policy committee meeting (no minutes available)
- Copy of current secondary health book being used
- ISDB budget

Demographic information:

- Characteristics of Boise or, if Boise not available, Ada County
 - Age, sex, race, ethnicity, marital status
 - Religious affiliation of Boiseans
 - Political affiliation of Boiseans
 - Economic indicators for Boise
 - Teen pregnancy rates in Boise
 - Teen STD rates in Boise
- Characteristics of ISDB students, teachers, and administrators:

Political information:

- School Board elections:
 - Voter turn-out
 - Number of candidates running
 - Number of incumbents running

- Local elections:
 - What were the main issues facing Boise? What was the political climate?
- State elections:
 - What were the main issues facing the state? What was the political climate?
- National elections:
 - What were the main issues facing the country? What was the political climate?

Social information

- Idaho YRBS results of communication between parents and children about HIV

The name of the document, description, source, date, and significance of the information were summarized using a document summary form (see Appendix D). The data collected from the ISDB, including Board meeting agendas and minutes, were public information and everything except the agenda for the policy committee meeting was obtained online (Independent School District of Boise, 2010a). All of the data collected from agency archives were public information and did not require any confidential handling. While visiting the ISDB, the researcher spoke with the Board Clerk, and was informed of the procedures for revising policy and the timeline for routinely reviewing policy.

Interviews

Between April 29, 2010 and August 2, 2010, seven interviews were conducted. The unstructured interviews began with approximately six questions and lasted between 30-60 minutes. Appendix E contains the original interview questions. All of interviewees provided informed consent.

Prior to the interview, the researcher reviewed the social aspects of effective interviewing. The researcher made every attempt to build rapport and encourage a comfortable and open discussion with the interviewee. During several of the interviews, the researcher reminded the interviewee about her commitment to confidentiality and the right of the interviewee not to answer any question. The researcher also reviewed some principles of objective interviewing and was cognizant to avoid leading questions. In addition, the researcher reviewed the research questions before each interview and adjusted the questions to fit the roles and responsibility of the interviewee and to obtain pertinent information that still needed to be collected.

After the interviews, the researcher wrote a detailed description of the encounter in a field diary. In a separate section of the diary, the researcher reflected on questions or issues that arose during the interviews. Also, as soon as possible after journaling, the researcher reread the notes and wrote down any impressions, possible relationships, prejudices, or ideas that needed to be explored further during data analysis (Morse & Field, 1995). The researcher also kept an Interview Summary Form to organize the data into a useable format (Appendix F).

Data Analysis

Analysis of Document Review of Contextual Information

The researcher completed the document summary form and read the documents many times for immersion into the data (Stake, 1995). Then, the researcher filed the data into groups: Demographics, ISDB policy and curriculum, Idaho State Department of Education policy and curriculum, legal, political, and social. During the process of re-reading the documents, writing about the case and discussing the case with the research committee, the researcher began to discern patterns, concepts, and connections (Stake, 1995). The researcher analyzed the relationships between categories and found meaning, concurrence, and consequences (Morse & Field, 1995).

Analysis of Interviews

During the interviews, the researcher made notes regarding the interviewee's gender, approximate age, race, ethnicity, and style of dress. The researcher also noted the setting of the interview, nonverbal cues, and impressions about the interview. The researcher transcribed the interview audio recordings, verbatim, and pertinent ideas and statements were noted. The researcher listened to the recordings and read the notes and transcripts many times to achieve data immersion (Stake, 1995). To organize the interview data, the researcher coded the notes with the document line number and participant identifier to ensure qualitative rigor. Using Microsoft Excel, the researcher color coded the data, by participant, and assembled all seven participants' notes into 30 concepts. Using an iterative process of comparing and contrasting the seven interviews,

the researcher analyzed the concepts and identified patterns of responses. Then, researcher aggregated the concepts into four main categories (Creswell, 1998). An associate professor in the Nursing School at BSU validated the categorical aggregation and interpretations.

Analysis Summary

Throughout the analysis, the researcher linked the findings to the research questions and the CCC Model to make meaningful conclusions about the influences that affect decision making regarding sex education in the ISDB (Burns & Grove, 2005). The researcher identified several main issues of greatest importance and a detailed narrative of the social, political, economic, and historical context was written and included in Chapter Four (Stake, 1995). The researcher compared the interpretations and conclusions with similar studies in the literature to check for consistency. The researcher also compared the findings with rival explanations to challenge the assumptions that were made when interpreting the data.

Researcher Bias

In this case study, I increased my understanding of the social reality that underlies the decision-making process of the ISDB. The ontological assumption used for “understanding reality” in this case study is based on an interpretivist interpretation – that reality is multiple, emergent, and shifting. The knowledge from this case study, which emerges from the data, was interpreted through my experiences, viewpoints, values, and

beliefs (Banister, Berman, Parker, Taylor, & Tindall, 1994). Because the reality of sex education decision making at ISDB is the picture I paint of reality, based on my experiences and perspectives, it is important that my background and assumptions are explicit, so the reader may interpret my conclusions (Merriam, 1998). Therefore, it is important that I disclose my relationship to the case and make clear any assumptions that may have influenced my ability to objectively analyze the data.

I am a part-time student in the Master of Science Nursing Program at Boise State University. In addition, I work at the State of Idaho, Department of Health and Welfare, Family Planning, STD and HIV Program. In my position as STD Program Coordinator, I review the most current local, state, and national STD morbidity and research. I see the large number of cases of teen parents, teens with STD, and abortions and I want to help. Being a mother of teens, I enjoy teens. I know they are doing the best they can, but that they may make many mistakes. I don't want these missteps to negatively affect their lives forever. I also believe it is unlikely that we can prevent many teens from having sex, so I want to provide them with everything they need to prevent STD and unintended pregnancy, including knowledge, condoms, birth control, access to care, etc.

It is my belief that parents have the right to teach their children their religious and family values about sexuality. I also believe the values and beliefs regarding abstinence-only are largely based on the religious beliefs of a limited segment of the population and should not be forced onto the entire population, especially in light of the severity of the current STD and unplanned pregnancy problems and the limited evidence of effectiveness of abstinence-only education. Not everyone who is religious supports

abstinence-only education. I have deep religious beliefs myself and connect with my higher power daily, through prayer, meditation, participating in a faith community, and trying to practice the principles of honesty, kindness, generosity, faith, service, and gratitude in my life. I have also tried to instill these values in my children. My religious affiliation most closely aligns with that of the Unitarian Universalist Association.

When discussions about sexuality came up in my household, my sons would always try to avoid it by saying “I already learned about that in school, mom” (Anonymous, personal communication, n.d.). My children attended the ISDB and received a good education. One of my sons received a four-year scholarship to Boise State University after graduating from Capital High School in the ISDB and now teaches for the ISDB. When my children were in school, I was an active member on the Board of the Parent Teacher Association (PTA), volunteered as a school nurse, and taught parents how to improve their parenting skills. I also worked for the ISDB for approximately one and one-half years as a Title I tutor. Several times I wrote letters to the ISDB administration advocating for later start times for high school students. That recommendation was never implemented. At the time I wrote the letter, I was not aware that to improve my chances of successfully influencing policy, I would need to join with other like-minded parents and take the issue to the Board of Trustees.

Summary

In Chapter Three, the researcher described how the research questions, CCC theory (Kelly & Steed, 2004), and the literature review informed the choice of a case

study design and the type of information collected for this research. The data sources were described, and included personal interviews and a review of many documents. The procedures for recruitment, protection of human subjects, and collection and analysis of the data were also described. And lastly, an honest account of the researcher's bias was revealed. Next, Chapter Four contains the results of the case study research and the answers to the research questions.

CHAPTER FOUR: RESULTS

The characteristics of the community of Boise, the community's appraisal of the problem of poor teen sexual health, and their collective strategy to address it, inform the Communities Coping with Change (CCC) model. The model, which was used for the theoretical base for this study, identifies the multidimensional influences that bring about a change in a community or maintain the status quo. The model also predicts how a community will respond to a problem.

Chapter Three described the multiple sources of data collected in this case study to implement the CCC model. Sources consist of a document review and personal interviews. In addition, the research methodology, including the procedures for recruiting participants, protection of human subjects, and collection and analysis of the data, was also addressed.

Chapter Four presents the findings of the ISDB document review and analysis of community characteristics. These findings provide the contextual landscape underlying ISDB decision making. Within this context, the research questions were answered, using information gathered from the interviews. The main categories that arose from the data are also presented.

Major Findings

Contextual Findings – Characteristics of the Boise Community

The first research question asked, “What were the characteristics of the Boise community?” Community characteristics provide the context for this case study and were assessed by looking at current policies, demographics, economic, political, legal, and social indicators (Kelly & Steed, 2004).

Boise Demographic Information

In 2009, the U.S. Census estimated that 205,707 people inhabited Boise: 49.5 percent males and 50.5 percent females. The average family size was 2.96 and the median age was 35.1 years. The majority of families in Boise (55.6 percent) had children between the ages of 6 and 17 years of age. Fifty percent of Idahoans over the age of 15 were married, 29.7 percent were never married, and 13.6 percent were divorced. Figure 3.1 depicts the racial and ethnic composition of Boise (U.S. Census Bureau, 2009).

Characteristics of ISDB Students, Teachers, and Administrators

The student body attending ISDB in 2009 was slightly more diverse than the general population of Boise; however, the majority of students were White. In 2009, the percentage of students reporting Hispanic ethnicity and Asian race were greater in the ISDB than found in the general Boise population. See Figure 3.2 for the entire breakdown of race / ethnicity in ISDB students (Independent School District of Boise, 2010e).

In 2009, 34 percent of ISDB teachers were male and 66 percent were female. Approximately two-thirds of ISDB students were from single-parent homes or homes where both parents work. Forty-two percent of ISDB students were from low-income families and were eligible for reduced-priced lunches (Independent School District of Boise, 2010e).

There are seven Trustees on the ISDB School Board. Four of the Trustees are White males and three are White females. The superintendent and deputy superintendent are White males. The Trustees are unpaid positions and the Trustees' experience on the Board ranges from 8-22 years.

Current Health Textbook

The ISDB high school health classes use the Glencoe Health book (Glencoe McGraw-Hill, 2003). The book was printed in 2003 and contains older statistics and some medical inaccuracies due to advancements in medicine and research. The book has a strict abstinence-only until marriage message. The chapter on HIV does not provide education on condoms as a prevention strategy.

The Glencoe health textbook is scheduled to be updated; however, the current recession has affected ISDB budgets and delayed purchasing new books. The total amount of the 2010-2011 ISDB budget reduction is discussed in the next section.

Economic Findings

ISDB Budget

The economy was sluggish from 2008-2010 and tax revenues for the State of Idaho were below forecasts. To balance the budget, the Idaho legislature cut funding for education in Idaho 7.5 percent in Fiscal Year 2011, compared to Fiscal Year 2010, a reduction of \$128,525,800 (Idaho State Department of Education, 2010a).

To compensate for the reduction in funding from the State, the ISDB Trustees reduced the 2010-2011 ISDB budget by six percent, or \$11.5 million less than 2009-2010. The total budget for 2010-2011 was \$187.4 million (Estrella, 2010). The ISDB Board reduced the education budget by eliminating 60 administrative, teaching, and support positions, deferring raises, furloughing employees, purchasing fewer books and technological equipment, and reducing bus routes (Gupta, 2010).

Economic Indicators for Boise

The estimated median family income for Boise in 2008 was \$64,519; however, 9.6 percent of Boise families were reported below the poverty line (U.S. Census Bureau, 2009). In October, 2009, the adjusted unemployment rate in Boise reached a high of 9.6 percent. Figure 4.1 shows the major occupational categories for Boise residents in 2009: 15.5% were employed in government, 14.4% were employed in business or professional services, 12.2% were employed in education, 12.2% were employed in healthcare, 11.9% were employed in retail, 11.7% were employed in manufacturing, 8.7% were employed

in leisure or hospitality, and 6.8% were employed in the construction industry. Statistics provided by the Idaho Department of Labor (2009).

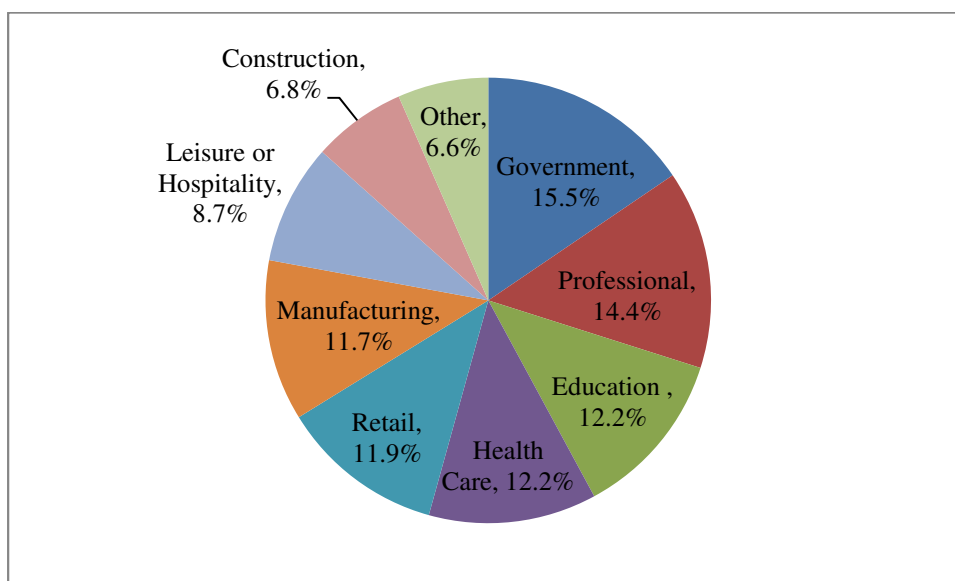


Figure 4.1. Type of Employment in Boise, 2009

Religious Findings

Research from the Association of Religion Data Archives shows that 49.2% of Ada County residents, where Boise is located, attend religious services. Of those who attend church in Boise, the majority are Mormons, followed by Catholics. Figure 4.2 illustrates the religious affiliation of those who attended church in Boise in 2000. It was estimated that 34% of church going Boiseans identified as Mormons and 27.6% identified as Catholic. The remaining 38.4% belonged to religious groups, such as

Protestant, Jewish, Hindu, Muslim, Bahá'í, and Unitarian (Association of Religion Data Archives, 2000).

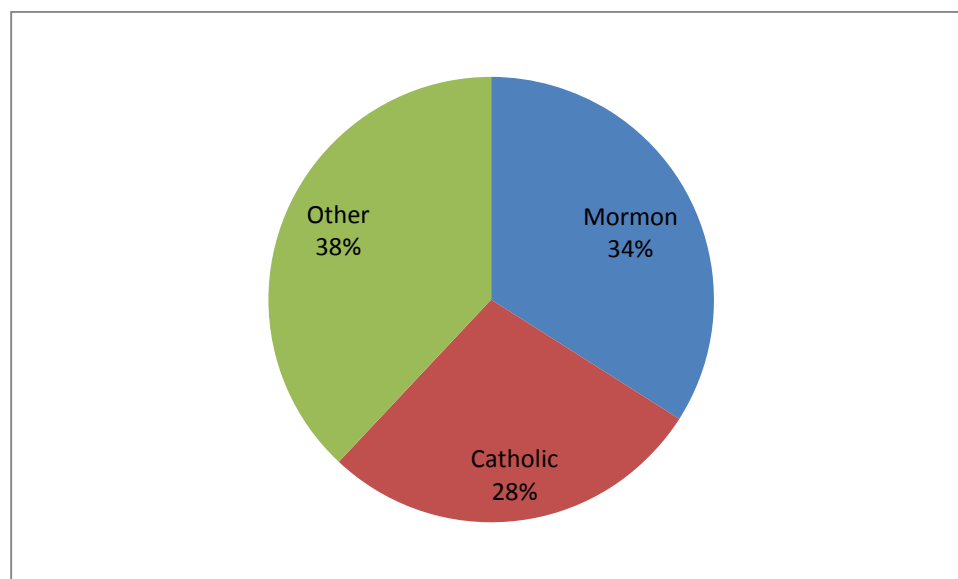


Figure 4.2. Religious Affiliations of Church-Going Residents of Boise, 2000.

Political Findings

School Board Elections

There are seven Trustees on the ISDB who are elected for staggered six year terms. The positions are unpaid and many hours of service are required. Trustees are political figures who are not necessarily educators, but bring the values of the community to bear on decisions made by the school. A Trustee must be knowledgeable about numerous issues, make many important decisions, and mediate conflict (personal

interviews, 2010). The sex education policy decisions are made by the ISDB Board of Trustees.

Three candidates ran for two open Trustee positions and were elected on September 7, 2010. Rory Jones, the Trustee with the longest tenure, and Joan Boren, who is new to the Board, were elected. Only 1.6 percent of registered voters in Boise voted (Statesman staff, 2010).

Political History of ISDB Sex Education Decisions

The last major change to the sex education policy occurred in 1985. None of the current Trustees were on the board at that time; however, the current Trustees have been told the decision was contentious. The conflict arose because the board voted for an opt-out policy and the community favored an opt-in policy. The researcher was not able to verify this, but apparently, there was a recall of the board members, which even included Trustees who voted against the opt-out policy and Trustees who were absent for the vote. In the next school board election, immediately following the decision, 13 candidates ran for the Board, largely to gain the power to put their views on sex education policy forward. Voter turn-out was high. Typical voter turn-out for school board elections is very low, between one and two percent (Confidential interview, 2010).

The HIV education policy was created in 1993 in response to the outbreak of HIV and AIDS (Acquired Immunodeficiency Syndrome) in the U.S. The process for creating the policy included public hearings and recommendations from an advisory committee. The advisory committees had strong medical input given by a prominent physician in

Boise, along with representation from parents, public health officials, and religious groups. Three of the seven current Trustees sat on the Board at that time. This was also a period of conflict in the community, and a great deal of misinformation, fear, and other strong emotions were reportedly displayed during public testimony. The Board Chairman kept the public meeting in control by insisting on respectful communication and ensuring that everyone who signed up to testify had an equal opportunity to speak (Confidential interview, 2010).

Political Activism in the ISDB

In September of 2009, President Obama spoke to students across the U.S. All schools were invited to televise the speech in their classrooms. Some conservative groups were suspicious of the speech and calls urging the ISDB not to broadcast the speech swamped the District office. Laird-Richards quoted Don Coberley, superintendent of ISDB, as saying "after the third phone call that morning, I got the distinct impression that these people were reading from the same script" (2009, p. 1). Knowing the students could view the speech on u-tube later, the ISDB decision-makers decided to leave it up to the principals whether to air the Obama speech. It is estimated one out of nine students viewed the speech. Laird-Richards also interviewed Dan Holler, public relations executive for ISDB, and Laird-Richards observed that "he did not hide his disgust with the circus the Republicans created with their hysteria, and said he believes the White House was taken by surprise at the Republican attacks" (2009, p. 1).

Political Affiliation

The Daily Caller ranked Boise as 98th in the top 100 conservative-friendly cities to live in America. The ranking is based on voting history in past presidential elections, tax burden, concealed weapons laws, abortion laws, weekly religious attendance, married family percentage, etc. (Palko, 2010). Even in the north end, which is considered the most liberal neighborhood in Boise, voter registration is 52 percent Republican, 45 percent Democrat, and 2 percent Independent (Sperlings Best Places, 2010). However, in Boise, three-fourths of the state legislators are Democrats and one-fourth are Republicans (Idaho Legislature, 2010b).

National Political Overview

In the area of sexual health, the federal government allocated more than \$100 million dollars to prevent teen pregnancy. The bulk of the money will be provided to states with evidence-based comprehensive sex education programs. Funding for abstinence-only programs has been substantially reduced and states providing abstinence programs must certify that the curriculum is medically accurate (National Campaign to Prevent Teen Pregnancy, 2010).

On a national level, the federal government spent billions of dollars to bail out the banking industry and stimulate the economy in 2009 and 2010. Afraid of deficit spending and an increasing tax burden, a group of activists called the Tea Party have been vehemently speaking out against government interference.

