Evaluation on Sexual Education Programs

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SW 683: Evaluation of Social Work

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Specific Evaluation Research Questions to Address. This evaluation aims to assess how schools are teaching youth sexual health education. Studies have shown that there is an array of different curriculums used to educate youth, depending on the area or ideals of the school and its participants. The government continues to fund abstinence-only programs, which leaves out information about proper communication between parents and peers, as well as proper use and effectiveness of contraceptives. Questions to be addressed in this evaluation are as follows: Are programs that teach abstinence-only sexual education effective in decreasing the frequency of unplanned pregnancies and sexually transmitted infections and diseases? Do abstinence-only programs work to prevent sexual intercourse? How does one account for the needs of youth that already decided to become active? What is the best approach to teaching youth sexual education? (The evaluation of the program is diagramed in a logic model in Figure 1).

Goals of Program Intervention to Assess:

Goal: To determine if a sexual education class, that offers youth a wide array of services is effective in reducing unplanned pregnancies; increasing healthy, safe sexual practices; decreasing risk of sexually transmitted diseases; and increasing positive communication skills between parents, peers and youth, will be a cost-beneficial and effective program implemented into our agency.

Objective 1: Decrease the number of unplanned teenage pregnancies

Objective 2: Decrease the frequency of sexually transmitted diseases and infections

Objective 3: Improve youth’s communication between their peers and their communication with their parents
Problem Statement of Program to Address. Adolescent pregnancy has been an on-going, serious social problem that continues to create increased health risks for both the pregnant adolescent and her child. Adolescent pregnancy has been reduced by 28% in the past decade; a 36% pregnancy rate decline in the United States that occurred between the years 1990 and 2002, but more education is needed to help teens learn how to prevent this issue. “The absence of information about the effectiveness of abstinence-oriented programs is particularly noteworthy in light of the fact that the federal government spends $176 million a year on abstinence-only education” (Abel & Greco, 2008, 223). There needs to be more information regarding the causes of teenage pregnancy and the effects of sexual education.

By teaching our youth proper sexual health education, there will be decreased rates of unplanned pregnancies, fewer sexually transmitted diseases, and healthier relationships and practices between individuals who choose to engage in sexual activity. Teen pregnancy has always been a social issue worldwide. With a more scientific understanding on how the body works and how to prevent pregnancy, there should be an absence, or near absence, of unplanned pregnancies. Sexual education classes are taught to children and youth throughout school to educate individuals on abstinence and safe sex practices. In general, sexual education classes should be taught to all youth on proper protection and on one’s mental, physical and emotional health.

There also needs to be programs available for children who have experienced abuse to be able to process their abuse and proper sexual education. According to Rubenzahl & Gilbert (2002), children of this population will continue the cycle of abuse if not taught proper, healthy sexual practices, or may have unhealthy, distant
relationships. By processing the abuse in a safe environment, youth will learn safe sex practices and healthy relationships, and stop the cycle of abuse. Policies should be made for all youth to attend sexual education classes, or have the option of taking them with a therapist in a safe environment. Programs teaching youth self-esteem and communication are often seen as significant in delaying adolescent sexual activity. Parents who express their feelings toward sexual abstinence will also be able to make positive changes in the sexual practices that their children engage in. Schools often teach youth basic sexual education, but youth may benefit by also having their parents be part of the sexual education sessions.

Programs supporting positive sexual education are necessary to delaying pregnancies and preventing sexually transmitted diseases. Programs need to be evaluated to ensure that youth are provided with an array of information, from how to stay abstinent, where to find and use proper contraceptives, and how to prevent sexually transmitted diseases and unplanned pregnancies. Schools and agencies need to provide education to approach all of these subjects, as well as learning to respect their own bodies and create healthy relationships. The logic model detailing how the program will work and the goals of the program are outlined as Appendix B.