State Political Overview

Traditionally, the majority of Idaho voters are conservative and Republicans dominate the state government. Many Republicans are fiscally conservative and are not in favor of the deficit spending the federal government used to stimulate the economy. This has shifted the Republican party to the right and many have joined the Tea Party. For example, the Republican party platform for 2010 includes an oath for candidates to pledge their loyalty to the principles of the Republican party. The platform also includes a call to repeal the 17th amendment (Hurst, 2010). The repeal would allow the state legislature to appoint Senators to the federal government; these officials would no longer be voted in by the public. In addition, Butch Otter, Governor of the State of Idaho, is joined by the Republican party in opposing any federal law that mandates citizens to carry health insurance.

Other conservative leaning legislation passed in Idaho in 2010 includes the Freedom of Conscience Bill for Health Care Providers. The bill gave healthcare workers the right to refuse to provide health care services that violates his or her conscience, including end of life care and abortifacients (Idaho Legislature, 2010a). The state of Idaho's constitution requires a balanced budget, so instead of raising taxes to offset the low tax revenues, the legislature cut funding to state government and education. The Idaho legislature voted to reduce the budget for education \$126.5 million in 2010, 7.5% less than in 2009 (Idaho State Department of Education, 2010a).

Local Political Issues

The main local issues facing the Boise community are education, air quality, and the trolley (Richert, 2009). Even Boiseans who are fiscally conservative are upset that the legislature cut the education budget because class sizes increased, instructional time was reduced, and bus services were cut (Richert, 2010). In addition, air quality in Boise can be poor, often exceeding federal health-based standards (Idaho Department of Environmental Quality, 2007). The vast majority of people working in Boise drive alone to work; however, efforts to reduce greenhouse emissions from cars by building a trolley in downtown Boise were met with resistance. Many Boiseans believed the \$60 million Transportation Investment Generating Economic Recovery (TIGER) grant from the federal government could be put to better use and downtown merchants could not agree on where the transit center should be placed (Frazier, 2009). In February 2010, the federal government denied all TIGER funds to Boise, including \$29 million for the bus system. The funds were awarded to cities with community support for the proposed projects. Many Boiseans believed the community was not consulted when planning the Trolley route, which led to the failure (Frazier, 2010).

Legal Findings

All ISDB policies must be consistent with the U.S. and Idaho laws concerning public education and must be within the guidelines established by the Idaho Legislature and State Board of Education (Independent School District of Boise, 2010a). The ultimate authority for guiding sex education in Idaho belongs to the Idaho Legislature.

Legislative statutes pertaining to sex education are located in Chapter 16 of Title 33 and contain Idaho Code 33-1608 through 33-1611. The codes regulate the Idaho State Board of Education, which in turn mandates the State Health Curriculum Standards. These standards guide the content of public instruction for all the school districts in Idaho, including the ISDB. Figure 4.3 depicts the specific Idaho Code and health curriculum standards and the hierarchy of the agencies control.

The Idaho legislature passed new content standards for health education in 2010 (Idaho State Department of Education, 2010b, p. 10). A committee comprised of health teachers, school administrators, community members, content experts and health care providers collaborated for over a year to draft the newly revised standards. The main change in the content standards that relates to sex education policy is found in the Growth, Development, & Family Life content standards for grades 9-12. It states that:

Family living includes the following topics: healthy relationships and sexuality, encouragement of abstinence from sexual activity, sexually transmitted diseases including HIV and their prevention, as well as methods of preventing pregnancy. Knowledge of factual, medically accurate and objective information is important along with personal, legal and economic responsibilities of parenthood and other consequences of sexual activity (p. 15).

Figure 4.3 depicts the hierarchy of Idaho Statutes, the Idaho State Board of Education Health Curriculum Standards, and Independent School District of Boise Policy.

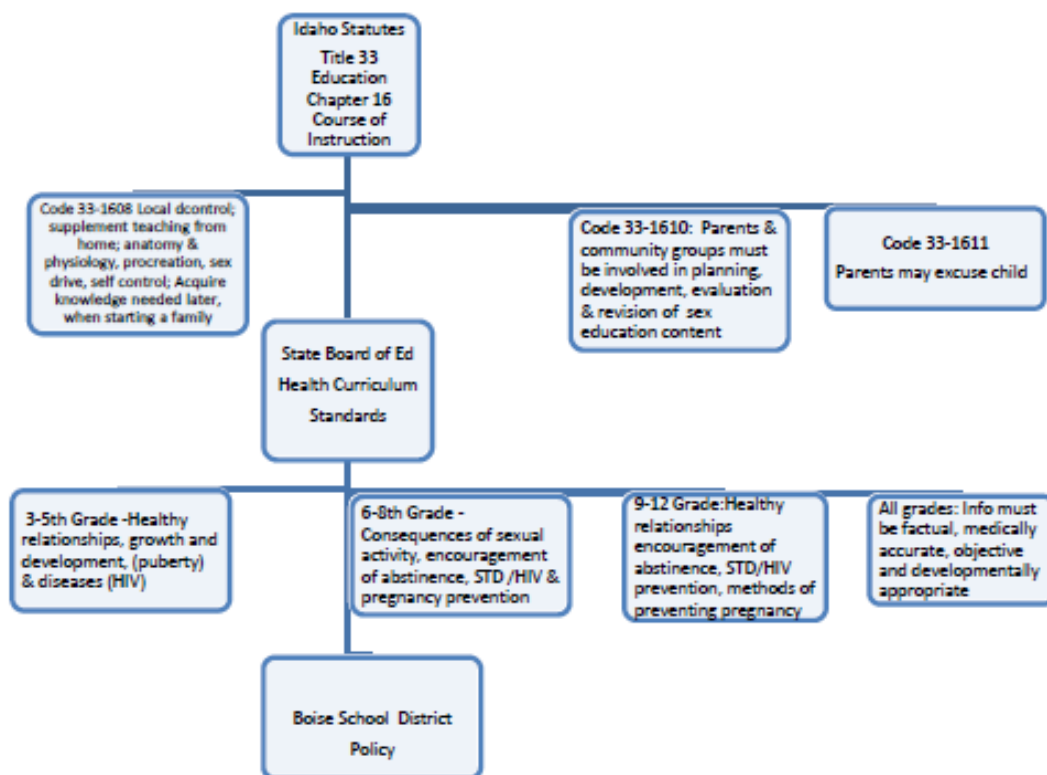


Figure 4.3. The Hierarchy of Idaho Statutes, Idaho State Board of Education Health Curriculum Standards and Independent School District of Boise Policy

According to the Idaho State Health Education Content Standards, the ISDB must teach students methods of preventing pregnancy, which is prohibited under the ISBD abstinence focused policy. In addition, the requirement that all health education content must be factual, medically accurate, and objective is new and was added to the curriculum standards for all grade levels. The Idaho Statute gives each school district local control over their sexuality education content; therefore, there is nothing that

requires the ISDB to comply with the State Board of Education Health Content Standards.

Social Findings

Teen Sexual Activity, STD, and Pregnancy Rates in Boise

The Youth Behavioral Risk Survey (YRBS) was developed by the CDC and is administered by the Idaho Department of Education. A representative sample of 9th-12th grade students in Idaho public schools were randomly selected to participate. Figure 4.4 illustrates the percent of Idaho students, by gender and grade level, who reported sexual activity in 2009. Nearly half of female students in the 11th and 12th grade reported having sex at least once. For males, 42.8 percent of 11th grade and 47.3 percent of 12th grade students reported sexual activity (Idaho State Department of Education, 2009) . This data was only statewide and not for only the ISDB.

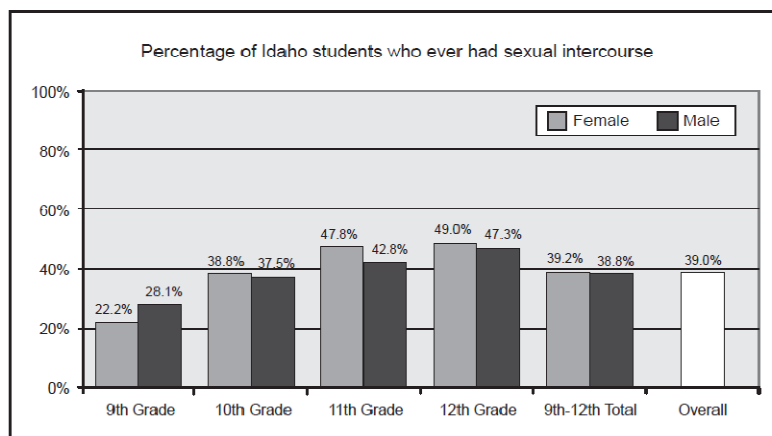


Figure 4.4. Percentage of Idaho Students Who Ever Had Sexual Intercourse, 2009

Figure 1.2 shows rates of teen pregnancy, abortion, and STD in Ada County over the last five years. Teen pregnancy rates increased 6.7 percent, abortion rates increased 13 percent (Idaho Bureau of Vital Records and Health Statistics, 2010), and reportable STDs increased 76 percent (Idaho Office of Epidemiology and Food Protection, 2010).

In 2008, the teen pregnancy rate in Ada County was 18.3 percent lower than rates for the entire state: 39.8 pregnancies per 1,000 females ages 15–19 in Ada County compared to 48.7 pregnancies per 1000 females ages 15–19 in Idaho (See Figure 1.2). Figure 4.5 compares Idaho teen pregnancy rates by health district. Boise rates were fifth highest out of seven districts (Idaho Bureau of Vital Records and Health Statistics, 2010, p. 64). The Ada County teen pregnancy rate mirrors the national teen pregnancy rate, which in 2006 was 41.9 pregnancies per 1,000 females ages 15–19 (National Campaign to Prevent Teen Pregnancy, 2010).

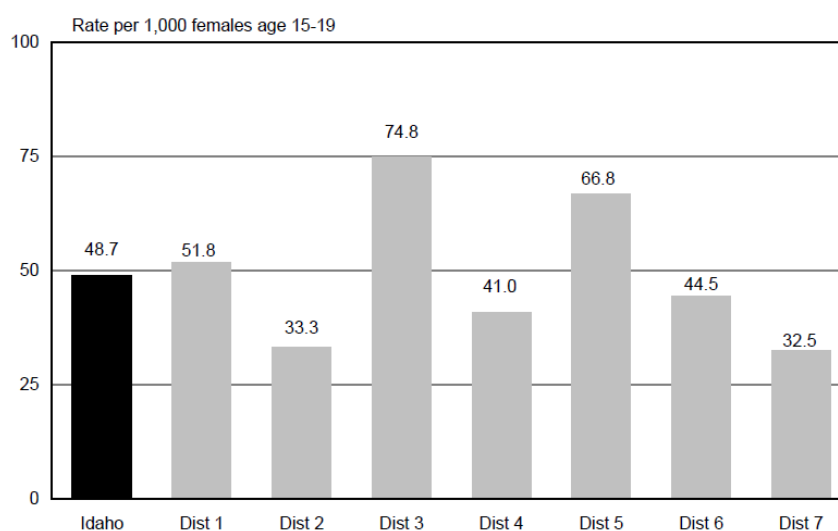


Figure 4.5. Idaho Teen Pregnancy Rates, Idaho and Districts 15-19 Year-Olds, 2008

In 2008, the Department of Health and Welfare commissioned a study that found teens were unaware of the risks of STD and misinformed about STD transmission and prevention. A telephone survey of 433 Idaho youth, ages 15-24, found common erroneous beliefs were that condoms were not effective at preventing STD, HIV is curable, and that you can tell by looking at someone whether they have an STD. Among females ages 15-17, 21 percent could not name a single STD; and of those, 16 percent were sexually active. Teens ages 15-17, of both genders, were found to be at the highest risk of contracting an STD (Northwest Research Group, 2007).

To estimate the number of students who are affected each year by poor sexual health, the rates of STD, unintended pregnancy, and abortion were applied to the total number of ISDB students in the grade levels that research indicated students typically become sexually active. The unintended pregnancy and abortion rates were applied only to females in the 9–12th grade at ISDB and the STD rates were applied to the total number of all 9–12th grade students enrolled at ISDB in 2009. An estimated 333 ISDB students had an STD, unintended pregnancy, or abortion in 2008, or roughly 5.5% of the student body population. The calculation for the estimated number of ISDB students with STD, abortion, and pregnancy is contained in Appendix H. The estimation does not include non-reportable STDs, such as HPV or herpes. When those diseases are taken into account, the CDC estimates one in four female teens are affected by a STD (Forhan, 2008). The estimation also does not consider that the same student may have had an STD and pregnancy or abortion.

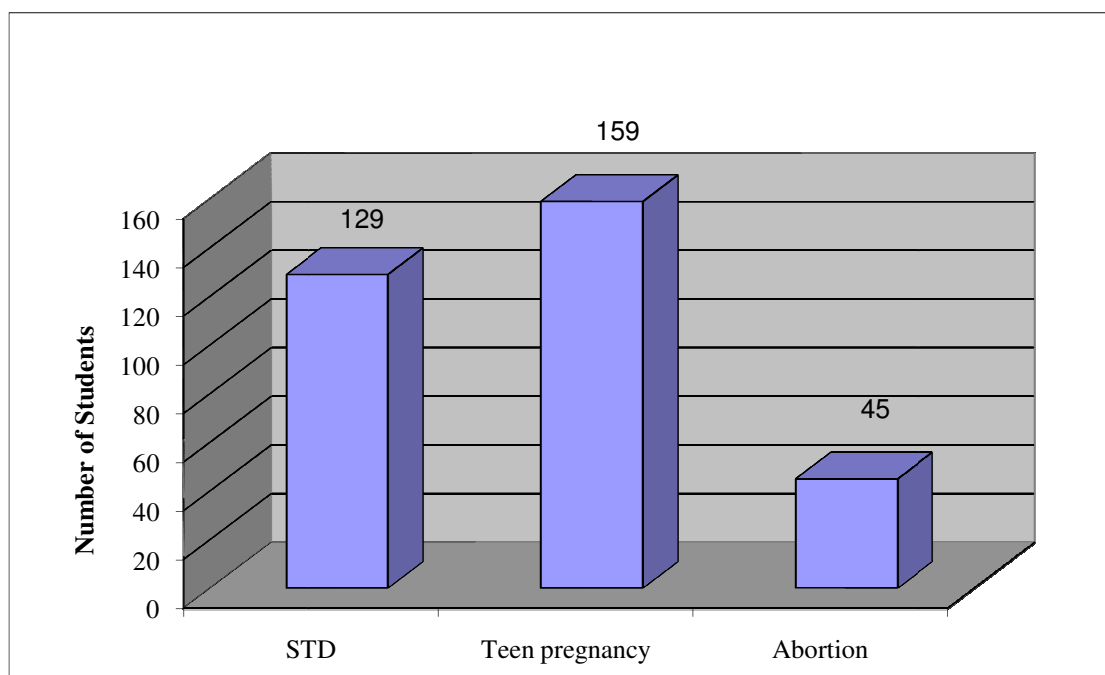


Figure 4.6. The Approximate Number of High School Students with STD, Teen Pregnancy, and Abortion, Independent School District of Boise, 2009

Figure 4.6 illustrates the estimated number of ISDB high school students with STD, pregnancy, or abortion.

Communication

There are a broad range of social issues at play in Boise, but because of time limitations for this study, the social aspects considered were communication between parents and children about sex education and support for comprehensive sex education. Providing sex education in the school would not be essential if students were educated about sexual health at home. However, the Idaho 2009 YRBS found that less than half of

students reported talking to their parents or an adult in their family about HIV (Idaho State Department of Education, 2009). Many parents are inhibited from talking to their teens about sex and rely on the school to teach sex education. According to national research, in 2002, only 44 percent of females reported talking to their parents about STDs or birth control. Communication about these issues declined significantly since 1995 when 52 percent of females reported talking to their parents about STDs and contraceptives (Robert & Sonenstein, 2010). Furthermore, lack of communication about sexuality was identified as a primary factor contributing to the rise of STD and unintended pregnancy in Ada County. Key informants, who were interviewed for the sexual health community needs assessment, expressed the need for improved communication within families, schools, healthcare agencies, and community-based organizations (Elliott, 2008).

In an attempt to determine support for comprehensive sex education, the public health districts in Idaho surveyed adults using the BRFSS administered by the Idaho Department of Health. Every year since 2005, adults were asked:

At what grade level do you think children should begin to receive comprehensive sex education in school? Comprehensive sex education includes not only discussions about reproductive systems and associated biological functions, but also sexual behavior; outcomes of sexual behavior including STD/AIDS education and prevention; talking with parents about sex; birth control methods, availability, and usage; and may include discussion on personal sexuality choices (Idaho Bureau of Vital Records and Health Statistics, 2009, pp. 10-13).

In response to this question, in 2008, 7.3% of adults in Idaho responded there should be no comprehensive sex education in schools. Adults over 35 years of age were nearly two and one half times more likely to oppose sex education in schools

than those 18 to 34 (9.2 percent vs. 3.8%). In the health district in which Boise is located, 5.4 percent of adults indicated that there should be no comprehensive sex education in the schools. Of Idahoans who supported any sex education, 38.5 percent thought it should begin in seventh grade or later (Idaho Bureau of Vital Records and Health Statistics, 2009).

Findings According to the Research Questions

The first research question, which focused on the characteristics of the Boise community, was answered in the "Contextual Findings – Characteristics of the Boise Community" section above. The rest of the research questions for this case study were:

- When the last decision regarding sex education curricula was made at the ISDB, what was the process?
- Who was involved and how? Were school nurses involved? Were health department nurses involved?
- What were the main issues and the context influencing policy?
- What problem-solving strategies were used to arrive at a decision?

The research questions were answered in regards to the new health education policy, which was implemented in April 2010. The new policy includes directives on sex education and HIV education for the ISDB.

ISDB Policy Change

In April, 2010 the Trustees created a new health education policy. The Trustees combined the sex education policy (#2132) and HIV education policy (#2133) under a new heading titled "Health Education." The new health education policy and former policies 2132 and 2133 are contained in Appendix G. The Trustees revised the policy during a routine review of policy that the Trustees are tasked with completing every three years.

The new policy was created to reduce redundancy and make the policy less controversial, so fewer parents would opt their children out of the coursework. It also broadened the policy and made it easier to teach in grade schools because now no notification to parents is required (Confidential interviews, 2010). The new policy contains the directive that health education must include human sexuality education based on the philosophy of abstinence until marriage (Independent School District of Boise, 2010b).

Process and Stakeholders Involved

According to the Board Clerk (personal communication, April 29, 2010) and the interviews (Anonymous, 2010), the policy was changed because a board member and the nursing supervisor believed the policies needed to be broadened to better reflect the needs of the children in the community. They wrote a draft of the proposed new policy and brought it to the ISDB Policy Committee in February 2010. The Committee made a few minor edits to the proposed policy and granted approval to proceed with the revisions.

The nursing supervisor sent the proposed policy to grade school nurses for input. The first reading of the proposed policy occurred at the ISDB Trustee meeting on March 22, 2010 (Independent School District of Boise, 2010c). The second reading of the proposed policy and approval occurred at the Board meeting on April 12, 2010 (Independent School District of Boise, 2010b). ISDB did not seek input from parents, the health department, or high school nurses. No advisory groups were formed to provide input. No parents, health agencies, or community members provided public testimony at the ISDB Board meeting.

Community Appraisal – Interviews

Another component of the Communities Coping with Change (CCC) model is appraisal. The appraisal is the community's perception of the situation and whether the problem is perceived as novel, predictable, uncertain, controversial, or controllable. This determination will influence how the community copes with the need to change, improve a situation, or maintain the status quo. For this case study, the appraisal was made by conducting face-to-face interviews and using the information key informants provided for the Ada County Sexual Health Community Needs Assessment (Elliott, 2008). The remaining research question concerning how the community solved the problem were also answered using the information obtained in the interviews. The interviews were conducted with:

- Two ISDB Trustees
- Two health teachers

- Two high school nurses
- One ISDB mid-level administrator

Categories Expressed in Interviews

The interviews were transcribed and listened to many times. Then, the transcriptions were coded and patterns of responses were identified. During the analysis, four main categories emerged:

- Adherence to the policies
- Communication – getting lost in the bureaucracy
- Conflict – “This is a tinderbox that we’re talking about here.”
- Pulled between values and reality

Adherence to the Policies

There was unanimous agreement by all those interviewed that abstinence is the policy at the ISDB. One participant summed it up: “Everybody that teaches health understands that we’re abstinence based and that’s pretty much the restriction, that birth control and those types of things are things that have not been approved by our board as far as not being able to be taught,” Another participant said, “Abstinence – I have to follow that no matter what. You know, if my thoughts are you have to protect these kids, they’re already past that point, I can’t.”

However, Board policy is intentionally broad to give direction to the classroom teacher, yet allow room for judgment. In the area of sex education, which is a sensitive

topic, one interviewee believed generalities may not protect the staff if a parent complains, saying, “This is so broad, I still think we could hang ourselves if we weren’t pretty careful.” Some participants interpreted the new policy as a slight opening to comprehensive sex education because the new title is comprehensive health education. One participant said: “I think it’s so broad because in the first line it says comprehensive health education; it’s so broad that you could say, well I included abstinence only and that is best, but to be totally comprehensive I included the other too.” When asked about ambiguity, one of the board members, said, “Oh my God, I don’t know. That’s a really good question, because it says based on the philosophy (of abstinence) it doesn’t outlaw.... This doesn’t prohibit anything else.”

Leaving the policy broad to allow for staff judgment also cultivates inconsistency in what is taught in the classroom. One nurse commented, “I have a health teacher in my building. He’s not the best health teacher in the world. So you would wonder what he would teach these kids. And every child receives the information differently. So there’s things he’s taught that I’ve had to go back and clean him up on. ‘No, that’s not correct; you need not give them that kind of information.’”

Some health teachers, often newer ones, stick to the textbook to protect themselves. For instance, one health teacher said, “With any sensitive topic such as this, I definitely stick to the book because the first thing parents are going to do is, that’s the most touchy subject and topic out there, so I stick to what’s in the book. And as much as I don’t agree with everything, it’s what I have to feed them.”

When the book is dated, or contains inaccuracies, such as in the ISDB textbook, adhering to it too closely can be problematic because it is not consistent with the Idaho State Board of Education Health Curriculum Standards, which requires “Information should be factual, medically accurate, objective and developmentally appropriate” (2010b, p. 6). If the book is used, students are receiving misinformation; however, the other health teacher said, “Textbooks help a ton for a new teacher because you don’t have a lot of activities and you can rely on that textbook to provide that information. I’ve done this for a long time, so whether right or wrong, I have a lot of activities. Not that the textbook is bad, but like, for instance, like HIV/AIDS, it’s dated.”

Another area of divergence in what interviewees said was taught in sex education classes in ISDB is concerning student questions. One teacher would answer questions beyond abstinence, if he was comfortable, knowledgeable, and believed the student was earnest when asking. The other teacher said: “If students have questions, it’s like, well, it’s something that you need to go home and talk to your parents about, because that’s what we’ve been told to do, been told to say.” However, many times during the interviews, participants mentioned our society does not feel comfortable discussing sex. The same health teacher said: “I wasn’t a kid that could talk to my parents about that (sex) so I recognize that, like, sometimes you’re going to go to our friends for the information, sometimes you go to your teachers for information. Rarely are you going to go to your parents for information.”

Nurses who teach sex education in the classroom will ask students with questions to come to the nurse’s office and talk one-on-one. This gives the students who are

uncomfortable talking to their parents another option to receive the information they need.

The policy is intentionally broad to leave room for flexibility, but in several interviews it was clarified that the ISDB curriculum implements the policy and gives specific guidance on what is taught. It was put aptly in one interview: “Any school board policy we have to follow to the letter, in terms of the bottom line but we also have the state mandated health curriculum.” The ISDB is mandated to follow the state curriculum standards; however, none of the people interviewed were aware of the recent revisions to the State Health Content Standards that require students be taught methods of preventing pregnancy and the effectiveness of contraceptives. The nurses also mentioned they must follow nursing policy, along with the ISDB policy and state policy. It seems difficult for staff involved to stay informed of the various policy and guidelines. This leads to the next category, Getting Lost in the Bureaucracy.

Communication: Getting Lost in the Bureaucracy

The teachers and school nurses said they had not been informed of the policy change. However, the interviews were conducted late in the school year or during summer vacation, from 4/20/2010-8/22/2010 so some ISDB staff believed they would be informed in the fall. One interviewee said, “With something like this, we’ll probably get an email. What happens is our supervisor looks at it and says, ‘How important is this. How much does this really impact or change what goes on in the classroom?’” Another interviewee did not think the information would be passed along and said, “In terms of

the administration passing down any policies, they don't. So, it's like, what I know and what I've brought from past experiences and what I research on my own."

When asked if sex education was a priority in the ISDB, one board member said, "For those people (with STDs and unintended pregnancy), it's at the top, but for the entire district, I don't think it is. I mean, we don't talk about it that much, unless we're talking about Marian Pritchert (school for pregnant students)." The Trustee went on to say that having Marian Pritchert does not help with prevention and offered, "You have Frank Church High School, which is the alternative high school and I know they have a lot of counseling in that school to try and, kind of, help the kids, kind of, recover from whatever caused them to be in that school."

There are two middle-level managers responsible for sex education at ISDB, one for high schools and one for elementary schools, but only the one responsible for elementary sex education participated in this policy change. The mid-level administrator asked grade school nurses for input regarding the health education policy. No input from high school nurses and health teachers was sought. When asked if the ISDB might consider teaching comprehensive sex education, the middle-level manager said it was not appropriate for grade school children.

When one of the high school nurses was questioned about whether she was solicited for input on the new policy, she said, "Sometimes I think we feel like we don't really have much say and something will come up from the board related to health and, you know, we do have a supervisor that represents us, but sometimes it feels like we do what the policy makers determine."

Both Trustees expressed many times that they value input from support staff, teachers, parents, students, and the community. However, one Trustee said that parent and teacher input did not affect this policy change. “It was just an internal thing. No parents even mentioned it. No one even testified.” The policy revision was published in the board agenda, which is an open meeting, but no other notification was made.

The Trustees, administrators, and frontline staff were not aware of the new State Health Curriculum Standards that went into effect in the fall of 2010. One important change to the state standards is the inclusion of teaching eighth and eleventh grade students methods to prevent pregnancy.

To revise the State Health Curriculum Standards, the Idaho Department of Education formed a committee made up of community members. The committee began working on the policy beginning early in 2009. An administrator from Meridian participated on the committee and promoted teaching students methods of birth control, to try and reduce the teen pregnancy in the Meridian School District. No administrators from the ISDB participated in the revision of the standards (Elliott, A., personal communication, September 20, 2010).

Conflict: “This is a Tinderbox That We’re Talking About Here!”

Consistently throughout all the interviews, the conservative culture of Boise was discussed. Many times stories of the past conflict involving the STD and HIV policy decisions were recounted. One interviewee said it was a huge hullabaloo and there were 2 ½ file cabinets full of comments from the last HIV decision. The ISDB Board let that

interviewee know they live in a conservative area and need to respect the conservative values of this community.

Several interviewees spoke about the last major policy decision on HIV education and mentioned it was a very hot topic in Boise. Four of seven people interviewed commented that the purpose of changing the comprehensive health education policy was to eliminate any references to HIV or sex, which may be controversial. As one mentioned, one of the reasons the new policy was crafted was “to honestly get rid of the words HIV and sex, because they tend to be lightning rods for some portions of the population”. And another said: “I think this is just a broad, not-getting-anybody’s-feathers-ruffled, policy.”

Of the interviewees that were not elected to their positions, four out of five said they could lose their jobs if they weren’t careful about what they teach students for sex education. One of the Trustees acknowledged the job threat by describing how a nurse would protect herself from repercussions when counseling an individual, sexually active student:

The nurse’s first responsibility is for your safety, okay. So in that instance I would think, the nurse would, pause if we’re talking about sex. First tell you, not to do it. And then secondly, I would imagine the nurse would tell you how to be safe, but I think they’d probably be bound to, to, to refer you to the counselor. I would think. If I was the nurse I would. Because you wouldn’t want, you wouldn’t want, that resting solely on your judgment. You would want to bring in another health care provider. You know, I would think, hm, I’m calling counseling, like it might not be physical health but its mental health, as well. Um. Yeah. I mean this is a tinder box that we’re talking about here.

The researcher told one interviewee that the Trustees were willing to consider comprehensive sex education if parents want it and bring it to the Board. The interviewee

thought the Board's positions might be jeopardized if they changed the policy to include comprehensive sex education and said, "I think deep down they (Board) would like to (use evidence-based comprehensive sex education curriculum) but they also like their position and they know they're being voted."

However, both Trustees were steadfast in their dedication to doing what was best for students and creating ISDB policy based on the predominant community values, even if it resulted in some people being unhappy or a failed re-election bid. One said, "We have to make decisions based on the good of the entire district and sometimes that's gonna tick off the minority." About half of the interviewees mentioned that a very vocal minority of the population controlled policy. One interviewee said, "It's a very small percentage but they really make sure they're where they need to be to make their voices heard."

When asked about the power of the vocal minority, a Trustee looked at the big picture and considered the possible long-term benefits, saying "Just because one subsection of the society can sway an election, more power to them! What about the apathetic 80 percent? Maybe these people surging to power is going to energize, you know, kind of wake the sleeping giant." In addition, the Trustee noted the Board elections are staggered, with Trustees serving six-year terms; therefore, a voter mobilization effort could only slightly impact the composition of the entire Board, unless there was a recall.

Pulled Between Values and Reality

The Trustees mentioned how important it is to accommodate all the diverse viewpoints of the community. One said that the board is “working as carefully as possible to fashion something (policy) that you believe is in the best interest of your students and as much as possible reflecting the community values.” The Trustee said that the new ISDB health education policy captures the important community value that teens are abstinent from sexual activity until marriage.

Many educators and policy makers believe sex education is best taught at home. An interviewee concurred but commented: “Ideally if a child had a certain amount of information, and sex is hard to talk about to someone that’s real close to you, but if they had the information before they ever got to school, all they’d (teachers) need to do is build on it. But it’s hard to teach a child sexual relationships if mom and dad are fighting and killing each other at home.”

The frontline workers all spoke about how difficult it is for many people to talk to their children about sex and frequently teens are not taught about sex or HIV education at home (Idaho State Department of Education, 2009). As one interviewee said: “They’re too busy trying to make a living and they’ve forgotten; they’ve quit parenting at the time the kid needs the direction.” Other parents do not have the skills or knowledge to teach their kids about sex (Elliott, 2008). This was candidly mentioned by one interviewee: “They’re too busy trying to solve their own sexual issues let alone teach their child what this zingy feeling is;” and another said, “It’s amazing how many kids are living in train wrecks.”

Yet, parents are the group the Trustees need to hear from in order to consider the issue. A Trustee talked about what would be required: “When they come to us they better have their research in order. I want to know who, what, where, and why – give us a list of references, give it to us way ahead of time of the board meeting.” Unfortunately, parental support for comprehensive sex education has been non-existent. Regarding the testimony to spare Marian Pritchert, the school for pregnant girls from budget cuts, one Trustee bemoaned, “I was very, I don’t know, (pause) disappointed. I expected more support” (for Marian Pritchert). The growing problem of unintended pregnancy and STD may not be addressed because the Board needs community support before taking action. “We look to the district, to the population for guidance,” commented one.

The Trustees were asked how the current \$1.25 million available grant funding from the federal government for evidence-based comprehensive sex education influences their decisions. Both Trustees stated there must be support within the community before the ISDB would pursue federal funding. One Trustee said, “I don’t know that, in general you know, if the federal government provides funding to adopt a certain curriculum that we would necessarily agree with it just because it’s federally funded. If we totally think our curriculum is, you know, fine, why would we change?”

Many times during the interviews, the Trustees voiced their commitment to honoring the values of the community and doing what is in the best interest of students; however, according to the interviews with the frontline ISDB staff and the sexual health community needs assessment, the needs of approximately 48 percent of the seniors (those who are sexually active) are not being met. Many teens lack knowledge of basic

information about sexuality, disease prevention, and birth control (Northwest Research Group, 2007). Research found an association between lack of knowledge and increases in rates of unintended pregnancy, abortion, and STD (Kirby, 2007). The BRFSS survey, which queried Idaho adults about their support for comprehensive sex education, found that Non-Hispanics were three times as likely to oppose sex education in schools than were Hispanics (7.7 percent vs. 2.4 percent) (Idaho Bureau of Vital Records and Health Statistics, 2009). Hispanic teens have far higher rates of unintended pregnancy than Whites or Blacks (Yang & Gaydos, 2010), drop out of school more frequently due to teen pregnancy, and are three times as likely as Whites to have an STD (Idaho Office of Epidemiology and Food Protection, 2010).

Ethical Issues of Being Pulled Between Values and Reality

Some interviewees doubt the policy is in the best interest of the students. One interviewee spoke about being unable to help the youth who are at risk when saying: “We can share our values and to hope and pray our kids follow that guidance but the reality is, how can you deny when you look at the studies looking at youth risk.” The study referred to was the YRBS, which found that 48 percent of Idaho teens are sexually active by the time they reach their senior year (Idaho State Department of Education, 2009). All of the frontline staff expressed feelings from sadness to frustration at not being able to provide comprehensive information when they know many students are sexually active.

An ethical concern of those supporting abstinence-only education is the belief it will send a mixed message (Elliott, 2008). One key informant, from the sexual health

needs assessment, teaches her clients strategies for communicating with their children about sex. She suggested saying: “As a parent, my value is for you to be abstinent, so that you don’t get HIV or pregnant, and can finish your education. But I know the sex drive is strong and sometimes things happen, so I want you to be safe and healthy, in case you get carried away.” Then, she gives the child information about birth control, condoms, and access to sexual health care (Elliott, 2008).

The Trustees and administrator did not seem aware of the rising rates of STD, abortion, or unintended pregnancy that was affecting youth. The ISDB does not teach methods of preventing pregnancy to sexually active student; but the nurses and health teachers refer sexually active students to CDHD and Planned Parenthood on an individual basis.

To accommodate the viewpoints of conservative groups, some interviewees felt they had to ignore the statistics on teen sexual activity, teen pregnancy, and STD morbidity. One interviewee said, “We have to ignore reality because of parents’ beliefs.” One RN stated, “Abstinence is best, 100 percent of the time, no question. But how realistic and practical is it?” When asked if the curriculum was adequate, one interviewee said, “I think it’s adequate as far as what the curriculum directs, but kids walk out the door not having an understanding of birth control. . . for the right kid that might be a life changer.” Four out of four of the frontline workers expressed support for comprehensive sex education. The frontline workers also said some parents want more sex education, including birth control, taught to their children.

Appraisal of the Change Event

The final research question concerning what problem-solving strategies the ISDB used to arrive at a decision is answered using Kelly and Steed's CCC model (2004). The model asserts a community's perception of the change event influences how the community copes with the problem and predicts future community action. In this case, the change event is the increase in STD, abortion, and unintended pregnancy in Ada County. All those interviewed perceive decisions about sex education as controversial, so much so, that conflict emerged as one of the main categories in the data. A detailed description of this perception was described previously in the section "Conflict: It's a tinderbox we're talking about here." The ISDB responded to the conflict using an avoidance strategy. Four of seven people interviewed commented that the purpose of changing the policy was to avoid controversy.

Interviewees talked about avoidance in the community, as well, saying "It's easier to kind of overlook then it is to deal with it and to deal with what's going to come from it. I think even though we know that abstinence-based sex education is not effective. The studies are out there that it's not effective and by not talking about it (sex), it doesn't mean people don't do it (have sex)."

During conflict laden change events, like this one, individuals also rely on emotional coping strategies (Kelly & Steed, 2004). One of the ISDB frontline staff voiced feelings of powerlessness when saying,

It would be nice to teach students more comprehensive sex education but we live in a community that is [names a conservative religion] . . .if something like this is brought up in the general public, in what you're going to teach my child, they will rise to the occasion and you will not see it in this state

for one long time if ever. IF EVER! Because they're in the district, they're in the community, they're in the administration. There's a lot of power there, with the political part, of what you do and don't do.

Another interviewee said: "Boise is a pretty conservative community . . .but sometimes with a community like this people will bury their heads in the sand and say if I don't talk about it or if my kids don't hear about it, it's kind of not there."

Kelly and Steed's (2004) model helps predict that when a community perceives they are powerless to actively participate in solving problems, they often become apathetic. Even though the frontline workers and some parents support comprehensive sex education, the Trustees and administrator state that no parents, teachers, high school nurses, or agencies participated in the policy change or have approached the ISDB to advocate for comprehensive sex education. Conversely, many times throughout the interviews, the Trustees expressed how much they value community and staff input on decisions. One Trustee said it can be hard to get input saying,

It's hard for people to even figure out what is it they need to do to make the policy. It's not something most people even look at very often. And it seems as though after working with a variety of people that there's a lot of reticence to even try and write it.

Summary

To understand the contextual factors underlying the decision-making process of the ISDB regarding sex education, many sources of information were collected and analyzed. Analysis of the interviews revealed four main categories influencing decisions regarding sex education in the ISDB, adherence to policies, conflict, values vs. reality, and communication in a bureaucracy. The community appraisal showed the ISDB and

community coped with the conflict using an avoidance strategy and the community may have become apathetic due to perceptions of powerlessness.

CHAPTER FIVE: DISCUSSION AND CONCLUSIONS

In Chapter Four, the researcher described the findings from the review of the ISDB Board minutes, secondary health textbook, policies, and health curricula, in addition to the demographic and historical findings about the city of Boise and the ISDB community. As indicated in the Communities Coping with Change Model (CCC), this information provided the context (Kelly & Steed, 2004) underlying the ISDB health education decision that was made in 2010. To perform the community appraisal, another component of the CCC model, the researcher interviewed ISDB Trustees, an administrator, and frontline staff, and the major categories that emerged from the interviews were also presented in Chapter Four. The researcher applied the overall CCC theory by examining the response of the Boise community to poor teen sexual health within the context of the current political, social, legal, and economic landscape of Boise. The CCC model shaped a detailed description of the decision-making process regarding sex education at the ISDB. With that robust understanding, the researcher answered the research questions, which were:

- When the last decision regarding sex education curricula was made at the ISDB, what was the process?
- Who was involved and how? Were school nurses involved? Were health department nurses involved?
- What were the characteristics of the Boise community?
- What were the main issues and the context influencing policy?

- What problem-solving strategies were used to arrive at a decision?

In Chapter Five, the researcher compares and contrasts the findings of this case study with the existing research on sex education practices and policy. The researcher also describes the implications of this research and how nurses and health care providers can more effectively advocate for a policy that provides evidence-based sex education programming. Lastly, the researcher recommends ideas for additional research that may facilitate changes designed to improve the sexual health of teens.

Discussion According to the Research Questions

The following section discusses the first research question, which was, “When the last decision regarding sex education curriculum was made at the ISDB, what was the process?”

Process for Revising the Comprehensive Health Education Policy

The Trustees reviewed all policies every three years and revised, if necessary. The entire process for creating and revising policy was presented in Chapter Four. Both Trustees commented that the policy on sex education had not been an issue since the last decision in 1985. The administrator and Trustees said no parents, teachers, nurses, or community members had mentioned changing the sex education policy since 1985; therefore, they had not considered changing it. However, the Trustees expressed a willingness to reconsider the current sex education policy if parents requested it.

The lack of parents, teachers, health care providers, or students appearing at the School Board meeting to discuss sex education policy was consistent with findings from the literature review, which indicated parents, teachers, health care providers, and students were inhibited from discussing sex (Cates, 2008; Elliott, 2008; Gawlinski, 2007). Due to this widespread aversion to discussing sex, the ISDB tradition of only revising the policy when parents bring the issue to the board was a barrier to objectively analyzing sex education policy in the ISDB.