**Literature Review.**

Research shows that, “more than one million pregnancies of adolescent females each year can be attributed, in large part, to trends in unprotected sexual intercourse in the population of American adolescents” (Jorgensen, Potts, & Camp, 2001, 401). Additionally, approximately 34 percent of ninth graders in the United States have reported to have voluntarily engaged in sexual activity, and 20 percent of sixth- and
seventh-graders who have also voluntarily engaged in sexual activity (Zanis, 2005). Moore and Sugland (1999) have found that teenage birth rates in the United States are two to ten times higher than the birth rates in other industrialized nations. Teenage parents are more apt to complete fewer years of schooling, limit their educational attainment, and have fewer employment opportunities than older parents are. Children of teenage parents are also at greater risk for poor birth outcomes and have poorer cognitive, behavioral, and school outcomes. Together, teenage mothers and their children are more apt to remain in a single-parent household and will obtain lower incomes throughout life.

“White teenagers have consistently had lower birth rates than African American or Hispanic teenagers, although the gap …is getting smaller” (Moore & Sugland, 1999, 38). As the education and use of contraceptives and an increase in individuals remaining abstinent, there has been a decrease of 15% of teenage youth with unplanned pregnancies (Moore & Sugland, 1999). However, sexual intercourse in general is becoming more common among adolescents under the age of 19, sex is being initiated at younger ages, there is a greater variety of sexual partners, and a larger use of infrequent and ineffective use of contraceptive methods (Jorgensen et al, 2001).

In general, communication, pressure, and support regarding sexual activity vary by gender. Males (65%) tend to perceive more pressure to engage in sexual activity, whereas females (57%) feel less pressure to engage in sexual activity. Males also begin engaging in sexual activity at younger ages than females. Males are less likely to speak to their parents about abstinence and perceive less support from parents for remaining abstinent. Females are more cautious when approaching sexual activity, are more likely to remain abstinent until marriage, and less likely to engage in promiscuity and causal
sex. This could be because they understand the immediate consequences of their decisions because they have to endure pregnancy and childbearing. However, the frequency of intercourse is the same for both genders (Smith, Steen, Schwendinger, Spaulding-Givens, & Brooks, 2005).

Sexual desire has traditionally been accepted as part of the male sexual development and a positive sexual identity for males. Women are trapped in their own dilemma, influenced by what the media is telling them to do and hearing that women are sex objects, not agents of their own sexual desire (Welles, 2005). Women have to be able to feel comfortable as an individual and learn to overcome their fears of the dangers of sex and the pressure to conform.

**Importance of Sexual Education Programs.** According to McKay (2001, p. 129), “sexual health education is a sensitive and sometimes controversial topic”. Programs educating youth on proper sexual health is important for his or her overall health and well being. Programs should be aimed at “sexual health enhancement”, which promotes positive self-image and self-worth and maintenance of physical/reproductive health, as well as “prevention of sexual health problems”, such as prevention of pregnancy, STD/STI/AIDS, exploitation, and abuse (McKay, p. 130). Women between the ages of 18 and 44 years old are the fastest growing group of people in the United States with HIV/AIDS, with African American women becoming more prone to the infection than white women are (Robinson et al, 2002). Education on STDs and HIV/AID prevention is necessary to keep these trends from increasing among the growing population of youth today.
Parents and guardians are a primary source of sexual education for youth. Adolescents usually look up to their parents, their values, and their expectations to base their choices of sexual activity and abstinence on. Youth are more likely to be able to resist peer pressure if they have an open relationship with their parents (McBride et al, 2007). The majority of polled youth and their parents reported wanting sexual health and sexuality education in schools. Both populations also expressed a need for providing students with information regarding birth control, reproduction, STD/AIDS prevention, healthy relationships, abstinence, sexual orientation, puberty, sexual abuse/rape, and individual, family, and community moral beliefs regarding sexuality. McKay (2001, p 131) states that “sexual health education programs are not ‘value-free’, but rather that, ‘Effective sexual health education provides opportunities for individuals to explore the attitudes, feelings, values and moral perspectives that may influence their own choices regarding sexual health’”.