According to the interviews, if parents or the community were to bring the issue of sex education to the ISDB Trustees, they would need to present well-organized research with scientific references so the Board could review the effectiveness of comprehensive sex education and abstinence-only curriculum. The information would need to be delivered to the Board at least a week before the issue was discussed.

However, parents may not be up to the task. As mentioned by the ISDB frontline staff and key informants in the Community Health Needs Assessment, many parents work long hours, and have difficulty making ends meet and relationships work (Elliott, 2008). Interviewees said it was surprising how many families suffered from divorce, abuse, addiction, and suicide. “They’ve stopped parenting,” one interviewee said. From these statements, one might deduce it is unlikely these parents are volunteering at the school or participating in policy making.

Furthermore, children from families with difficult social problems may need comprehensive sex education more than other families, since they are at higher risk for teen pregnancy (Mollborn & Morningstar, 2010). Families in low socioeconomic groups

frequently suffer from the impacts of teen pregnancy more than other groups (Greenwell, 2010). These families are often ill-equipped to advocate for themselves, let alone make presentations to the Trustees; but, hearing the personal experiences of those affected by teen pregnancy or HIV may be what motivates the Trustees to prioritize sexual health issues. Health professionals, who are knowledgeable about teen sexual health and know the research, need to work with affected families to bring these issues to the Board. Unfortunately, this may not happen, because as mentioned by one Trustee, even professionals are intimidated from speaking publically and bringing policy issues to the Board.

The second research question was, “Who was involved in the 2010 health education policy and how?” The next section discusses the stakeholder’s involvement in the policy process.

Community Involvement

Idaho Code 33-1610 mandates that parents and school district community groups shall be involved in planning, developing, evaluating and revising any instruction in sex education (Idaho Legislature, 2009a). During the interviews, the Trustees and administrator stated that parents were not formally notified of the revision to the sex education policy, but that all ISDB Board meetings are open to the public. Parents are not only responsible for bringing the issue of sex education to the Board, but they are also responsible for checking the ISDB Website to learn when the policy was revised. Choosing not to publicize the revision to the sex education policy may reflect the Board’s

inhibition from discussing matters regarding sexuality. The budget problems may have taken precedence, or it may have been a decision to avoid the conflict associated with sex education decisions, like ISDB experienced in the past.

The avoidance of ISDB to openly review the sex education policy matches a tendency of school boards, found in the research literature, to circumvent high-profile, controversial decisions in order to avoid parental complaints and keep the peace with special interest groups (Donovan, 1998; Geraci, 1996; Opfer & Denmark, 2001). In addition, research showed that Board members spent more time on decisions that were viewed as controversial or had the potential to impact future school board elections (Brown, 1985). This was congruent with the ISDB Trustees, who most likely chose to avoid a decision that would expend a lot of time and energy for an issue they do not view as a priority.

Fourteen out of fifteen key informants interviewed for the Sexual Health Community Needs Assessment supported comprehensive sex education as the primary strategy to reduce STD and unintended pregnancy in Ada County (Elliott, 2008); however, since 1985, no nurses or other health professionals had provided input to the Board about this very important issue. Community members seem to be waiting for the ISDB to have a public forum on the issue and the ISDB was waiting for the community or parents to bring it to the Board. The health care providers, nurses, and public health workers in the community complained about abstinence-only education (Elliott, 2008), but were not collaborating to advocate for teen sexual health.

Nursing Involvement

The high school nurses counseled sexually active students one-on-one and referred students to CDHD or PPGNWI for services. From their experience with students with unintended pregnancy and STD, high school nurses were acutely aware of the needs of sexually active students and saw firsthand how the lack of knowledge put teens at greater risk. Even with the high school nurses' extensive experience with students at risk, the high school nurses were not asked for input about the new health education policy because they do not teach sex education. Only elementary school nurses teach sex education at the ISDB. When interviewed, the mid-level administrator said ISDB was not open to teaching comprehensive sex education because it was not appropriate for grade school children. The administrator seemed unconcerned with the needs of high school students, of which 48 percent are sexually active by their senior year. Nor did the mid-level administrator seem aware of the connection between increased student knowledge and lower rates of STD, unintended pregnancy, and abortion. The administrator had volumes of documents about the past sex education conflict and had been warned to respect the conservative values of Boise. Perhaps this is why the administrator strictly adhered to the abstinence-only philosophy and was firm about not going beyond it. The high school nurses had been told to strictly adhere to abstinence, as well.

If the high school nurses want to provide input on sex education policy in the ISDB, they need to instigate it themselves, since it has not been solicited by the ISDB administration. However, without the support of the mid-level management, the school

nurses may be more effective if they collaborate with other nurses outside ISDB and have health professionals outside the ISDB present the information directly to the Board.

The research question, “What were the characteristics of the Boise community?” is discussed in the following section.

Characteristics of Boise

The interviews and document review clearly defined Boise as a conservative community. The ISDB Trustees, administrator, and staff assumed that because Boise is a conservative, predominantly Republican, community that there will be more support for abstinence-only education. However, this is inconsistent with research that suggested that parental support for comprehensive sex education is consistent across political and religious lines (Kaiser Family Foundation, 2002).

Furthermore, non-partisan support for comprehensive sex education has not been investigated in Boise. The Trustees and administrators seemed unaware of national and local research that suggested the vast majority of parents support comprehensive sex education (Idaho Bureau of Vital Records and Health Statistics, 2009). When one Trustee was shown that the survey which indicated 95% of adults in CDHD supported comprehensive sex education, he dismissed it in disbelief. Since no effort was made to assess parental support for comprehensive sex education in Boise, a group would need to present the Trustees with the current research on non-partisan, parental support for comprehensive sex education and let the Trustees have time to read and cogitate on the research.

The research question “What were the main issues and the context influencing policy?” is answered in the next section.

Main Issues

Economic Recession

Undoubtedly decisions about where and how to cut ISDB expenses due to the cuts in education funding took precedence over decisions regarding the health education policy. Research on decision making shows individuals typically prefer a course of action that conserves energy (Anderson, 2003). A major analysis and revision of the sex education policy would require a great deal of time and energy on the part of ISDB Trustees and administrators. An advisory board would need to be assembled, research would need to be conducted and verified, and the issue would need to be communicated to the community and public forums would need to be held. Especially when Trustees do not view teen pregnancy and STD as a priority problem, investing a large expenditure of time to debate the issue was unlikely.

Textbook

As a result of decreased state funding for education, ISDB budgets were reduced and the Board decided to delay purchasing new books. High school health classes continued to use the Glencoe Health book, which contains older statistics and some medical inaccuracies (Glencoe McGraw-Hill, 2003). This budgetary decision, which was not directly related to the sex education policy, significantly impacted what was taught

for sex education. Because some teachers were still using the outdated textbook, students were likely taught inaccurate information. And according to at least one interviewee, the health teachers may not have known the information was outdated and inaccurate.

A survey of teachers in Illinois showed the available curriculum and materials influenced what was taught for sex education more than school policy, personal values, community values, state laws, or parental input (Lindau et al., 2008). Using an outdated textbook and teaching students inaccurate information about health increases the chances that students are not receiving a quality education. For instance, the Glencoe Health book states that HPV is incurable, but does not mention most individuals clear the infection spontaneously. The book also states condoms are not effective at preventing HPV and does not mention the HPV vaccine. According to the CDC, condoms may protect against HPV. In addition, condom users experience more rapid clearance of HPV and less incidence of cancer than non-condom users (Center for Disease Control and Prevention, 2010a). By teaching inaccurate content, the ISDB is not adhering to the Idaho State Board of Education, Health Content Standards, that mandate that “Information should be factual, medically accurate, objective and developmentally appropriate” (2010b, p. 6). It is unknown whether the Trustees considered that health classes would be receiving inaccurate information when they decided to cut funding for textbooks. It is uncertain they know now, unless someone brings it to their attention.

Research suggested that teaching only the failure rate of condoms and contraceptives deters students from using condoms and birth control and has contributed to the recent increase in unintended pregnancy and STD in the U.S. (Bruckner &

Bearman, 2005; Strayhorn & Strayhorn, 2009; Underhill et al., 2007b). Sadly, using the Glencoe Health book may be contributing to the increased rates of unintended pregnancy and STD in Idaho because students have been taught that condoms are not effective. This may also be part of the reason why over 30 percent of Idaho youth surveyed did not believe condoms were effective at preventing STD (Northwest Research Group, 2007). If this nearly one-third of Idaho students, who did not think condoms work, stopped using condoms, this could have contributed to the increased rates of STD in Idaho. The explanation seems plausible and is consistent with the research by Bruckner and Bearman (2005), Strayhorn and Strayhorn (2009), and Underhill et al. (2007b). Furthermore, teaching students that condoms are not effective does not “instruct students in the knowledge and behaviors necessary to support lifelong habits of healthy living,” as the ISDB policy mandates (Independent School District of Boise, 2010b, p. 19). To meet the standards of ISDB policy and to adhere to the State Health Education Standards, ISDB will need to stop using the parts of the Glencoe textbook.

Policy decisions regarding sex education are complex and intertwined with other policy decisions not directly related to the new health education policy. Budgetary decisions about cutting instructional time, how much of the overall budget is allocated for textbooks, which textbooks to use, which books are replaced, and when, all influenced what was taught. In addition, decisions regarding the content of the ISDB health curriculum guidelines also greatly influenced what students were taught about sex education in the classroom.

The last research question was “What problem solving strategies were used to arrive at a decision?” This question was answered using the appraisal component of the CCC model. The data collected for the appraisals came from the personal interviews and Community Sexual Health Needs Assessment. The research question is discussed in the following section. A discussion of the four categories that emerges from the interviews also follows.

Problem Solving Strategies

The ISDB dealt with the perceived controversy embedded in sex education policy decisions by avoiding conflict and removing the terms Sex Education and HIV Education from the policy. Otherwise, the content of the policies remained the same. The sex education and HIV education policy was obfuscated so it would not raise the ire of very vocal special interest groups. The interviews and findings of the political characteristics of Boise showed special interest groups were well organized and could mobilize many constituents to telephone decision makers and voice their opinions. The conservative groups have used this collective strategy of mass mobilization, described by Kelly and Steed in the CCC model (2004), to effectively influence decisions. This is consistent with the research that suggested Board members frequently take action to keep the peace with special interest groups (Donovan, 1998; Geraci, 1996; Opfer & Denmark, 2001), which allows the vocal minority to impose their will on the majority (Neutens, 1992). Historically, Congress was influenced to fund abstinence-only education when the Concerned Women for America made over 30,000 phone calls to Congress complaining

about comprehensive sex education (Concerned Women for America, 2009). This research supported the notion that special interest groups have the power to sway policy decisions.

Using Kelly and Steed's (2004) CCC model to analyze the dynamics of power in the community, it appears groups supporting women's reproductive health rights and comprehensive sex education in Boise have failed to influence policy in the past. For many advocates, this resulted in an emotional reaction of powerlessness and apathy. To illustrate this point, consider the Freedom of Conscious Bill that passed the Idaho Legislature in 2010. The law classifies emergency contraceptives as an abortifacient drug, which is medically inaccurate. Many professionals in public health, nursing and healthcare spent a considerable amount of time educating the legislature about the medical inaccuracy and the ramifications of restricting access to emergency contraception. During public testimony, several health care providers testified against the bill. In summary, they said they already have adequate protection under their own Boards, and that having to explain to a pharmacist the rationale for prescribing a medication violates patient confidentiality. The providers were also concerned that if a pharmacist refused to dispense a medication, it may limit access to end-of-life care and contraceptives in rural areas (Spencer, personal communication, March 18, 2010). In spite of the vast majority of health care workers objecting to the bill, the legislature ignored the testimony and passed the law (Idaho Legislature, 2010a).

Moreover, in 2009, Planned Parenthood Federation of the Greater Northwest in Idaho (PPGNWI) strategized with other stakeholders to implement comprehensive sex

education in Idaho. PPGNWI planned to conduct a telephone survey to determine parental support for comprehensive sex education and to organize a group of advocates (Pena, A., personal communication, January 23, 2009). PPGNWI hired a national pollster and the survey has been conducted. The research has not been released but the unofficial numbers look promising for parental support for comprehensive sex education (Evans, J., personal communication, October 1, 2010).

Additionally, in 2008, the ACLU conducted research on the possibility of implementing comprehensive sex education in Boise. The ACLU determined, even if comprehensive sex education was allowed, there was not adequate instructional time in health class to teach students comprehensive sex education. All evidence-based comprehensive sex education curriculums contain a strong abstinence message and content about personal empowerment, healthy relationships, refusal skills, condom negotiation, or birth control. Discussion of these topics takes time and all of the programs shown to be effective require more class time than is available in health classes at ISDB. And the positive effects of evidence-based comprehensive sex education curricula can only be assured if the lessons are implemented with fidelity. Therefore, the ACLU terminated the effort to advocate for comprehensive sex education (Carles, T., personal communication, March 31, 2009). Unless health classes are restructured, which is highly unlikely due to the emphasis on science, math, and reading, the ISDB will not be eligible to receive the federal funding to implement evidence-based comprehensive sex education programs, since the programs must be implemented with fidelity (National Campaign to Prevent Teen Pregnancy, 2010). Boise is missing out on the funding that other Idaho

areas like Coeur d'Alene, Lewiston, Wilder, Mountain Home, Burley, Ririe, and Blackfoot are taking advantage of. In the fall of 2010, those areas all implemented Reducing the Risk, a 15 session, evidence-based comprehensive sex education curriculum, through grants from the Idaho Adolescent Pregnancy Prevention Program (Humphrey, K., personal communication, September 28, 2010). After those programs are firmly in place, it will be enlightening to track the STD, teen pregnancy, and abortion rate trends in those areas and evaluate the outcomes of the programs against areas that have abstinence-only education.

Nonetheless, during the interviews, when asked if there was adequate instructional time to teach birth control, as mandated in the State Board of Education, Health Curriculum Standards, the health teachers thought that adding another day for teaching emergency contraception and birth control was possible. One interviewee stated that providing teens with knowledge of emergency contraception alone could have a major impact on the rates of unintended pregnancy. It appeared the ACLU did not believe adding one day to the sex education coursework at ISDB was worth the energy and effort that such a policy change would require.

Adherence to the Policies

As written previously, all ISDB policies are governed by the guidelines established by the Idaho Legislature and State Board of Education (Independent School District of Boise, 2010a). As shown in Figure 4.3, all ISDB policies must adhere to Idaho Code and the State Board of Education, Health Curriculum Standards. In 2010, new State

Board of Education, Health Curriculum Standards were approved by the Idaho Legislature and an important change was the inclusion of a mandate to teach 9-12th grade students methods to prevent pregnancy (Idaho State Department of Education, 2010b). The Trustees, administrators, and frontline staff were not aware of the new Health Curriculum Standards that went into effect in July of 2010. The lack of awareness of the new standards was inconsistent with research that suggested state and local laws were a significant influence on what was taught for sex education (Landry et al., 1999).

One frontline ISDB worker, who said ISDB must abide by the State Health Curriculum Standards, was confused by the incongruence between ISDB policy and the State Health Curriculum Standards. The interviewee said, “Um, but uh, I guess you could, like, look at it as, kinda, being in conflict with what the state, uh, standards are.”

One must wonder if the ISDB Trustees would have retained the philosophy of abstinence in the new health education policy if they had been aware of the State Board of Education, Health Curriculum Standards. With the budget cuts, the Trustees may not have time to keep up on the latest changes to the State Health Curriculum Standards or the statistics showing the health problems associated with teen sexual activity. The interviews clearly showed that sex education and issues related to teen sexual health are not a priority for the ISDB and the lack of awareness of the new State Board of Education, Health Curriculum Standards may be a reflection of that.

However, in Idaho Code 33-1608, school districts are given the power to exercise local control over their sex education curricula (Idaho Legislature, 2009a). Therefore, each school district in Idaho can ultimately decide to teach whatever they choose,

regardless of the State Board of Education Health Curriculum Standards. Therefore, any effort by groups in Idaho to introduce comprehensive sex education policy must be done district by district.

Communication – Getting Lost in the Bureaucracy

Many times during the interviews, the Trustees mentioned how important it is to gather input from teachers, parents, and the community when making policy. The Trustees wanted to hear from and honor all viewpoints. However, the Trustees did not know who was asked to give input on the new health education policy. The mid-level administrator, who oversees grade school nurses, was involved in this policy change; therefore, only grade school nurses were asked to give input. Health teachers and high school nurses were not given the opportunity to provide input, which was unfortunate because they were the professionals who see the lack of knowledge about sexual health in teens and know firsthand how it negatively affects teens. The ISDB administrator was also unable to answer questions regarding the high school textbook. During the interview, the administrator was adamant about adhering to the abstinence-only policy and was not approachable when discussing comprehensive sex education.

The researcher is doubtful the administrator would be open to feedback that supported comprehensive sex education. The support of mid-level administrators is imperative if policy regarding comprehensive sex education is to be considered at the ISDB. Otherwise, ISDB staff would have to bypass the administrator and speak directly to the Trustees. This may violate the norms of most organizations in which employees

communicate up the chain of command. To violate this norm, especially in a bureaucratic agency like a school district, may jeopardize an employee's position.

Many times the researcher requested an interview from another ISDB administrator responsible for high school health education and curricula, but the phone calls and emails went unanswered. None of the frontline ISDB interviewees had been informed of the new comprehensive health education policy and one said he may not be informed if the supervisor thought it was unimportant. This suggests ISDB does not prioritize sex health issues and that comprehensive sex education is not supported by the ISDB administration.

Conflict - "This is a Tinderbox That We're Talking About Here"

The history of conflict loomed large over ISDB board and administration. Even though none of the Trustees were present at the last sex education decision, one of the Trustees revealed "war stories" were told whenever the topic of sex education was mentioned. The HIV education decision was also contentious and, as one Trustee put it, there was a great "churning in the community." The lore about the reactions of the community to the new sex education policy in 1985 and the HIV education policy in 1993 seemed to be projected onto the current community as if opinions on sex education have been frozen in time. The controversies of the past greatly impacted current sex education decision making in the ISDB. It was assumed the community still wanted abstinence-only education and no effort was made to assess the current community support for comprehensive sex education.

The interviews revealed that ISDB Trustees undertook an avoidance strategy to cope with the perceived conflict that accompanied sex education decisions. To avoid further controversy, the Trustees combined the former sex education and HIV education policies, removed the terms sexuality education and HIV education from the titles and renamed the policy, “Health Education. The precepts of the policies did not change, only the name of the policy did. This tendency of school districts to avoid conflict was also described by stakeholders in the Sexual Health Community Needs Assessment of Ada County (Elliott, 2008).

The Trustees avoidance of sex education policy, which was perceived as controversial, was consistent with research on decision making, which suggested that individuals assigned more weight to the risks associated with a choice than to the possible benefits (Anderson, 2003). The Trustees, administration, and frontline staff remarked that providing inappropriate sex education could threaten their positions. This significant personal risk outweighed the potential positive outcomes that teens may experience by taking an evidence-based, comprehensive sex education class. And adopting comprehensive sex education was even more unlikely because the Trustees and administrator were not aware of the current research showing abstinence-only curricula were ineffective.

Pulled Between Values and Reality

During the interviews, the frontline workers spoke frequently about how the philosophy of abstinence until marriage was the value of the community and what parents

wanted for their children, but it was not the reality of how things are. This observation matches research on American's sexual activity, which found 95 percent of people were sexually active before they got married (Finer, 2007). This finding could be explained because Americans are delaying marriage. In 2004, the average age of marriage was 25.3 for females and 27.1 for males (U.S. Census Bureau, 2004), making the ideal of abstinence until marriage unachievable for most since few individuals wait until their mid-twenties or later to engage in sexual activity.

The frontline staff at ISDB were in favor of comprehensive sex education because students were misinformed and lacked knowledge about sexuality. This perception was supported by the research done by Health and Welfare, which showed that Idaho young people were misinformed about STDs, transmission, risks, and prevention methods (Northwest Research Group, 2007). Frontline staff said many students were getting their information about sex from the media and not from their parents or the school. Boise teens not discussing sex with their parents was consistent with a new study by Robert and Sonenstein (2010), which found only 44 percent of teen girls reported talking to their parents about sex, birth control, or HIV prevention in 2002, down from 52 percent in 1995.

The interviewees all encouraged parental involvement; but, four out of four of the frontline staff said many parents do not have the inclination, knowledge, or skills to teach students about sex. And many parents do not set a good example of healthy sexuality for their children. When considering the students' lack of knowledge and the research indicating nearly half of high school students reported sexual activity (Idaho State

Department of Education, 2009), it provided strong evidence in support of teaching comprehensive sex education to students. All of the frontline staff expressed feelings from sadness to frustration at not being able to provide comprehensive information when they knew many students were sexually active. This presented an ethical dilemma to the frontline staff because they knew many teens were sexually active; but, the students were not being taught how to protect themselves against HIV or unintended pregnancy. Frontline workers opinions were consistent with the ethical position of the United Nations that young people have the right to be armed with the means to protect themselves against abuse and exploitation, unintended pregnancies, STDs and HIV (Office of the United Nations, 1998).

An ethical concern of those supporting abstinence-only education was the belief that it will send a mixed message (Elliott, 2008). Many providers in Boise commented that parents can stay true to their value of abstinence and still provide young people with information on birth control and condoms. This was consistent with statements made by Dr. John Douglas, director of the sexually transmitted disease division at CDC. Maggie Fox reported him as saying, “We haven't been promoting the full battery of messages; we have been sending people out with one seatbelt in the whole car” (2009, p. 1).

Implications and Recommendations

The findings of this research showed that the ISDB Board depends on parents and the community to bring the sex education issue up for discussion. The Board is open to reviewing and considering new approaches to sex education. Therefore, nurses, teachers,

parents, and other community members will need to collaborate to effectively present the Board with current research on the growing problem of poor teen sexual health, the ramifications of the problem, and how evidence-based sex education can improve teen health outcomes.

A pertinent finding from the community appraisal showed that when making decisions regarding sex education, Board members and administrators have been greatly influenced by past conflicts that occurred when ISDB made sex education and HIV education decisions. As a result, Trustees and administrators avoid sex education decisions and take a very conservative approach. An advocacy group presenting research on sex education to the Trustees would need to assuage the Board of their fears of community repercussions by showing strong, unified, community support. A well organize, advocacy group of many nurses and other healthcare professionals, parents, representatives from the faith community, and business leaders would help the Board feel confident that there was widespread support for thoroughly reviewing the policy. The members of the advocacy group could frequently remind the Trustees that those societies that speak openly about sex and teach comprehensive sex education have lower rates of teen pregnancy, abortion, and STD than the U.S. Furthermore, their teens initiate first sex later than those in the U.S (Abma, Martinez, Mosher, & Dawson, 2004).

In addition, Trustees are busy volunteers with many competing priorities, so having a strong professional group present scientific research on the effectiveness of sex education curricula would save the Board time because they would not have to completely organize an advisory board. The group would also be wise to present many

research studies, including local ones, indicating the vast majority of parents support comprehensive sex education across political and religious lines. And lastly, the group would need to counteract any mass mobilization efforts that special interests groups may undertake to circumvent ISDB adopting evidence-based sex education curricula. The supporters of evidence-based sex education would need to be prepared to mobilize an equal or greater amount of community support than the special interest groups.

The case study also found that the Trustees and mid-level administrators may not have the time or interest to fully review their abstinence-only sex education philosophy or to get input from all staff who work in the area of teen sexual health. Information from the interviews showed administration strictly adhered to the abstinence-only philosophy and were not open to reviewing it; therefore, the request for a full review of the sex education policy may be more accepted if it comes from outside the ISDB. Frontline ISDB staff supporting evidence-based sex education would be encouraged to participate in the advocacy group and present the issue to the Trustees. There may be less internal ISDB resistance and more open communication if the information on teen sexual health was presented by an advocacy group from outside ISDB.

Helping young people find the inner strength to consider their own health and their own goals for the future before making the decision to have sex is not something that can be accomplished in five easy lectures. Questioning students so they consider the long-term consequences of their choices is most effectively done in a client-centered, non-judgmental manner and approached when the student is ready to hear the message. Teaching students about boundaries, partner choices, communication, negotiation, and

self-esteem are part of evidence-based sex education curricula and multiple sessions are required to deliver this content – all of which are vitally important to the effectiveness of the programs. As a district, ISDB will need to restructure their health classes in order to have adequate time to teach sex education programs that have been shown to delay initiation of sex, reduce the number of sex partners, increase condom and birth control use, and ultimately decrease STD, teen pregnancy, and abortion.

The research also showed that there was a large variation in what was taught to students in different health classes across ISDB, depending on the experience, knowledge, and values of the teacher and the type of ISDB school. Adopting an evidence-based sex education curriculum, implemented with fidelity, would ensure all students at the ISDB receive the same quality health education.

Teaching young people to make healthy sexual choices takes time and open communication, free of fear and manipulation. It also takes the partnership of schools, parents, churches, and youth groups. For the community of Boise to address this problem, it may require a review of priorities, a restructuring of the school day and curricula, improving access to sexual health care for teens, and a willingness to honestly discuss sex with youth. Many parents are frightened of discussing birth control or condoms with their children because they fear it will send a mixed message (Elliott, 2008). A paradigm shift is needed to see that parental values and reality are not polar opposites. Parents can value abstinence and their child's health. One key informant, for the sexual health needs assessment, helps her clients communicate with their children by suggesting they say: "As a parent, my value is for you to be abstinent, so that you're safe and complete your

education. But I know the sex drive is strong and sometimes things happen, so I want you to have what you need to be healthy, in case you get carried away.” Then, she gives the child information about birth control, condoms and access to sexual health care.

A recent research study found that family planning and sex education policy had a direct effect on teen birth rates. Yang and Gaydos found that demographics, cultural issues, and policy jointly influenced teen birth rates; however, regression analysis showed that no single factor alone explained the increase in teen birth rates that the U.S. experienced in 2006 and 2007 (2010). States that had abstinence-only policies were associated with higher rates of teen pregnancy in Whites and Blacks, but not in Hispanics, indicating that other factors besides type of sex education were at play. Also, minorities have higher teen birth rates, but not all states with high proportions of minorities had higher birth rates than states with a predominantly White population. This indicated more than race and ethnicity influenced teen pregnancy rates (Yang & Gaydos, 2010).

This research speaks to the complexity of addressing teen sexual health issues and the need to look at the entire sphere of policy, demographics, social, political, and legal issues when considering strategies to reduce teen pregnancy. The case study on the decision-making process regarding sex education at the ISDB provided a rich analysis of the context and other extenuating factors influencing teen pregnancy and STD in the community of Boise. The research also adds to the body of knowledge that can be used to inform effective strategies to promote teen sexual health.

Implications for Nursing

Research indicated that many administrators and teachers depend on nurses to provide specific, up-to-date information about sex education, sexual health, and contraception (King & Eckstein, 2005). This case study showed that many teachers depend on the school nurse for this type of information as well. The case study also found the Trustees would be willing to learn from a nurse, if the nurse brought information to the Board. Nurses would be extremely valuable members of an advocacy group working to introduce evidence-based sex education curricula into the ISDB because nurses have a high degree of credibility with the ISDB Board. They work within the school district, know the problem first-hand, and could provide anonymous anecdotes describing the impact of these issues on ISDB students. And nurses understand the research on sex education. Of great importance, nurses can advocate for teen sexual health from a nursing perspective – striving only to improve the health of teens, not to advocate for a certain religious belief or political party.

By working with Trustees and administrators to establish policy that supports evidence-based school curricula for the prevention of teen pregnancy, ISDB nurses fulfill their role as a school nurse as outlined by the National Association of School Nurses (NASN). The NASN platform states that the school nurse should assist with the “selection, development and presentation of effective reproductive health education programs” (2004, p. 1, para 10).

ISDB students are at risk but they are not being taught how to reduce that risk and be sexually healthy. Nurses can help craft policy that will ensure all teens receive basic

comprehensive sex education. Nurses have a strong tradition of meeting the needs of marginalized populations and underage students, and many parents fit into this group because they have no power to advocate for themselves. In addition, research indicated only 2.4 percent of Hispanics in Boise's health district oppose comprehensive sex education in schools (Idaho Bureau of Vital Records and Health Statistics, 2009). From this survey it appears Hispanics want their children informed about birth control and methods to prevent STD. Therefore, to work towards eliminating health disparities, and support the viewpoints of the vast majority of Hispanics, nurses should advocate for policy that will provide Latino students with the knowledge they need to be healthy and remain in school.

Furthermore, the information gathered from the interviews suggested that education and prevention counseling are not provided equally to all classrooms in the ISDB because of differences in the skill level and experience of health teachers. In addition, one-on-one counseling about sexuality is only provided to students who seek out these services from the school nurse. Furthermore, high risk students attending alternative schools receive more counseling and services than students in traditional high schools. But when the data suggests nearly 50 percent of Boise teens are sexually active, it is apparent not just teens in alternative schools are having sex. All the students need this information. Nurses should promote policies that will ensure equitable sex education to all ISDB students, regardless of race, ethnicity, or background. One very effective strategy for doing so would be to provide evidence-based comprehensive sex education to the ISDB.

Limitations

This case study had limitations. The analysis of the sex education policy decision was confined to the ISDB, a relatively small area, and cannot be generalized to other areas. Each school district in Idaho has autonomy to choose its own sex education policy. Since the majority of school districts in Idaho have abstinence-only policies for sex education, perhaps other school districts may be interested in researching the feasibility of implementing an evidence-based curriculum. This case study can be used as a template for a theory-based method to analyze the context and process of each district's sex education decision-making process. However, it cannot provide the context and information to inform the decisions of other districts to pursue a policy change or to determine the best strategies to go about changing policy.

Recruiting high school health teachers to participate in the research was challenging. A total of nine health teachers were contacted before interviews with two health teachers could be arranged. The teachers were contacted during the last week of the school year and during the summer, which may have been a barrier to participation. The research may also be biased by the selection of participants because those who agreed to be interviewed may be more comfortable talking about sexuality than those who did not participate. In addition, those who agreed to participate may be more supportive of sex education and research about it than those who did not participate.

The number of participants interviewed for the case study was small. More interviews with trustees and frontline workers would have added to the depth and breadth of the findings. Additionally, six of the seven interviews were audio recorded. Data

collected from notes taken during the non-recorded interview were not as precise and could not be quoted, due to issues of accuracy and lack of verification.

The ISDB Website lists two administrators who were responsible for sex education. Only one of the administrators participated in the case study, limiting the information collected from mid-level management at ISDB. However, the data collected showed that administrator who was interviewed was the only administrator who participated in the process of creating the new health education policy. Nonetheless, the administrator who was not interviewed had participated in sex education policy issues at ISDB in the past, especially curricular ones, and would have been another pertinent source of historical and contextual information.

The findings of the case study indicated that decisions made about curricula, budgets, and textbooks influenced the content of the sex education taught at ISDB. The case study did not include analysis of the decision-making process in those areas. In addition, some ISDB students are taking high school health on-line. Due to time limitations, the content of the on-line sex education health curriculum was not included in the case study. Moreover, it is unknown how many ISDB students take health on-line. And lastly, due to time limitations, the researcher did not ask an interviewee to verify the categories derived from the interview data. Member checking would have added another dimension of rigor to the case study.

The CCC Model includes a community outcomes component that is used to evaluate and compare the outcomes of the policy or interventions. The outcomes also include a comparison of the effects of the interventions based on the type of advocacy the

community engaged in. The outcomes of the new comprehensive health education policy were not included in this case study because the policy was newly approved April 12, 2010 and there was not adequate time for an evaluation.

Recommendations for Further Research

The findings of this case study showed various ISDB policies influenced what was taught for sex education. Further analysis of how the Trustees prioritize issues and create fiscal and curricular policy is needed to more fully understand the complex set of factors influencing what is taught for sex education in the ISDB. Ideally, there would be open communication in the ISDB, which allows nurses and health teachers to promptly approach the Trustees when the needs of students were not being met. Quickly resolving unmet student needs would improve nursing practice and education. Therefore, research is needed to identify the barriers facing ISDB frontline staff, both within themselves and in the ISDB system, that prevent them from participating in policy development at the ISDB.

Further research is also recommended to assess the outcomes of the CCC model. Research would include measuring the rates of teen pregnancy, abortion, and STD in Boise. These rates could be compared to the Meridian School District, which has a comprehensive sex education option. About half of Meridian parents choose comprehensive sex education that includes instruction about sexual identity, condoms, and birth control (T. Carles, personal communication, March 31, 2009). In addition, more research on the needs of the Hispanic community and sex education could be conducted.

The findings of the case study indicated that parents, teachers, health care providers, and students are inhibited when discussing sexuality. Research that delves into the dynamics of communication about sexuality could be utilized to increase communication and has the potential to greatly improve sexual health, education, family relationships, and healthcare.

And finally, research that increases the understanding of teens' perspectives on sexual health and how sex education is taught would be useful in creating more effective sex education programs. Additional research that clearly identifies parental support for comprehensive sex education in Boise is also needed.

Summary

Key informants, from the sexual health community needs assessment conducted in 2008, indicated students lacked knowledge about sexuality and agreed that comprehensive sex education was the best strategy for improving teen sexual health (Elliott, 2008). However, the recommendations could not be put into place because the Independent School District of Boise (ISDB) had an abstinence until marriage policy of sex education. This case study, which included one-on-one interviews and a document and archival record review, analyzed the factors that influenced sex education decisions. ISDB Board minutes, existing policy, and health curriculum were reviewed, in addition to demographic and historical information about the city of Boise and the ISDB community. The influences were complex and involved cultural, political, legal, and economic pressures.

Conflict from the past, strict adherence to the existing abstinence-only policy, the Board of Trustee's perceptions about the conservative values of the Boise community, and poor communication due to organizational bureaucracy were found to be the major influences on sex education policy decisions. Decisions in the past had been contentious and ISDB members strictly adhered to the abstinence-only policy to avoid any further conflict. A common perception, among ISDB administration and Trustees, that parents supported teaching only abstinence superseded providing comprehensive sex education. A bureaucratic organizational structure and competing priorities for education prevented a free flow of information between the ISDB Trustees, staff, and the community.

The ISDB Trustees depended on the community to bring information about sex education to the Board. The community had not done so because they were unaware of the procedure. This contributed to the Trustees and ISDB staff being uninformed about the growing problem of poor teen sexual health in Boise.

The findings of the case study suggested the community needs to become more involved in creating sex education policy at the ISDB. Trustees need to know there is a problem and supplied with the research necessary to make fully informed sex education policy decisions. Nurses, teachers, parents, and other community members must collaborate and make a unified effort to overcome the ISDB Trustees perception that the majority of the Boise community supports abstinence-only sex education.

REFERENCES

- Abma, J. C., Martinez, G. M., Mosher, W. D., & Dawson, B. S. (2004). Teenagers in the United States: Sexual activity, contraceptive use and childbearing, 2002. *Vital Health Statistics* Retrieved October 6, 2011 from http://www.cdc.gov/nchs/data/series/sr_23/sr23_024.pdf.
- Academy for Education and Development. (2009). Diffusion of effective behavioral interventions Retrieved December 12, 2009 from www.effectiveinterventions.org
- Allen, A., & Plank, D. N. (2005). School board election structure and democratic representation. *Educational Policy*, 19(3), 510-527.
- American Medical Association. (2001). The parent package. Retrieved October 17, 2011 from <http://www.ama-assn.org/ama/pub/physician-resources/public-health/promoting-healthy-lifestyles/adolescent-health/patient-handouts.shtml>
- Anderson, C. J. (2003). The psychology of doing nothing: Forms of decision avoidance result from reason and emotion. *Psychological Bulletin*, 129(1), 139-167.
- Association of Religion Data Archives. (2000). County membership report. Retrieved February 1, 2010, from Pennsylvania State University http://www.thearda.com/mapsReports/reports/counties/16001_2000.asp
- Avert. (2008). Abstinence, sex education and HIV prevention. Retrieved October 17, 2011 from <http://www.avert.org/abstinence.htm>
- Banister, P., Berman, E., Parker, I., Taylor, M., & Tindall, C. (1994). *Qualitative methods in psychology: A research guide*. Buckingham: Open University Press.

- Bleakley, A., Hennessy, M., & Fishbein, M. (2006). Public opinion on sex education in U.S. schools. *Archives of Pediatrics Adolescent Medicine*, 160(11), 1151-1156.
- Blinn-Pike, L. (2008). Sex education in rural schools in the United States: Impact of rural educators' community identities. *Sex Education: Sexuality, Society and Learning*, 8(1), 77-92.
- Bogden, J. E. (2006). CDC's Coordinated School Health Program model. Alexandria, VA: National Association of State Boards of Education.
- Boyer, P. S. (2001). Sex education. *The Oxford companion to United States history*. Oxford University Press.
- Brown, E. J., & Simpson, E. M. (2000). Comprehensive STD/HIV prevention education targeting U.S. adolescents: Review of an ethical dilemma and proposed ethical framework. *Nursing Ethics*, 7(4), 11.
- Brown, K. M., Akintobi, T. H., Pitt, S., Berends, V., McDermott, R., Agron, P. et al. (2004). California school board members' perceptions of factors influencing school nutrition policy. *Journal of School Health*, 74(2), 52-58.
- Brown, R. D. (1985). An exploratory study of centextual factors as influences on school board evaluation information needs for decision making. *Education Evaluation and Policy Analysis*, 7(4), 437-445.
- Bruckner, H., & Bearman, P. (2005). After the promise: The STD consequences of adolescent virginity pledges. *Journal of Adolescent Health*, 36(4), 271-278. doi: S1054-139X(05)00055-8 [pii]10.1016/j.jadohealth.2005.01.005 [doi]

- Bruess, C. E., & Greenberg, J. S. (2008). Resolving ethical issues when conducting sexuality education. *American Journal of Sexuality Education*, 3(4), 313-322.
- Burns, N., & Grove, S. K. (2005). *The practice of nursing research: Conduct, critique, and utilization*. (5th ed.). St Louis, MO: Elsevier Saunders.
- Cates, J. R. (2008). Education on Sexually Transmitted Infections: Finding Common Ground among Youth, Parents, Providers and Policy Advocates. *Sex Education: Sexuality, Society and Learning*, 8(2), 129-143.
- Centers for Disease Control and Prevention. (2007a). *Health education curriculum analysis tool*. Atlanta, GA: Department of Health and Human Services,.
- Centers for Disease Control and Prevention. (2007b). *Teen birth rate rises for first time in 15 years*. Atlanta: U.S. Department of Health and Social Services Retrieved October 11, 2011 from <http://www.cdc.gov/nchs/pressroom/07newsreleases/teenbirth.htm>.
- Centers for Disease Control and Prevention. (2009a). April is STD awareness month. Atlanta: U.S. Department of Health and Human Services Retrieved October 6, 2011 from <http://www.cdc.gov/Features/STDAwareness/>.
- Centers for Disease Control and Prevention. (2009b). Sexual and Reproductive Health of Persons Aged 10--24 Years: United States, 2002-2007. *Morbidity Mortality Weekly Report*. Retrieved October 12, 2011 from <http://www.cdc.gov/mmWR/PDF/ss/ss5806.pdf>.
- Centers for Disease Control and Prevention. (2009c). *Trends in reportable sexually transmitted diseases in the United States, 2008*. Atlanta: United States

Department of Health and Social Services. Retrieved October 16, 2011 from
<http://www.cdc.gov/std/stats08/trends.htm>.

Centers for Disease Control and Prevention. (2010a). *Condoms and STDs: Fact sheet for public health personnel*.

Centers for Disease Control and Prevention. (2010b). *Diagnoses of HIV infection, by race/ethnicity and selected characteristics, 2008 - 37 states and 5 U.S. dependent areas with confidential name-based HIV infection reporting*. Atlanta: Retrieved October 11, 2011 from
<http://www.cdc.gov/hiv/surveillance/resources/reports/2008report/table3b.htm>.

Centers for Disease Control and Prevention. (2010c). *Healthy youth: National trends in risk behaviors, sexual behaviors factsheet*.