Effectiveness of Sexual Abstinence Programs. Citing Jorgensen et al (2001, p 402), “abstinence-based interventions in general are ineffective”. According to Zanis (2005), sexually active students do not change their views towards abstinence after attending abstinence-only sexual education classes. There remains a group of individuals without social, psychological, and health support based on the curriculum given by only teaching abstinence to youth. Zanis reports that all sexually active youth who had been a part of abstinence-only programs had engaged in sex during the program or within weeks after the program had ended. These youth expressed wanting more information on sexuality, as opposed to learning more about abstinence, as this was no longer a choice they felt inclined to follow. Sexually active students expressed want for further information
regarding where to obtain contraception, how to use contraception, and the effectiveness of each type of contraception. For the students who were abstinent, there remained a need for ways to avoid peer pressure and stay abstinent. There continues to be a risk of pregnancy and sexually transmitted diseases with this program’s absence of proper education. However, this program was effective in decreasing the frequency of sexual intercourse and intentions of youth to not date older individuals.

Factors alluding to youth at risk for sexual activity. Students who have decided to engage in sexual activity at earlier ages than others may base their decisions in past experiences, including sexual or physical abuse. More than half of sexual active youth reported living in a single-parent household. Many youth who decided to engage in sexual intercourse reported in doing so before age 14, and involved with a person at least three years older than them (Zanis, 2005).

Sugland and Moore (1999) discuss several factors place children and youth at risk for teenage childbearing: family problems, school problems, behavior problems, and poverty and low income. Families that provide too little monitoring tend to have poor communication between youth and their parents. Parents of this nature tend to fail at teaching values or encouraging goal-settings, and do little to counteract stereotypical cultural and media views, leading teens to learn sexual practices based on the media or by peers. Teenagers who perform below their grade levels, have poor school achievement, and who drop out of school are two to five times more likely to conceive a child before high school completion. Behavior issues in school, including smoking, drinking, using drugs, or engaging in delinquent behavior are also more likely to become teenage parents. Youth who grow up in poverty are also less likely to see an end to poverty. They perceive
limited opportunities for themselves, and are less likely to avoid safe-sex practices. Bunting & McAuley (2004) add that family, peer and partner support are particularly important to childbearing teenagers. Support from each of these groups is essential in leading the mother and child to a life outside of poverty and despair.

There are five factors that appear to have a significant impact on teenage pregnancy: self-esteem, parent-teen attachment, parent-teen communication, parental values toward abstinence, and the teen’s ability to resist peer pressure. Abel and Greco (2008) continue to explain why each factor may be important in preventing teenage pregnancy. Lower self-esteem may contribute to faulty decision making about risk-taking behaviors and sexuality. Higher levels of self-esteem may serve as a preventative factor for adolescents to early onset sexuality. Timing and content of parental communication impact sexual behavior of adolescent children. Teens whose mothers discussed healthy and safe sexual practices were significantly less likely to participate in unprotected sexual intercourse. Parental values portrayed to youth through attachment and communication also have an impact in a youth’s future decision making process. Those with parental values favoring sexual abstinence are linked to reducing teenage pregnancy risk. Also, females who have a close relationship with their fathers are less likely to engage in early sexual activity. Peers and peer pressure always have and always will play a critical role in influencing the onset of teenage sexual activity and other high-risk behaviors. Lastly, the parent-child attachment can play a roll in indicating sexual behavior. Parents who portray warmth and support to their children decrease high-risk adolescent sexual behavior, such as sexual promiscuity, teen pregnancy, and unprotected sex. Unresponsive and uncaring
parental behavior is likely to result in children who grow up feeling insecure and unable to develop healthy, meaningful relationships.

**Sexual Health Education and Child Abuse.** Victims of child sexual abuse often process information on sex much differently than the general population of school-age children. Children who have experienced sexual trauma will often skip school or class during sexual education courses to avoid distress associated with general sexual education. Victims often react negatively to discussions of sexual material, even when it is non-abusive. For instance, half of the abused children responded by primarily reflecting affective distress, whereas none of the non-abused children gave negative response during the interview stimuli (Rubenzahl & Gilbert, 2002).