Concerned Women for America. (2009). *History*. Retrieved 12/22/2009, from
<http://www.cwfa.org/history.asp>

Cotton, L., Brazier, J., Hall, D. M. B., Lindsay, G., Marsh, P., Polnay, L. et al. (2000). School nursing: costs and potential benefits. *Journal of Advanced Nursing*, 31(5), 1063-1071.

Creswell, J. W. (1998). *Qualitative inquiry and research design: Choosing among five traditions*. Thousand Oaks, CA: Sage Publications, Inc.

Darroch, J. E., Landry, D. J., & Singh, S. (2000). Changing emphases in sexuality education in U.S. public secondary schools, 1988-1999. *Family Planning Perspectives*, 32(5), 204.

- Dodge, B., Zachry, K., Reece, M., Lopez, E., Herbenick, D., Gant, K. et al. (2008). Sexuality education in Florida: Content, context, and controversy. *American Journal of Sexuality Education*, 3(2), 183-209.
- Donovan, P. (1998). School-based sexuality education: The issues and challenges. *Family Planning Perspectives*, 30(4), 188-193.
- Duberstein Lindberg, L., Santelli, J., & Singh, S. (2006). Changes in formal sex education: 1995-2002. *Perspectives on Sexual and Reproductive Health*, 38(4), 8.
- Eagle Forum. (2000). Nosy "evaluations" could hurt abstinence programs. *Education Reporter*, (173). Retrieved from <http://www.eagleforum.org/educate/2000/june00/nosy.html>
- Eisenberg, M. E., Bernat, D. H., Bearinger, L. H., & Resnick, M. D. (2008). Support for comprehensive sexuality education: Perspectives from parents of school-age youth. *Journal of Adolescent Health*, 42(4), 352-359.
- Elliott, A. E. (2008). Sexual health community needs assessment. *Unpublished*. Boise State University. Boise.
- Estrella, A. (2010, 6/15/2010). Boise school district adopts tight 2010-2011 budget; Meridian next. *Idaho Statesman*. Retrieved from <http://www.idahostatesman.com/2010/06/15/1231621/boise-adopts-tight-2010-2011-budget.html>
- Fineberg, H. V. (2008). *Domestic abstinence-only programs: Assessing the evidence*. Washington, D.C.: U.S. House of Representatives, Committee on Oversight and Government Reform. Retrieved from

http://www7.nationalacademies.org/ocga/testimony/Abstinence_Only_Sex_Ed_Programs_and_HIV_Infection.asp.

Finer, L. B. (2007). Trends in premarital sex in the United States, 1954-2003. *Public Health Reports*, 122(1), 73-78.

Forhan, S. (2008). *Nationally representative CDC study finds one in four teenage girls has an STD*. Atlanta: Retrieved October 11, 2010 from <http://www.cdc.gov/stdconference/2008/press/release-11march2008.pdf>.

Fox, M. (November 16, 2009). Sex infections still growing in the U.S., says CDC. *Reuters*. Retrieved from <http://www.reuters.com/article/idUSTRE5AF14A20091116?pageNumber=2>

Frazier, D. R. (September 30, 2009). Statesman readers bash Bieter's trolley. *Boise Guardian*. Retrieved from <http://boiseguardian.com/2009/09/30/bieter-trolley-folly-is-bashed-in-daily-comments/>

Frazier, D. R. (2010). No stopping a runaway train (trolley) enthusiast. *Boise Guardian*, (February 21, 2010). Retrieved from <http://boiseguardian.com/2010/02/21/no-stopping-a-runaway-train-trolley-enthusiast/>

Gawlinski, J. R. (2007). A teacher's point of view on family life (sex) education. *American Journal of Sexuality Education*, 2(2), 73-78.

Geraci, B. (1996). Local decision making: A report from the trenches. *Educational Leadership*, 53(4), 50-52.

Glencoe McGraw-Hill. (2003). *Glencoe health, student edition*. Columbus, Ohio: McGraw Hill.

- Green, L. W., & Krueter, M. (2005). *Health promotion planning: An educational and ecological approach* (4th ed.). New York, NY: McGraw-Hill Companies, Inc.
- Greenwell, M. (2010). Why teen pregnancy is a poverty problem. Retrieved October 11, 2010 from http://uspoverity.change.org/blog/view/why_teen_pregnancy_is_a_poverty_problem
- Grembowski, D. (2001). *The practice of health program evaluation*. Thousand Oaks: Sage Publications.
- Gupta, N. (2010, June 15, 2010). *Boise school district forced to make difficult budget cuts, 2010*, from <http://www.ktvb.com/news/Boise-School-District-forced-to-make-difficult-budget-cuts-96338729.html>
- Haffner, D. W., & deMauro, D. (1996). *Teaching fear: The religious right's campaign against sexuality education*. Washington, D.C.
- Harrison, S. (2005). Under-12s have sex one night and play with Barbie dolls the next. *Nursing Standard*, 19(39), 14-16.
- Hayter, M., Piercy, H., Massey, M.T., & Gregory, T. (2008). School nurses and sex education: Surveillance and disciplinary practices in primary schools. *Journal of Advanced Nursing*, 61(3), 273-281.
- Hess, F. M., & Leal, D. L. (1999). Politics and sex-related programs in urban schooling. *Urban Affairs Review*, 35(1), 24-43.
- Hoffman, S. (2006). By the numbers: The public cost of teen childbearing. *National Campaign to Prevent Teen Pregnancy*.

- Howard-Barr, E. M., & Moore, M. J. (2007). Florida residents' preferred approach to sexuality education. *American Journal of Sexuality Education*, 2(3), 27-37.
- Hurst, D. (2010). Idaho GOP accepts platform with loyalty oath, call for repeal of 17th Amendment. *IdahoReporter.com*, (June 27, 2010). Retrieved from IdahoReport.com website: <http://www.idahoreporter.com/2010/idaho-gop-accepts-platform-with-loyalty-oath-call-for-repeal-of-17th-amendment/>
- Idaho Administrative Code, IDAPA 08.02.03. Retrieved 12/11/10 from: adm.idaho.gov/adminrules/rules/idapa08/0203.pdf
- Idaho Bureau of Vital Records and Health Statistics. (2009). *Analysis from the Behavioral Risk Factor Surveillance System: Results from public health district sponsored questions, 2001 - 2008*. Boise:ID. Retrieved October 11, 2011 from <http://healthandwelfare.idaho.gov/LinkClick.aspx?fileticket=XCQyu3KcA3c%3D&tabid=913&mid=5458>.
- Idaho Bureau of Vital Records and Health Statistics. (2010). *Vital statistics annual reports, 2004-2008*. Boise: Idaho Department of Health and Welfare. Retrieved October 11, 2011 from <http://healthandwelfare.idaho.gov/Health/VitalRecordsandHealthStatistics/HealthStatistics/VitalStatistics/tabid/914/Default.aspx>.
- Idaho Department of Environmental Quality. (2007). *Summertime air pollution response plan*. Boise.
- Idaho Department of Labor. (2009). *Local labor market information*.

Idaho Legislature. (2009a). *Education, course of instruction, Title 33*. Retrieved October 6, 2010 from <http://www.legislature.idaho.gov/idstat/Title33/T33CH16SECT33-1610.htm>

Idaho Legislature. (2009b). *Feasibility of school district services consolidation*. Retrieved from <http://www.legislature.idaho.gov/ope/publications/reports/r0904.html>

Idaho Legislature. (2010a). Freedom of conscience for health care professionals. *SB1351*, from <http://www.legislature.idaho.gov/legislation/2010/S1353.htm>

Idaho Legislature. (2010b). *Idaho legislative districts*. Retrieved from <http://www.legislature.idaho.gov/about/district.cfm#d20>

Idaho Office of Epidemiology and Food Protection. (2010). *Reported sexually transmitted disease. Boise*. Department of Health and Welfare. Retrieved from <http://www.healthandwelfare.idaho.gov/Health/FamilyPlanningSTDHIV/STDStatistics/tabid/393/Default.aspx>.

Idaho State Department of Education. (2009). *Idaho youth risk behavior survey*.

Idaho State Department of Education. (2010a). *FY 2011 public schools budget approved by JFAC*. March 3, 2010, from <http://www.sde.idaho.gov/site/schoolsbudget/>

Idaho State Department of Education. (2010b). Health content standards. Boise: Retrieved October 11, 2010 from http://www.sde.idaho.gov/site/content_standards/health_standards.htm.

Independent School District of Boise. (2010a). *Board of Trustees*. Retrieved October 11, 2010 from <http://www.boiseschools.org/board/index.html>

- Independent School District of Boise. (2010b). *Board of Trustees. April 12th meeting packet*. Retrieved October 11, 2010 from http://www.boiseschools.org/board/meeting/archive/2010/2010_04_12/index.html
- Independent School District of Boise. (2010c). *Board of Trustees. March 22, 2010 Meeting Packet*. Retrieved October 11, 2010 from http://www.boiseschools.org/board/meeting/archive/2010/2010_03_22/index.html
- Independent School District of Boise. (2010d). *Boise School District health services*. Retrieved from <http://www.boiseschools.org/health/>
- Independent School District of Boise. (2010e). *Boise School District statistics*. Retrieved October 11, 2010 from http://www.boiseschools.org/district_info/district.html
- Ito, K., Gizlice, Z., Owen, J., Foust, E., & Leone, P. (2006). Parent opinion of sexuality education in a state with mandated abstinence education: Does policy match parental preference? *Journal of Adolescent Health, 39*(5), 634-641.
- Jemmott, J. B., Jemmott, L. S., & Fong, G. T. (2010). Efficacy of a theory-based abstinence-only intervention over 24 months: A randomized controlled trial with young adolescents. *Archives of Pediatric Adolescent Medicine, 164*(2), 152-159.
- Joint Committee on National Health Education Standards. (2007). *National health education standards: Achieving excellence*. Atlanta: CDC.
- Jones, S. A. (2008). Provision of sex and relationships education for young people. *Nursing Standard, 23*(14), 6.

- Jorm, A. F., Korten, A. E., Rodgers, B., Jacomb, P. A., & Christensen, H. (2002). Sexual orientation and mental health: Results from a community survey of young and middle-aged adults. *The British Journal of Psychiatry*, 180(5), 423-427.
- Kaiser Family Foundation. (2000). *Sex education in America: A series of national surveys of students, parents, teachers and principals*. Menlo Park, CA: Kaiser Family Foundation.
- Kaiser Family Foundation. (2002). Sex education in the United States: Policy and politics. *American Journal of Health Education*, 33(5), 282-289.
- Kelly, G. J., & Steed, L. G. (2004). Communities coping with change: A conceptual model. *Journal of Community Psychology*, 32(2), 201-216.
- King, D. K., & Eckstein, J. M. (2005). Manual for school health programs.
- Kirby, D. (2007). *Emerging answers 2007: Research findings on programs to reduce teen pregnancy and sexually transmitted diseases*. Washington D.C.: The National Campaign to Prevent Teen Pregnancy.
- Laird-Richards, J. (September 16, 2009). *Did Boise school district bend under Republican pressure?* Retrieved October 4, 2010 from Examiner.com website: <http://www.examiner.com/political-buzz-in-boise/did-boise-s-school-district-bend-under-republican-pressure>
- Landry, D. J., Kaeser, L., & Richards, C. L. (1999). Abstinence promotion and the provision of information about contraception in public school district sexuality education policies. *Family Planning Perspectives*, 31(6), 280.

- Leap, C. J. (2006). National profile of local health departments. *Journal of Public Health Management and Practice*, 12(5), 496-498.
- Lindau, S. T., Tetteh, A. S., Kasza, K., & Gilliam, M. (2008). What schools teach our patients about sex: Content, quality, and influences on sex education. *Obstetrics and Gynecology*, 111(2 Pt 1), 256-266. doi: 10.1097/01.AOG.0000296660.67293.bf [doi]
- Macgillivray, I. K. (2004). Gay rights and school policy: A case study in community factors that facilitate or impede educational change. *International Journal of Qualitative Studies in Education*, 17(3), 347-370.
- Manlove, J., Romano-Papillo, A., & Ikramullah, E. (2004). *Not yet: Programs to delay first sex among teens*. Washington, DC:.
- Martin, S., Rector, R. E., & Pardue, M. G. (2004). *Comprehensive sex education vs. authentic abstinence: A study of competing curriculae*.
- Melville, K. (2006). *Learning to finish: The school drop out crisis: The University of Richland, Pew Partnership for Civic Change*.
- Merriam, S. B. (1998). *Qualitative research and case study applications in education*. San Francisco, CA.: Jossey-Bass Publishers.
- Merriam-Webster Online Dictionary. (Ed.) (2009).
- Mollborn, S., & Morningstar, E. (2010). Investigating the relationship between teenage childbearing and psychological distress using longitudinal evidence. *Journal of Health and Social Behavior*, 50(3), 310-326.

- Morse, J. M., & Field, P. A. (1995). *Qualitative research methods for health professionals* (2nd ed.). Thousand Oaks, CA: Sage Publications, Inc.
- National Association of School Nurses. (2004). *Position statement: The role of the school nurse in supporting adolescent parents*.
- National Campaign to Prevent Teen Pregnancy. (2007). *Teen birth rates: How does the United States compare?* Retrieved October 5, 2010 from http://www.thenationalcampaign.org/resources/pdf/TBR_InternationalComparison.pdf
- National Campaign to Prevent Teen Pregnancy. (2010). *Federal funding for teen pregnancy prevention programs*.
- Neutens, J. J. (1992). Sexuality education in comprehensive school health programs: Surviving the "moral smog". *The Journal of School Health*, 62(2), 2.
- Newton, P. M., & Sackney, L. (2005). Group knowledge and group knowledge processes in school board decision making. *Canadian Journal of Education*, 28(3), 434-457.
- Northwest Research Group. (2007). *Closed Loop Marketing & Idaho Department of Health & Welfare STD prevention research*.
- Office of the United Nations. (1998). *International guidelines on HIV/AIDS and human rights* (pp. para. 30h). Geneva: Office of the United Nations High Commissioner for Human Rights and the Joint United Nations.
- Opfer, V. D., & Denmark, V. (2001). Sorting out a sense of place: School and school board relationships in the midst of school-based decision making. *Peabody Journal of Education*, 76(2), 101-118.

- Palko, C. (2010). *America's 100 most conservative-friendly counties*. Retrieved October 17, 2010 from <http://dailycaller.com/2010/03/15/americas-100-most-conservative-friendly-counties-numbers-81-100/>
- Pew Health Professions Commission. (1995). *Critical challenges: Revitalizing the health professions for the twenty-first century*. UCSF: San Francisco, CA.
- Piercy, H., & Hayter, M. (2009). Effective sex education in primary schools: A study. *British Journal of School Nursing*, 4(4), 5.
- Pittman, V., & Gahungu, A. (2006). Comprehensive sexuality education or abstinence-only education: Which is more effective? *Journal of Research for Educational Leaders*, 3(2), 60-91.
- Richert, K. (2009, September 13, 2010). *Boise City council elections: How far apart are Thomson and Litster?* Retrieved October 17, 2010 from http://voices.idahostatesman.com/2009/10/21/krichert/boise_council_elections_how_far_apart_are_thomson_and_litster_wa
- Richert, K. (2010, September 13, 2010). *Idaho politics: A tale of two Boise swing districts*. Retrieved October 11, 2010 from http://voices.idahostatesman.com/2010/09/10/krichert/idaho_politics_tale_two_boise_swing_districts
- Robert, A. C., & Sonenstein, F. L. (2010). Adolescents' reports of communication with their parents about sexually transmitted diseases and birth control: 1988, 1995 and 2002. *Journal of Adolescent Health*, 46(2010), 532-537.

Santelli, J., Ott, M., 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. doi:

10.1016/j.jadohealth.2005.10.006

Shields, T. (1996). Conservatives hope to gain control of Charles County school board, *Washington Post*.

Siecus. (2008). *We're outta here: 25 states withdraw from crumbling Title V Abstinence-only-until-marriage program*. Retrieved from

<http://www.cfw.org/Document.Doc?id=275>

Sperlings Best Places. (2010). *Best places to live in Boise*. Retrieved October 11, 2010

from <http://www.bestplaces.net/zip-code/Boise-Idaho-83702.aspx#>

Stake, R. (1995). *The art of case study research*. Thousand Oaks, CA: Sage.

Statesman staff. (2010). Incumbent, parent volunteer claim Boise School Board seats.

Idaho Statesman. Retrieved from

<http://www.idahostatesman.com/2010/09/07/1331423/incumbent-parent-volunteer-claim.html>

Strayhorn, J. M., & Strayhorn, J. C. (2009). Religiosity and teen birth rate in the United States. *Journal of Reproductive Health*, 6, 14. doi: 1742-4755-6-14

[pii]10.1186/1742-4755-6-14 [doi]

Trenholm, C., Devaney, B., Fortson, K., Quay, L., Wheeler, J., & Clark, M. (2007).

Impacts of four Title V, section 510 abstinence only education programs.

Mathematica Policy Research, Inc. Princeton: N.J.

U.S. Census Bureau. (2004). *Estimated median age at first marriage: 1890 to present*.

U.S. Census Bureau. (2009). *American Community Survey: Demographic and Housing*

Estimates for Boise, Idaho. Retrieved October 1, 2010 from

http://factfinder.census.gov/servlet/ADPTable?_bm=y&-

[geo_id=16000US1608830&-qr_name=ACS_2008_3YR_G00_DP3YR5&-](http://factfinder.census.gov/servlet/ADPTable?_geo_id=16000US1608830&-qr_name=ACS_2008_3YR_G00_DP3YR5&-)

[ds_name=ACS_2008_3YR_G00_-&-_lang=en&-_sse=on](http://factfinder.census.gov/servlet/ADPTable?_ds_name=ACS_2008_3YR_G00_-&-_lang=en&-_sse=on)

U.S. Department of Health and Social Services. (2005). *Public health workforce study*.

U.S. House of Representatives Committee on Government Reform - Minority Staff.

(2004). *The content of federally funded abstinence-only programs*. Washington,

D.C.: Retrieved from

http://www.apha.org/apha/PDFs/HIV/The_Waxman_Report.pdf.

U.S.A. Social Security Administration. (2007). *Separate program for abstinence*

education. Silver Spring, MD: Retrieved from

http://www.ssa.gov/OP_Home/ssact/title05/0510.htm#ft20.

Underhill, K., Montgomery, P., & Operario, P. (2007a). Sexual abstinence only

programmes to prevent HIV infection in high income countries: Systematic

review. *British Medical Journal*, 335, 248-252.

Underhill, K., Montgomery, P., & Operario, D. (2007b). Systematic review of

abstinence-plus HIV prevention programs in high-income countries. *PLoS Med*,

4(9), e275.

- University of Washington Health Sciences Libraries. (2007). *Evidence based practice tool summary*. Retrieved October 18, 2010 from <http://healthlinks.washington.edu/ebp/ebptools.html>
- Yang, Z., & Gaydos, L. M. (2010). Reasons for and challenges of recent increases in teen birth rates: A study of family planning service policies and demographic changes at the state level. *Journal of Adolescent Health, 46*(6), 517-524.
- Yin, R. K. (2003). *Applications of case study research* (2nd Ed., Vol. 34). Thousand Oaks: Sage.
- Young, M., & Bailey, W. (1998). The politics of abstinence education: from Reagan's Title XX to welfare reform's Title V. *International Electronic Journal of Health Education, 1*(4), 207-212.
- Young, M., & Penhollow, T. (2006). The impact of abstinence education: What does the research say? *American Journal of Health Education, 37*(4), 194-202.

APPENDIX A

Idaho State Board of Education, Health Content Standards

Kindergarten to Grade 2

Standard 1: Comprehend Core Concepts

Core Concepts of Health Education for K-Grade 2 are defined below:

Alcohol, Tobacco & Other Drugs

The use of alcohol, tobacco, and other drugs has major implications in the lifelong health of individuals. Implications include the effects, influences, and prevention of the use of alcohol, tobacco products, and other types of drugs on the body.

Nutrition & Physical Activity

To be ready to learn and to achieve their fullest potential, children need to be well nourished and physically active. In order to enhance physical, mental, emotional, and social health, students need to acquire the knowledge and skills to make healthy food choices and engage in lifelong physical activity.

Injury Prevention & Safety

Unintentional and intentional injuries rank among the greatest threats to the health of children and young adults. Knowledge about prevention through safe living habits, healthy decisions, violence prevention, emergency response and an understanding of the consequences of one's decisions will help to prevent many injuries.

Mental, Emotional & Social Health

Mental, emotional and social well-being is a foundation for building good health which includes a sense of security, identity, belonging, purpose and competence in order to strive toward a healthy and productive life.

Prevention & Control of Disease

Individuals can have a considerable measure of control over their own health and the chances of contracting most illnesses. Health-related choices and decisions regarding prevention of communicable and non-communicable diseases can include recognizing risk factors, identifying methods of contraction and transmission, as well as the prevention and treatment of disease. Information should be factual, medically accurate, objective and developmentally appropriate.

Consumer & Community Health

Consumers need to understand how health care services are provided as well as how individuals can take an active role in deciding on the use of health related services and products. Community health may include recognizing appropriate health professionals and products.

Health Education Standards Approved by Legislature January 2010 for Fall 2010 School District Adoption 1

Growth, Development & Family Life

A healthy family unit is vital to the well-being and successful development of children and youth. Growth and development includes the stages of life, and changes in relationships with others that accompany social development and the aging process. Information should be factual, medically accurate, objective and developmentally appropriate.

Environmental Health

Individuals need to be aware of the impact of environmental issues and hazards on personal health. Environmental health may include precautions and behaviors to safeguard personal health, and practices that will reverse or slow down environmental pollution and related problems.

Goal 1.1: Students will comprehend core concepts related to health promotion and disease prevention to enhance health including: Alcohol, Tobacco and Other Drugs; Nutrition and Physical Activity, Injury Prevention and Safety; Mental, Emotional and Social Health; Prevention and Control of Disease; Consumer and Community Health; Growth, Development and Family Life; and Environmental Health.

K-2nd Grade Objectives

Objective(s): By the end of Second Grade, the student will be able to:

K-2.H.1.1.1. Identify that healthy behaviors affect personal health.

K-2.H.1.1.2. Recognize that there are multiple dimensions (i.e. emotional, intellectual, physical and social) of health.

K-2.H.1.1.3. Describe ways to prevent communicable diseases.

K-2.H.1.1.4. List ways to prevent common childhood injuries.

K-2.H.1.1.5. Describe why it is important to seek health care.

K-2.H.1.1.6. Identify body systems.

Standard 2: Analyzing Influences

Goal 1.1: Students will analyze the influence of family, peers, culture, media, technology, and other factors on health behavior.

K-2nd Grade Objectives

Objective(s): By the end of Second Grade, the student will be able to:

K-2.H.2.1.1 Identify how the family influences personal health practices and behaviors.

K-2.H.2.1.2 Identify what the school can do to support personal health practices and behaviors.

K-2.H.2.1.3 Describe how the media can influence health behaviors.

Standard 3: Accessing Information

Goal 1.1. Students will demonstrate the ability to access valid information and products and services to enhance health.

Health Education Standards Approved by Legislature January 2010 for Fall 2010 School District Adoption 2

K-2nd Grade Objectives**Objective(s): By the end of Second Grade, the student will be able to:**

K-2.H.3.1.1. Identify trusted adults and professionals who can help promote health.

K-2.H.3.1.2. Identify ways to locate school and community health helpers.

Standard 4: Interpersonal Communication**Goal 1.1: Students will demonstrate the ability to use interpersonal communication skills to enhance health and avoid or reduce health risks.****K-2nd Grade Objectives****Objective(s): By the end of Second Grade, the student will be able to:**

K-2.H.4.1.1. Demonstrate healthy ways to express needs, wants, and feelings.

K-2.H.4.1.2 Demonstrate listening skills to enhance health.

K-2.H.4.1.3 Demonstrate ways to respond when in an unwanted, threatening, or dangerous situation.

Standard 5: Decision Making**Goal 1.1: Students will demonstrate the ability to use decision-making skills to enhance health.****K-2nd Grade Objectives****Objective(s): By the end of Second Grade, the student will be able to:**

K-2.H.5.1.1 Identify situations when a health-related decision is needed.

K-2.H.5.1.2 Differentiate between situations when a health-related decision can be made individually or when assistance is needed.

Standard 6: Goal Setting**Goal 1.1 Students will demonstrate the ability to use goal-setting skills to enhance health.****K-2nd Grade Objectives****Objective(s): By the end of Second Grade, the student will be able to:**

K-2.H.6.1.1. Identify a short-term personal health goal and take action towards achieving the goal.

K-2.H.6.1.2. Identify who can help when assistance is needed to achieve a personal health goal.

Standard 7: Practice Healthy Behavior**Goal 1.1. Students will demonstrate the ability to practice health-enhancing behaviors and avoid or reduce health risks.****K-2nd Grade Objectives****Objective(s): By the end of Second Grade, the student will be able to:**

Health Education Standards Approved by Legislature January 2010 for Fall 2010 School District Adoption 3

K-2.H.7.1.1. Demonstrate healthy practices and behaviors to maintain or improve personal health.

K-2.H.7.1.2. Demonstrate behaviors that avoid or reduce health risks.

Standard 8: Advocacy

Goal 1.1. Students will demonstrate the ability to advocate for personal, family, and community health.

K-2nd Grade Objectives

Objective(s): By the end of Second Grade, the student will be able to:

K-2.H.8.1.1. Make requests to promote personal health.

K-2.H.8.1.2. Encourage peers and family to make positive health choices.

Health Education Standards Approved by Legislature January 2010 for Fall 2010 School District Adoption 4

**IDAHO CONTENT STANDARDS
HEALTH EDUCATION
Grades 3-5**

Standard 1: Comprehend Core Concepts

Core Concepts of Health Education for Grades 3-5 are defined below:

Alcohol, Tobacco & Other Drugs

The use of alcohol, tobacco, and other drugs has major implications in the lifelong health of individuals. Implications include the effects, influences, prevention and treatment of the use of alcohol, tobacco products, and other types of drugs on the body.

Nutrition & Physical Activity

To be ready to learn and to achieve their fullest potential, children need to be well nourished and physically active. In order to enhance physical, mental, emotional, and social health, students need to acquire the knowledge and skills to make healthy food choices and engage in lifelong physical activity.

Injury Prevention & Safety

Unintentional and intentional injuries rank among the greatest threats to the health of children and young adults. Knowledge of prevention through safe living habits, healthy decisions, violence prevention, emergency response and an awareness of the consequences of one's decisions, will help to prevent many injuries.

Mental, Emotional & Social Health

Mental, emotional and social wellbeing is a foundation for building good health which includes a sense of security, identity, belonging, purpose and competence in order to strive toward a healthy and productive life.

Prevention & Control of Disease

Individuals can have a considerable measure of control over their own health, including the risks of contracting most illnesses. Health-related choices and decisions regarding prevention of communicable and non-communicable diseases can include recognizing risk factors, identifying methods of contraction and transmission, as well as the prevention and treatment of disease including HIV. Information should be factual, medically accurate, objective and developmentally appropriate.

Consumer & Community Health

Consumers need to understand how health care services are provided and how individuals can take an active role in determining the use of health related services and products. Community health includes providing valid and appropriate health information, education, services, and products.

Health Education Standards Approved by Legislature January 2010 for Fall 2010 School District Adoption 5

Growth, Development & Family Life

A healthy family unit is vital to the well-being and successful development of children and youth. Growth and development includes the stages of life, changes that occur during puberty, and changes in relationships with others that accompany social development and the aging process. Family living includes healthy relationships, information regarding growth and development, and disease including HIV and their prevention. Information should be factual, medically accurate, objective and developmentally appropriate.

*Reference to Idaho Education Code Title 33, Chapter 16, Sections 1608-1611

Environmental Health

Individuals need to be aware of the impact of environmental issues and hazards on personal health. Environmental health may include precautions and behaviors to safeguard personal health, and practices that will reverse or slow down environmental pollution and related problems.

Goal 1.1: Students will comprehend core concepts related to health promotion and disease prevention to enhance health including: Alcohol, Tobacco and Other Drugs; Nutrition and Physical Activity, Injury Prevention and Safety; Mental, Emotional and Social Health; Prevention and Control of Disease; Consumer and Community Health; Growth, Development and Family Life; and Environmental Health..

Grade 3-5 Objectives

Objective(s): By the end of Fifth Grade, the student will be able to:

- 3-5.H.1.1.1. Describe the relationship between healthy behaviors and personal health.
- 3-5.H.1.1.2 Identify examples of emotional, intellectual, physical, and social health.
- 3-5.H.1.1.3 Describe ways in which a safe and healthy school and community environment can promote personal health.
- 3-5.H.1.1.4 Describe ways to prevent common childhood injuries and health problems.
- 3-5.H.1.1.5. Describe when it is important to seek health care.
- 3-5.H.1.1.6. Describe the impact of health behaviors on body systems.

Standard 2: Analyzing Influences

Goal 1.1: Students will analyze the influence of family, peers, culture, media, technology, and other factors on health behavior.

Grade 3-5 Objectives

Objective(s): By the end of Fifth Grade, the student will be able to:

- 3-5.H.2.1.1 Describe how the family influences personal health practices and behaviors.
- 3-5.H.2.1.2 Identify the influences of culture on health practices and behaviors.
- 3-5.H.2.1.3 Identify how peers can influence healthy and unhealthy behaviors.
- 3-5.H.2.1.4 Describe how the school and community can support personal health practices and behaviors.
- 3-5.H.2.1.5 Describe ways that technology can influences personal health.

Health Education Standards Approved by Legislature January 2010 for Fall 2010 School District Adoption 6

Standard 3: Accessing Information

Goal 1.1. Students will demonstrate the ability to access valid information and products and services to enhance health.

Grade 3-5 Grade Objectives

Objective(s): By the end of Fifth Grade, the student will be able to:

3-5.H.3.1.1 Identify characteristics of valid health information, products, and services.

3-5.H.3.1.2 Locate resources from home, school, and community that provide valid health information.

Standard 4: Interpersonal Communication

Goal 1.1: Students will demonstrate the ability to use interpersonal communication skills to enhance health and avoid or reduce health risks.

Grade 3-5 Objectives

Objective(s): By the end of Fifth Grade, the student will be able to:

3-5.H.4.1.1 Demonstrate effective verbal and nonverbal communication skills to enhance health.

3-5.H.4.1.2 Demonstrate refusal skills that avoid or reduce health risks.

3-5.H.4.1.3 Demonstrate nonviolent strategies to manage or resolve conflict.

3-5.H.4.1.4 Demonstrate how to ask for assistance to enhance personal health.

Standard 5: Decision Making

Goal 1.1: Students will demonstrate the ability to use decision-making skills to enhance health.

Grade 3-5 Objectives

Objective(s): By the end of Fifth Grade, the student will be able to:

3-5.H.5.1.1 Identify health-related situations that might require a thoughtful decision.

3-5.H.5.1.2 Analyze when assistance is needed when making a health-related decision.

3-5.H.5.1.3 List healthy options to health related issues or problems.

3-5.H.5.1.4 Predict the potential outcomes of each option when making a health-related decision.

3-5.H.5.1.5 Choose a healthy option when making a decision.

3-5.H.5.1.6 Describe the outcomes of a health related decisions.

Standard 6: Goal Setting

Goal 1.1 Students will demonstrate the ability to use goal-setting skills to enhance health.

Grades 3-5 Objectives

Objective(s): By the end of Fifth Grade, the student will be able to:

3-5.H.6.1.1 Set a personal health goal and track progress toward its achievement.

Health Education Standards Approved by Legislature January 2010 for Fall 2010 School District Adoption 7

3-5.H.6.1.2 Identify resources to assist in achieving a personal health goal.

Standard 7: Practice Healthy Behavior

Goal 1.1. Students will demonstrate the ability to practice health-enhancing behaviors and avoid or reduce health risks.

Grades 3-5 Objectives

Objective(s): By the end of Fifth Grade, the student will be able to:

3-5.H.7.1.1 Identify responsible personal health behaviors.

3-5.H.7.1.2 Demonstrate a variety of healthy practices and behaviors to maintain or improve personal health.

3-5.H.7.1.3 Demonstrate a variety of behaviors that avoid or reduce health risks.

Standard 8: Advocacy

Goal 1.1. Students will demonstrate the ability to advocate for personal, family, and community health.

Grades 3-5 Objectives

Objective(s): By the end of Fifth Grade, the student will be able to:

3-5.H.8.1.1 Express opinions and give accurate information about health issues.

3-5.H.8.1.2 Encourage others to make positive health choices.

Health Education Standards Approved by Legislature January 2010 for Fall 2010 School District Adoption 8

**IDAHO CONTENT STANDARDS
HEALTH EDUCATION
Grades 6-8**

Standard 1: Comprehend Core Concepts

Core Concepts of Health Education for Grades 6-8 are defined below:

Alcohol, Tobacco & Other Drugs

The use of alcohol, tobacco, and other drugs, has major implications in the lifelong health of individuals. This includes the effects, influences, prevention, and treatment of the use of alcohol, tobacco products, and other types of drugs on the body.

Nutrition & Physical Activity

Youth are best ready to learn and achieve their fullest potential when they are well nourished and physically active. Nutrition and physical activity education increases knowledge and skills to make healthy food choices and to engage in lifelong physical activity which will promote health and preventable diseases.

This includes connections to physical, mental, emotional and social health; energy level; self image; and physical fitness.

Injury Prevention & Safety

Unintentional and intentional injuries rank among the greatest threats to the health of young. Knowledge about prevention through safe living habits, healthy decisions, violence prevention, emergency response, and an understanding of the consequences of ones decisions will help to prevent injuries.

Mental, Emotional & Social Health

Mental, emotional and social wellbeing is a foundation for building good health and includes a sense of security, identity, belonging, purpose and competence in order to strive toward a healthy and productive life. Knowledge and skills may include emotional intelligence, suicide prevention, stress management, communication skills, conflict resolution, and mental illness.

Prevention & Control of Disease

Individuals have a considerable measure of control over their own health and the risk of contracting most illnesses. Health-related choices and decisions regarding prevention of communicable and non-communicable diseases, include recognizing risk factors, identifying methods of contraction and transmission, as well as the prevention and treatment of disease. Information and discussion of sexually transmitted diseases, HIV and AIDS are important components of this content area. Information should be factual, medically accurate, objective and developmentally appropriate.

Health Education Standards Approved by Legislature January 2010 for Fall 2010 School District Adoption 9

Consumer & Community Health

Consumers need to understand how health care services are provided as well as how individuals can take an active role in determining the use of health related services and products. Community health may include recognizing and accessing valid and appropriate health information, education, services, and products.

Growth, Development & Family Life

A healthy family unit is vital to the well-being and successful development of adolescence. Growth and development includes the stages of life, changes that occur during puberty, and changes in relationships with others that accompany social development and the aging process. Family living includes healthy relationships and sexuality, consequences of sexual activity, encouragement of abstinence from sexual activity, sexually transmitted diseases including HIV, pregnancy prevention, and methods of prevention. Information should be factual, medically accurate, objective and developmentally appropriate.

*Reference to Idaho Education Code Title 33, Chapter 16: Sections 1608-1611

Environmental Health

Individuals need an awareness of the impact of environmental issues and hazards on personal health. Environmental health may include precautions and behaviors to safeguard personal health and practices that reverse or slow down environmental pollution and related problems.

Goal 1.1: Students will comprehend core concepts related to health promotion and disease prevention to enhance health including: Alcohol, Tobacco and Other Drugs; Nutrition and Physical Activity, Injury Prevention and Safety; Mental, Emotional and Social Health; Prevention and Control of Disease; Consumer and Community Health; Growth, Development and Family Life; and Environmental Health.

Grade 6-8 Objectives

Objective(s): By the end of Eighth Grade, the student will be able to:

- 6-8.H.1.1.1 Analyze the relationship between behaviors, body systems, and personal health.
- 6-8.H.1.1.2 Describe the interrelationships of emotional, intellectual, physical, and social health in adolescence.
- 6-8.H.1.1.3 Analyze how the environment affects personal health.
- 6-8.H.1.1.4 Describe how family history can affect personal health.
- 6-8.H.1.1.5 Describe ways to reduce or prevent injuries and adolescent health problems.
- 6-8.H.1.1.6 Explain how appropriate health care can promote personal health.
- 6-8.H.1.1.7 Describe the benefits of and barriers to practicing healthy behaviors.
- 6-8.H.1.1.8 Examine the likelihood of injury or illness if engaging in unhealthy behaviors.

Health Education Standards Approved by Legislature January 2010 for Fall 2010 School District Adoption 10

Standard 2: Analyzing Influences

Goal 1.1: Students will analyze the influence of family, peers, culture, media, technology, and other factors on health behavior.

Grade 6-8 Objectives

Objective(s): By the end of Eighth Grade, the student will be able to:

6-8.H.2.1.1 Examine how family, culture, peers, school, and community influence healthy and unhealthy behaviors.

6-8.H.2.1.2 Analyze the influence of media and technology on personal and family health.

6-8.H.2.1.3 Explain how the perceptions of norms influence healthy and unhealthy behaviors.

6-8.H.2.1.4 Explain the influence of personal values and beliefs on individual health practices and behaviors.

6-8.H.2.1.5 Describe how some health risk behaviors can influence the likelihood of engaging in unhealthy behaviors.

6-8.H.2.1.6 Explain how school and public health policies can influence health promotion and disease prevention.

Standard 3: Accessing Information

Goal 1.1. Students will demonstrate the ability to access valid information and products and services to enhance health.

Grade 6-8 Objectives

Objective(s): By the end of Eighth Grade, the student will be able to:

6-8.H.3.1.1 Analyze the validity of healthy information, products, and services.

6-8.H.3.1.2 Access valid health information from home, school, and community.

6-8.H.3.1.3 Locate reliable and valid health products and services and determine accessibility.

6-8.H.3.1.4 Describe situations that may require professional health services.

Standard 4: Interpersonal Communication

Goal 1.1: Students will demonstrate the ability to use interpersonal communication skills to enhance health and avoid or reduce health risks.

Grade 6-8 Objectives

Objective(s): By the end of Eighth Grade, the student will be able to:

6-8.H.4.1.1 Apply effective verbal and nonverbal communication skills to enhance health.

6-8.H.4.1.2 Demonstrate refusal and negotiation skills that avoid or reduce health risks.

6-8.H.4.1.3 Demonstrate effective conflict management or resolution strategies.

6-8.H.4.1.4 Demonstrate how to ask for assistance to enhance the health of self and others.

Health Education Standards Approved by Legislature January 2010 for Fall 2010 School District Adoption 11

Standard 5: Decision Making

Goal 1.1: Students will demonstrate the ability to use decision-making skills to enhance health.

Grade 6-8 Objectives

Objective(s): By the end of Eighth Grade, the student will be able to:

- 6-8.H.5.1.1 Identify circumstances that can help or hinder healthy decision-making.
- 6-8.H.5.1.2 Determine when health-related situations require the application of a thoughtful decision-making process.
- 6-8.H.5.1.3 Distinguish when individual or collaborate decision-making is appropriate.
- 6-8.H.5.1.4 Distinguish between healthy and unhealthy alternatives to health-related issues or problems.
- 6-8.H.5.1.5 Predict the potential short-term and long-term impact of each alternative on self and others.
- 6-8.H.5.1.6 Choose healthy alternatives over unhealthy alternatives when making a decision.
- 6-8.H.5.1.7 Analyze the outcomes of a health-related decision.

Standard 6: Goal Setting

Goal 1.1 Students will demonstrate the ability to use goal-setting skills to enhance health.

Grades 6-8 Objectives

Objective(s): By the end of Eighth Grade, the student will be able to:

- 6-8.H.6.1.1 Assess personal health practices.
- 6-8.H.6.1.2 Develop a goal to adopt, maintain, or improve a personal health practice.
- 6-8.H.6.1.3 Apply strategies and skills needed to attain a personal health goal.