**Purpose of Study.** There is a lot of literature present regarding the issues of unplanned pregnancies and the issues that youth experience today. The main purpose of this evaluation is to assess whether or not a sexual health education class incorporating elements of abstinence, proper use of contraceptives and safe sex practices, will be more beneficial in decreasing the rates of unplanned pregnancies and sexually transmitted diseases and infections, when compared to an abstinence-only program.

**Specific Research Design.** This evaluation will use a quasi-experimental design, with a time series experiment design (O→O→X→O*→O*), to test the effectiveness of the program. Surveys on the beginning knowledge of the youth will be taken prior to intervention. Youth will also be given a pretest on basic sexual knowledge that would be covered in the sexual health class. An eight-week sexual health course would then be given to all participants, followed by posttest after intervention. Two years later, the
youth will be tested again with the same posttest to see how effective the program will be long-term.

Due to the limited population available in the area, this evaluation will not use a randomized sample or control group to compare results to. The group will be compared to schools in which abstinence-only programs are taught, and based on similar populations of youth. Comparing results to national statistics on youth pregnancies and sexually transmitted diseases on youth will assess long-term results of our intervention.

**Strengths of a Time Series Design.** This design will evaluate the beginning knowledge, the knowledge gained from intervention, and the knowledge retained years after intervention. Because the program is new, it will have to constantly be revised to meet the needs of the youth. Time series designs are also useful for this type of evaluation because youth are being tested at different times in life. We will be able to look at long-term knowledge retained from the intervention. A full evaluation will be taken as well as an assessment of how effective our program will be.

**Limitations of a Time Series Design.** Follow-up will also be difficult because youth are constantly moving, and to keep updated information could be challenging, especially with 150 youth. Because of the follow-up survey design, mailings will need to go out to youth, possibly with incentives to filling the posttest out, which costs money. The agency does not have very much extra money in the budget for these types of evaluations, and therefore an extensive evaluation may not be possible. This type of evaluation design may cause bias because youth are being tested repetitively. Depending on how long the tests are, youth may not answer to their full intellect ability.
Sample. To make our evaluation plan valid, we will survey at least 70 youth per year. The program will be reevaluated in two years to ensure that the program is effective, and will include a sample size of 140-150 total youth for the evaluation. The sample of youth used to evaluate our program will primarily come from referrals given by other social service agencies in the area. We will continue to receive most of our participants from other agencies. This will meet a need of many surrounding agencies, as well as help our agency market its programs to outside agencies for other referrals. In particular, we will target foster care agencies. This population may have a special interest in our program because many youth in care change schools multiple times while in high school, lessening the chance of proper sexual health exposure to occur.

Our program also tailors a couple courses specifically to sexually abused children, a characteristic of many foster care youth. Our program will focus on how to process youth can process their abuse in a positive way, help the youth to understand the abuse, and learn what behaviors are or are not appropriate. Therapists will be present to help youth process the abuse throughout each session. Often, youth with a sexual abuse history will skip classes covering sexual education because it brings up hard feelings for them. Our program would invite a safe environment where youth could feel comfortable asking questions, as well as process their feelings and past with professionals and a support group of other youth with similar experiences.

All youth ages 14-21 will be eligible for the sexual education classes. Due to limited space availability, intervention groups cannot be more than 10-15 youth. This will keep the sessions more intimate and will create an open environment for youth to feel comfortable asking questions.
Part of our recruitment efforts for all of our programs consist of mailing information to other agencies in the area. If needed, to obtain more youth for our program we will also provide transportation to youth within a 20-mile radius. Because social agencies are constantly receiving new clients, the need for referral will always be present. Appendix B2 contains the form for participant informed consent, which contains information on what the program is, their right as a participant, our intent with their information, as well as their rights for confidentiality. Confidentiality and privacy will be difficult to maintain with groups specifically geared towards sexual abuse. All teens involved will have to have some sort of past sexual abuse to be referred to our sexual abuse portion of the sexual health education intervention groups. All participants will be part of focus and therapy groups that revolve around how to positively work through their past abuse and stop the cycle of abuse. If youth do not feel comfortable being involved in this intervention group, they are able to join the other intervention groups that we have with throughout the year. A social worker will have to refer youth with a sexual abuse history, and will have to vouch for the youth that they will be appropriate to other youth in the group.