Standard 7: Practice Healthy Behavior

Goal 1.1. Students will demonstrate the ability to practice health-enhancing behaviors and avoid or reduce health risks.

Grades 6-8 Objectives

Objective(s): By the end of Eighth Grade, the student will be able to:

- 6-8.H.7.1.1 Explain the importance of assuming responsibility for personal health behaviors.
- 6-8.H.7.1.2 Demonstrate healthy practices and behaviors that will maintain or improve the health of self and others.
- 6-8.H.7.1.3 Demonstrate behaviors that avoid or reduce health risks to self and others.

Standard 8: Advocacy

Goal 1.1. Students will demonstrate the ability to advocate for personal, family, and community health.

Health Education Standards Approved by Legislature January 2010 for Fall 2010 School District Adoption 12

Grades 6-8 Objectives**Objective(s): By the end of Eighth Grade, the student will be able to:**

- 6-8.H.8.1.1 State a health-enhancing position on a topic and support it with accurate information.
- 6-8.H.8.1.2 Demonstrate how to influence and support others to make positive health choices.
- 6-8.H.8.1.3 Work cooperatively to advocate for the health of individuals, families, schools and the community.
- 6-8.H.8.1.4 Identify ways in which health messages and communication techniques can be altered for different audiences.

Health Education Standards Approved by Legislature January 2010 for Fall 2010 School District Adoption 13

**IDAHO CONTENT STANDARDS
HEALTH EDUCATION
Grades 9-12**

Standard 1: Comprehend Core Concepts

Core Concepts of Health Education for Grades 9-12 are defined below:

Alcohol, Tobacco & Other Drugs

The use of alcohol, tobacco, and other drugs, has major implications in the lifelong health of individuals. These include the effects, influences, prevention and treatment of the use of alcohol, tobacco products, and other drugs on the body.

Nutrition & Physical Activity

For adolescents to learn and achieve to their fullest potential they need to acquire knowledge and skills to make healthy choices in food selection and engage in lifelong physical activity. This knowledge includes the link between healthy eating and exercise with physical, mental, emotional and social health; energy level; self image; and physical fitness.

Injury Prevention & Safety

Unintentional and intentional injuries rank among the greatest threats to the health of adolescence. Adolescents require knowledge that prevention includes safe living habits, healthy decisions, violence prevention, emergency response and an understanding of the consequences of one's decisions.

Mental, Emotional & Social Health

Mental, emotional and social well-being are foundations for building good health. These foundations include a sense of security, identity, belonging, purpose and competence in order to strive toward a healthy and productive life. Knowledge and skills may include emotional intelligence, suicide prevention, stress management, communication skills, conflict resolution, and mental illness.

Prevention & Control of Disease

Individuals have a considerable measure of control over their own health and the risks of contracting illnesses. Health-related choices and decisions regarding prevention of communicable and non-communicable include recognizing risk factors, identifying methods of contraction and transmission, as well as the prevention and treatment of disease. Accurate information and discussion of sexually transmitted diseases, HIV infection and AIDS are necessary and important components of this content area. Information should be factual, medically accurate, objective and developmentally appropriate.

Health Education Standards Approved by Legislature January 2010 for Fall 2010 School District Adoption 14

Consumer & Community Health

Consumers need to understand how health care services are provided as well as how individuals can take an active role in determining the use of health related services and products. Consumer and community health include recognizing and accessing valid and appropriate health information, services, and products. This includes knowledge about health insurance, health related research, advertising and fraudulent claims.

Growth, Development & Family Life

A healthy family unit is vital to the well-being and successful development of adolescence. Growth and development includes the stages of life, and changes in relationships with others that accompany social development and the aging process. Family living includes the following topics: healthy relationships and sexuality, encouragement of abstinence from sexual activity, sexually transmitted diseases including HIV and their prevention, as well as methods of preventing pregnancy. Knowledge of factual, medically accurate and objective information is important along with personal, legal and economic responsibilities of parenthood and other consequences of sexual activity.

*Reference to Idaho Education Code Title 33, Chapter 16, Sections 1608-1611

Environmental Health

Individuals need to be aware of the impact of environmental issues and hazards on personal health. Environmental health includes precautions and behaviors to safeguard personal health, and practices that will reverse or slow down environmental pollution and related problems.

Goal 1.1: Students will comprehend core concepts related to health promotion and disease prevention to enhance health including: Alcohol, Tobacco and Other Drugs; Nutrition and Physical Activity, Injury Prevention and Safety; Mental, Emotional and Social Health; Prevention and Control of Disease; Consumer and Community Health; Growth, Development and Family Life; and Environmental Health.

Grade 9-12 Objectives

Objective(s): By the end of Twelfth Grade, the student will be able to:

- 9-12.H.1.1.1 Predict how behaviors can affect health status.
- 9-12.H.1.1.2 Describe the interrelationships of emotional, intellectual, physical, and social health.
- 9-12.H.1.1.3 Analyze how environment and personal health are interrelated.
- 9-12.H.1.1.4 Analyze how genetics and family history can affect personal health.
- 9-12.H.1.1.5 Propose ways to reduce health problems.
- 9-12.H.1.1.6 Analyze the relationship between access to health care and health status.
- 9-12.H.1.1.7 Compare and contrast the benefits of and barriers to practicing a variety of healthy behaviors.

Health Education Standards Approved by Legislature January 2010 for Fall 2010 School District Adoption 15

9-12.H.1.1.8 Analyze the potential severity of health problems that result from engaging in unhealthy behaviors.

Standard 2: Analyzing Influences

Goal 1.1: Students will analyze the influence of family, peers, culture, media, technology, and other factors on health behavior.

Grade 9-12 Objectives

Objective(s): By the end of Twelfth Grade, the student will be able to:

9-12.H.2.1.1 Analyze how the family and culture influence health beliefs and behaviors.

9-12.H.2.1.2 Analyze how peers influence health beliefs and behaviors.

9-12.H.2.1.3 Evaluate how the school and community can affect personal health practice and behaviors.

9-12.H.2.1.4 Analyze how the media and technology influence health beliefs and behaviors.

9-12.H.2.1.5 Analyze how the perception of norms influences healthy and unhealthy behaviors.

9-12.H.2.1.6 Analyze how some health risk behaviors can influence the likelihood of engaging in unhealthy behaviors.

9-12.H.2.1.7 Analyze how public health policies and government regulations can influence health promotion and disease prevention.

Standard 3: Accessing Information

Goal 1.1. Students will demonstrate the ability to access valid information and products and services to enhance health.

Grade 9-12 Objectives

Objective(s): By the end of Twelfth Grade, the student will be able to:

9-12.H.3.1.1 Evaluate the validity of health information, products, and services.

9-12.H.3.1.2 Determine the accessibility of health information, products, and services.

9-12.H.3.1.3 Access valid and reliable health information, products, and services.

9-12.H.3.1.4 Use resources from home, school, and community that provide valid health information.

9-12.H.3.1.5 Determine when professional health services may be required.

Standard 4: Interpersonal Communication

Goal 1.1: Students will demonstrate the ability to use interpersonal communication skills to enhance health and avoid or reduce health risks.

Grade 9-12 Objectives

Objective(s): By the end of Twelfth Grade, the student will be able to:

9-12.H.4.1.1 Use skills for communicating effectively with family, peers, and others to enhance health.

9-12.H.4.1.2 Demonstrate refusal, negotiation, and collaboration skills to enhance health and avoid or reduce health risks.

9-12.H.4.1.3 Demonstrate strategies to prevent, manage, or resolve interpersonal conflicts without harming self or others.

9-12.H.4.1.4 Demonstrate how to ask for and offer assist to enhance the health of self and others.

Standard 5: Decision Making

Goal 1.1: Students will demonstrate the ability to use decision-making skills to enhance health.

Grade 9-12 Objectives

Objective(s): By the end of Twelfth Grade, the student will be able to:

9-12.H.5.1.1 Examine barriers that can hinder healthy decision-making.

9-12.H.5.1.2 Determine the value of applying a thoughtful decision-making process in health-related situations.

9-12.H.5.1.3 Justify when individual or collaborative decision-making is appropriate.

9-12.H.5.1.4 Generate alternatives to health-related issues or problems.

9-12.H.5.1.5 Predict the potential short-term and long-term impact of each alternative on self and others.

9-12.H.5.1.6 Defend the healthy choice when making decisions.

9-12.H.5.1.7 Evaluate the effectiveness of health-related decisions.

Standard 6: Goal Setting

Goal 1.1 Students will demonstrate the ability to use goal-setting skills to enhance health.

Grades 9-12 Objectives

Objective(s): By the end of Twelfth Grade, the student will be able to:

9-12.H.6.1.1 Assess personal health practices and overall health status.

9-12.H.6.1.2 Develop a plan to attain a personal health goal that addresses strengths, needs, and risks.

9-12.H.6.1.3 Implement strategies and monitor progress in achieving a personal health goal.

9-12.H.6.1.4 Formulate an effective long-term personal health plan.

Standard 7: Practice Healthy Behavior

Goal 1.1. Students will demonstrate the ability to practice health-enhancing behaviors and avoid or reduce health risks.

Grades 9-12 Objectives

Objective(s): By the end of Twelfth Grade, the student will be able to:

9-12.H.7.1.1 Analyze the role of individual responsibility in enhancing health.

Health Education Standards Approved by Legislature January 2010 for Fall 2010 School District Adoption 17 Health Education Standards Approved by Legislature January 2010 for Fall 2010 School District Adoption 18

9-12.H.7.1.2 Demonstrate a variety of healthy practices and behaviors that will maintain or improve the health of self and others.

9-12.H.7.1.3 Demonstrate a variety of healthy practices and behaviors that avoid or reduce health risks to self and others.

Standard 8: Advocacy

Goal 1.1. Students will demonstrate the ability to advocate for personal, family, and community health.

Grades 9-12 Objectives

Objective(s): By the end of Twelfth Grade, the student will be able to:

9-12.H.8.1.1 Use accurate peer and societal norms to formulate a health-enhancing message.

9-12.H.8.1.2 Demonstrate how to influence and support others to make positive health choices.

9-12.H.8.1.3 Work cooperatively as an advocate for improving personal, family, and community health.

9-12.H.8.1.4 Adapt health messages and communication techniques to target a specific audience.

APPENDIX B

Social Security Administration, Section 510; Abstinence Only Requirements

Social Security Administration, Section 510; Abstinence Only Requirements

- (A) Has as its exclusive purpose, teaching the social, psychological, and health gains to be realized by abstaining from sexual activity;
- (B) Teaches abstinence from sexual activity outside marriage as the expected standard for all school age children;
- (C) Teaches that abstinence from sexual activity is the only certain way to avoid out-of-wedlock pregnancy, sexually transmitted diseases, and other associated health problems;
- (D) Teaches that a mutually faithful monogamous relationship in the context of marriage is the expected standard of human sexual activity;
- (E) Teaches that sexual activity outside of the context of marriage is likely to have harmful psychological and physical effects;
- (F) Teaches that bearing children out-of-wedlock is likely to have harmful consequences for the child, the child's parents, and society;
- (G) Teaches young people how to reject sexual advances and how alcohol and drug use increases vulnerability to sexual advances; and
- (H) Teaches the importance of attaining self-sufficiency before engaging in sexual activity (U.S.A. Social Security Administration, 2007, p. 401)

APPENDIX C

Interviewee Recruitment Script

Hi, My name is Annabeth Elliott and I'm a graduate student working on my Master of Science Nursing Degree at BSU.

For my thesis I am conducting a case study of the decision making process regarding sex education at the Independent School District of Boise.

The purpose of the case study is to understand the decision making process related to sex education at the Boise School District better, so nurses and health professionals have more knowledge about how to effectively assist school decision-makers to implement evidence-based, sex education curricula.

To gather that information, I am interviewing several people who were involved in the current or past sex education curriculum decision making process. Would you be willing to participate in the case study by answering at least six questions? It is voluntary, entirely confidential and will take approximately ½ hour?

If yes, schedule an interview at a time and place chosen by the subject.

Script requesting an appointment to obtain archived records

Hi, My name is Annabeth Elliott and I'm a graduate student working on my Master of Science Nursing Degree at BSU.

For my thesis I am conducting a case study of the decision making process regarding sex education at the Independent School District of Boise.

The purpose of the case study is to understand the decision making process related to sex education at the Boise School District better, so nurses and health professionals have more knowledge about how to effectively assist school decision-makers to implement evidence-based, sex education curricula.

To gather that information I would like permission to look at the meeting minutes and written documentation from the most recent sex education decision your agency made. Would that be possible? If yes, schedule an interview at a time and place chosen by the subject.

APPENDIX D

Document Summary Form

Name of the document:

Description of the document:

Agency, policy, demographic, morbidity or risk with which the document is associated:

Significance of document:

Summary of content:

APPENDIX E

Original Interview Questions

Questions for Health Teacher

- Describe your position in the Boise School District and how you got into it?
- Have you been informed of the new health education policy that was implemented this July?
- What do you think of it? Why do you think it was changed?
- Do you interpret it that you can go beyond abstinence as long as you cover abstinence?
- Were you asked for input?
- What book do you use when teaching sex education? May I make a copy?
- Before this policy change, did you have to get special permission from parents to teach sex education?

Questions for Trustees

- How did you become a Board member?
- What precipitated the new comprehensive health education policy change?
- What were the main issues with this policy?
- How are decisions regarding sex education at the Boise School District made?
- How were parents, teachers, school nurses and the health department and the community involved in the decision?
- Describe some of the problems, if any, the Board has encountered with sex education policy in the past?

APPENDIX F

Interview Summary Form

Position of the interviewee:

Approximate age, race and gender of interviewee:

Overall perception of interview:

Main points that emerged from the interview :

Congruence or inconsistencies with other interviewees:

Additional questions to ask other interviewees:

APPENDIX G

**New Comprehensive Health Education Policy and
Former Sex Education and HIV Education Policy**

**NEW POLICY WILL REPLACE:
#2132 FAMILY LIFE/SEX EDUCATION AND #2133 HIV/AIDS EDUCATION**

**2132
Page 1 of 1**

Health Education

The Board is committed to and recognizes the responsibility for providing comprehensive health education to District students. The goal of the health curriculum is to promote optimal health and prevent disease. The health curriculum shall:

- Instruct students in the knowledge and behaviors necessary to support lifelong habits of healthy living;
- Foster skills to make responsible decisions in the social, mental and physical aspects of life and the concept of wellness;
- Include human sexuality education, based on the philosophy of sexual abstinence until marriage; and
- Be age and developmentally appropriate.

Upon request, a parent/guardian shall have an opportunity to review the curriculum and the materials prior to student instruction.

A parent/guardian who wishes to have a student exempt from some or all of the health curriculum may do so by submitting a written request to the principal or designee. (See Exemption from Portions of Curriculum #2111).

**2132
Page 1 of 1**

Family Life/Sex Education

~~The Board recognizes that the responsibility of providing human sexuality education to children rests with the home, the church faith-based institutions, the community, and the schools.~~

~~The Superintendent or designee shall provide age appropriate family life/sex education instruction to students within the parameters outlined by the Board. The curriculum shall be based on the philosophy of sexual abstinence until marriage.~~

~~Upon request, a parent/guardian shall have an opportunity to review the curriculum and the materials prior to student instruction.~~

~~A parent/guardian who wishes to have a student exempt from some or all of the family life/sex education curriculum may do so by submitting a written request to the principal or designee. (See Exemption from Portions of Curriculum #2111)~~

~~Adopted: 6/01/98 Reviewed: 8/11/03 -- 7/11/05 Revised: 5/7/07~~
Cross-Reference: Student Curriculum Requirements (K-12) #2110

Legal Reference: Exemptions from Portions of Curriculum #2111
Curriculum Development Implementation and Evaluation #2114
I.C. 33-1608 through 33-1611

2133

Page 1 of 1

HIV/AIDS Education

The Board recognizes the importance of providing HIV/AIDS (Human Immuno-Deficiency Virus/Acquired Immune Deficiency Syndrome) education regarding blood borne pathogens and sexually transmitted diseases (STDs) to students through the home, the church faith-based institutions, the community, and the schools. Whenever appropriate, the District will cooperate with others to assist in diminishing the effects of this these diseases.

The Superintendent or designee shall provide age appropriate HIV/AIDS instruction in the areas of blood borne pathogens and sexually transmitted diseases (STDs) to District kindergarten through twelfth (K-12) grade students within the parameters outlined by the Board. The curriculum shall be based on the philosophy of sexual abstinence until marriage.

Parents/guardians shall have an opportunity to review the curriculum and the materials prior to their students' instruction.

Parents/guardians who wish to have their students exempt from some or all of the HIV/AIDS blood borne pathogens or STD instruction may do so by submitting a written request to the principal or designee. (See Exemption from Portions of Curriculum #2111)

Adopted: 6/01/98 Reviewed: 8/11/03 -- 7/11/05 Revised: 5/7/07

Cross Reference: Student Curriculum Requirements (K-12) #2110
Exemptions from Portions of Curriculum #2111
Curriculum Development Implementation and Evaluation #2114

Handbook Reference: Health Education AIDS Supplement

Legal Reference: I.C. 3-506(1)

APPENDIX H

**Calculations for the Approximate Number of High School Students with STD, Teen
Pregnancy and Abortion, Independent School District of Boise, 2009**

The number of 9th grade students was estimated. ISDB enrollment for 7th–9th grade in 2009 was 5,648 students (Independent School District of Boise, 2010, e). The researcher took one-third of 5,648, or 1,882 to arrive at an estimated number of 9th grade students. There were 6,026 high school students (10th–12th grade) enrolled in ISDB in 2009. Therefore 1,882 9th grade students + 6,026 10th–12th grade students = 7,908 9th–12th grade students. The 2008 rate applied to the student population for STD was 16.29, teen pregnancy was 39.8 and abortion was 11.3 (Idaho Bureau of Vital Records and Health Statistics, 2010; Idaho Office of Epidemiology and Food Protection, 2010)

APPENDIX I

List of Abbreviations

LIST OF ABBREVIATIONS

ACLU - American Civil Liberties Union
AIDS - Acquired Immunodeficiency Syndrome
ASHA - American Social Hygiene Association
BRFSS - Behavioral Risk Factor Surveillance System
BSU – Boise State University
CCC - Communities Coping with Change Model
CDC – Centers for Disease Control and Preventions
CDHD – Central District Health Department
CWA - Concerned Women for America
HECAT - Health Education Curricula Analysis Tool
HIV - Human Immunodeficiency Virus
HPV - Human Papilloma Virus
IRB - Institutional Review Board
ISDB - Independent School District of Boise
PPGNWI - Planned Parenthood Federation of the Greater Northwest in Idaho
RN - Registered Nurses
STD - Sexually Transmitted Disease
TIGER - Transportation Investment Generating Economic Recovery
U.S.A. United States of America
U.S. - United States
vs. - versus
YRBS - Youth Risk Behavior Survey

APPENDIX J

John Wiley and Sons License, Terms and Conditions

JOHN WILEY AND SONS LICENSE TERMS AND CONDITIONS

Sep 29, 2010

This is a License Agreement between Annabeth Elliott ("You") and John Wiley and Sons ("John Wiley and Sons") provided by Copyright Clearance Center ("CCC"). The license consists of your order details, the terms and conditions provided by John Wiley and Sons, and the payment terms and conditions.

All payments must be made in full to CCC. For payment instructions, please see information listed at the bottom of this form.

License Number	2518480552394
License date	Sep 29, 2010
Licensed content publisher	John Wiley and Sons
Licensed content publication	Journal of Community Psychology
Licensed content title	Communities coping with change: A conceptual model
Licensed content author	Gail J. Kelly, Lyndall G. Steed
Licensed content date	Mar 1, 2004
Start page	201
End page	216
Type of use	Dissertation/Thesis
Requestor type	University/Academic
Format	Print and electronic
Portion	Figure/table
Number of figures/tables	1
Original Wiley figure/table number(s)	Figure 1
Will you be translating?	No
Order reference number	
Total	0.00 USD

Terms and Conditions