*Data Collection and Measurement.* Data will be collected prior to intervention, as well as after. Referral information and prior survey information will include youth demographics- including area they live in, age, sex, family income, and family structure, past sexual history, past history of education on sexual practices, as well as some questions testing their current knowledge of sexual health education. This will help us to evaluate our program based on other youth in the state, and possibly nation-wide, and their knowledge on sexual health education. This will cause some bias with external
validity, but will allow us to conduct a fair comparison of our program with a similar youth sample.

To be considered a successful intervention, the program will successfully decrease the number of unplanned teenage pregnancies, decreased the frequency of sexually transmitted infections and diseases, increase the use of contraceptives, increase knowledge of sexual education, and increase communication between parents and peers. Posttests will be compared to pretests to evaluate knowledge acquired during the 8-week intervention. Long-term evaluation of the effectiveness of the program will be conducted with post-graduation tests given to youth two years after intervention. If the program has long-term, lasting positive effects, the program will be considered a success.

**Analysis Plan.** The evaluation used will be formative. The program will continue to be evaluated and altered depending on the needs of the youth and the community. The curriculum will be geared towards the needs of those participating per population of participants and the comfort of the youth. A beginning and end evaluation survey will be given to participants and their parents. Measurement will include testing of prior knowledge before intervention, tests to evaluate what was learned during the intervention, and a follow-up survey given two years after completion of the program to evaluate long-term effects of our program. Success rates and statistics from outside programs will be compared with our program. The data will be put into an SPSS program and analyzed to determine long-term effectiveness of the program.

This is a cost-benefit and cost-effective analysis. If the tests show that knowledge from our program is decreasing unplanned pregnancies, decreasing sexually transmitted diseases and infections, increase contraceptive use, maintain knowledge on safe sex
practices, and increase communication, our program will be considered a success.

Success will also be defined by comparing our program outcomes to the outcomes of other intervention programs in the area and nation-wide. If our program shows similar or better results to the national average of prevention, we will continue with our program.

All measurements will be interval measurements. We will use pretest and posttest scores to determine whether or not the program shows positive results. The analysis of the program is in the table below:

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<thead>
<tr>
<th>Type of Measurement</th>
<th>Short-term outcomes</th>
<th>Long-term Outcomes</th>
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<tbody>
<tr>
<td>Goal of Program:</td>
<td></td>
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<tr>
<td>To determine if a sexual education class, that offers youth a wide array of services is effective in reducing unplanned pregnancies; increasing healthy, safe sexual practices; decreasing risk of sexually transmitted diseases; and increasing positive communication skills between parents, peers and youth, will be a cost-beneficial and effective program implemented into our agency.</td>
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<tr>
<td>Objective 1:</td>
<td>Interval Prolong youth in their first sexual experiences</td>
<td>Less youth will have unplanned pregnancies and will wait longer to have children</td>
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<tr>
<td>Decrease the number of unplanned teenage pregnancies</td>
<td></td>
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<tr>
<td>Objective 2:</td>
<td>Interval Better education on resources in neighborhoods, and use of contraceptives will increase</td>
<td>Increase youth’s awareness of safe sex practices and less frequency of STDs/STIs</td>
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<tr>
<td>Decrease the frequency of sexually transmitted diseases and infections</td>
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<tr>
<td>Objective 3:</td>
<td>Interval Communication and education between parents and teens will be clearer and youth will follow parents’ values and morals regarding sexual practices</td>
<td>Less sexual partners over time and delay in first sexual experience</td>
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<tr>
<td>Improve youth’s communication between their peers and their communication with their parents</td>
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Conclusion of Program. Before assessing any program, strengths and weaknesses of the program must be explored. Strengths supporting the start of the program and continuation of the program are very positive. Due to the small groups, there will be an intimate setting where youth will be able to have more one-on-one time and comfort asking questions in a safe environment. We will also have a group for youth that have been sexually abused. This will be helpful portion of our program that will allow youth to process their abuse in a healthy way. This need is currently not being treated by other agencies in the area, making our program unique and helpful for the sexually abused population. The program will also help us recruit more youth and gain recognition with other agencies and communities. The main sample population for our intervention will come from foster care youth in our program, as well as other clients at other social agencies.

Unfortunately, like every program, there are a few limitations that our program should expect to encounter. There are few programs to compare results to based on long-term results and culture. Cultural factors and outside influences could affect the results of our intervention. External validity creates bias on the effectiveness of our program, making our program results less valid. Other sexual health classes that youth may have in school or through other agencies may have in school or another program will have effects on our results as well. Another limitation deals with the program’s limited budget and staff availability.

The program will consist of several intervention groups, teaching youth ages 14-21 proper sexual health education. The intervention groups will show an increase knowledge of sexual education, decrease unplanned teenage pregnancies, explore
contraceptive use and how to obtain contraceptive, abstinence and limited number of partners, and decrease in sexually transmitted infections and diseases. If our program can show improvements in most or all of these areas, our program will be considered a success and will continue to serve youth in Washinaw County. Our results must be comparable to other sexual education programs, serving youth of similar demographics, and having similar results. Results will be evident with our two-year follow-up posttests.
References


Appendix:

Appendix A (Abstracts):

**Abstract (Technical)**

Teenage pregnancies have been a world-wide social issue for years. While the amount of pregnancies is decreasing, there still continues to be issues regarding young women having children before they are ready. This study will evaluate a sexual health educational program that will educate youth on how to prevent unplanned pregnancies, limit the number of sexual partners, decrease unsafe sexual practices that lead to sexually transmitted infections and diseases, and increase communication between youth and their parents and peers. This study will include a quasi-experimental design, which tests the effectiveness of the intervention through a time-series design: \( O \rightarrow O \rightarrow X \rightarrow O^* \rightarrow O^* \). The youth will be given a survey asking questions about youth’s demographics, past sexual experience, and sexual knowledge will be given prior to the intervention. Youth will also be given a pre-test assessing their knowledge about safe sexual practices and sexually transmitted diseases. After the intervention, posttests will be given, as well as an additional posttest that will be re-administered to the youth two years after intervention. The effectiveness of the program will be compared to other sexual health programs in the area to determine if this program is cost-beneficial and cost-effective using an SPSS system to compare data.

**Abstract (Non-Technical)**

Teenage pregnancies have been a world-wide social issue for years. While the amount of pregnancies is decreasing, there still continues to be issues regarding young women
having children before they are ready. This study will evaluate a sexual health educational program that will educate youth on how to prevent unplanned pregnancies, limit the number of sexual partners, decrease unsafe sexual practices that lead to sexually transmitted infections and diseases, and increase communication between youth and their parents and peers. A survey asking questions about youth’s demographics, past sexual experience, and sexual knowledge will be given prior to the start of the program. Youth will also be given a pre-test assessing their knowledge about safe sexual practices and sexually transmitted diseases. The youth will be tested again after the program, as well as two years after to assess the effectiveness of the program.

Appendix B (Informed Participant Consent):

**Informed Participant Consent:**

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**Sexual Education Program-Informed Participant Consent Form**

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Dear Participant:

The purpose of this study is to evaluate the effectiveness of sexual health programs. The program will discuss issues of pregnancy, proper use of contraception, communication with parents and peers, and other sexual practices. The course encourages all youth to be respectful and open-minded of other youth in the program.

You will be asked a series of questions based on your past sexual history and your current knowledge regarding safe sexual practices. These responses will remain confidential, will
only be used to assess the effectiveness of the program, and will be used to help tailor our program to the participating youth’s needs. You do not need to answer any questions you do not feel comfortable responding to, and are able to drop out of the program at any time. The results of these tests will be used to improve education for youth and increase prevention of unplanned pregnancies and sexually transmitted diseases.

We appreciate your participation and encourage you ask any questions about this study or your participation. Thank you.

Sincerely,

Jaime Bachmeier  
Evaluation Specialist