COMMITMENT TO EXCELLENCE

Shenendehowa Central Schools

Health Advisory Council

Report and Recommendations

June 2012

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Background

As with any course, the district frequently uses different organizations and/or enrichment activities to enhance the curriculum including guest speakers, performers and field trips. For many years, representatives of Planned Parenthood were invited as guest speakers by the health teachers, at no charge to the district, for three days for each health class to reinforce what is taught on the subject of abstinence, sexually transmitted diseases and contraception.

Over the years, some parents have expressed concern over this particular enrichment activity. Last May, there were more parents than usual expressing concern about the activity and expressed that their child felt uncomfortable or pressured into talking about things that he/she did not feel comfortable talking about. At the same time, the district was aware of federal hearings regarding the role and continued funding of Planned Parenthood.

This prompted the district to put the enrichment component of the health program on hold with the notion that the entire sexual health program would be reviewed by the Health Advisory Council, a subcommittee of the district's Health and Wellness Committee, to ensure that the curriculum is being delivered in a way that all students feel safe and respected.

While under review, the content of the district's sexual health education program did not change. Certified health education teachers continued to provide the curriculum that fulfills the Commissioner's regulations (see Appendix A to read the regulations).

The Health Advisory Council

(Pursuant to NYSED Chapter 11, Subchapter G, Part 135.3)

The Health Advisory Council is a group of educators, health professionals, community members and parents who were charged with providing an objective assessment of the program. The council was asked to address the following charge using objectivity and applicable research as the guidepost:

Charge:

The Health Advisory Council is a sub-committee of the District Health and Wellness Committee, which is co-chaired by Rebecca Carman, Director for Policy and Community Development and Lisa Ostrowski, Director of Food Services. The purpose of the Health Advisory Council is to advise the Administration and Board of Education regarding the health education provided at Shenendehowa Central Schools. The Health Advisory Council will advocate for responsible health education and adequately funded quality resources to meet the health education priorities of students, community, and educators. The Health Advisory Council shall be responsible for making recommendations concerning the content, implementation, and evaluation of the HIV/AIDS Health Education instruction program.

Council Members

Rebecca Carman (academic administrator for health)
Kelly DeFeciani (public information officer, parent)
Nicole Holehan (health education teacher)
Amy Preston (health education teacher)
Carol Funyak (health education teacher)
Jean Botillo-Faulisi (parent)
Penny Thompson (school nurse)
Maureen Silfer (Shen Parents' Choice Coalition, parent) - resigned after the final meeting
Gretchel Hathaway (parent)
Idalia Sepulveda (clergy, parent)
Dee Lowman (clergy)
Sister Rose Casaleno (clergy)
Annette Morere (community member)
Laraine Longhurst (community member)
Bill Casey (community member)
Andrew McCarty (BOE, parent)
Rick Mincher (BOE, parent)
Dr. Anthony Marinello (physician)
Jeanne Ann Dahl (nurse practioner, parent)

The Health Advisory Council (continued)

Composition:

The Health Advisory Council consists of members appointed by the Health and Wellness Committee. Members are chosen for their demonstrated concern for health education issues. Members of the council are representative of the school and community. The Health Advisory Council shall consist of parents, school board members, appropriate school personnel, and community representatives, including representatives from religious organizations.

Role of the council:

Pursuant to NYSED regulations, the Board of Education shall have final determination of the content of the curriculum and approve its implementation, and shall be responsible for the evaluation of the district's HIV/AIDS Health Education instructional program.

The council has no responsibility whatsoever to direct district resources, such as funding or decisions regarding curriculum delivery (i.e. guest speakers). The council is convened and is charged to provide advice on health education, alcohol/drug prevention, AIDS instruction, nutrition and other related areas. The council will make written recommendations pertaining to the content, implementation and evaluation of the Comprehensive Health Program to the Superintendent of Schools.

Functions of the council: The council shall meet as needed to assess the progress of aspects of the school health program, including, but not limited to:

- Engaging in collaborative and productive discussions
- Completing a program needs assessment
- Reviewing and providing recommendations to the Superintendent and Board of Education
- Providing awareness information to constituents
- Facilitating communication with constituents

Minutes:
Minutes will be kept to ensure that the work of the council is documented and used to develop recommendations.

Health Advisory Council Charge

The Health Advisory Council will advocate for responsible health education and adequately funded quality resources to meet the health education priorities of students, community, and educators.
The Health Advisory Council shall be responsible for making recommendations concerning the content, implementation, and evaluation of the HIV/AIDS Health Education instruction program.
The council has no responsibility whatsoever to direct district resources, such as funding or decisions regarding curriculum delivery (i.e. guest speakers).

Health Advisory Council Process

The Health Advisory Council met four times and completed a comprehensive review of Shenendehowa's current sexual health education program and alternative options. Every effort was made to focus on the charge, although the council has included suggestions for the consideration of the superintendent and Board of Education based on conclusions reached in completing its recommendations.

Meeting 1 - February - Overview of existing program

The district's health teachers presented the current sexual health education program in detail (see Appendix B).

Summary of Key Points:

- At Shen, health education is taught for twenty weeks to students in middle school (grade 8) and in high school (grades 11 or 12). Ten days of that curriculum is designated for sexual health education, mandated by New York State. In past years, Planned Parenthood came in for three of those days to reinforce what was being taught by the health education teachers.
- Certified health education teachers and administrators have used the Commissioner's regulations (http://www.p12.nysed.gov/sss/schoolhealth/schoolhealtheducation/CR135.pdf) and NYSED guidance document (http://www.p12.nysed.gov/sss/schoolhealth/schoolhealtheducation/GuidanceDocumentFinal1105.pdf) to develop the curriculum, with the primary focus on abstinence and the secondary focus on contraception. Shen meets current New York State standards (required) for sexual health education. The district is not required to meet the national standards (http://www.futureofsexed.org/documents/josh-fose-standards-web.pdf). The main national components not met are lessons on sexual identity, masturbation and abortion.
- In grade 8, students learn about the reproductive system (review of and extension from 7th-grade science), abstinence, Sexually Transmitted Diseases (STDs), HIV/AIDS, teen pregnancy, gender stereotypes in the media and healthy relationships.
- In high school, students learn about abstinence, contraception HIV/AIDS (methods of transmission, the incubation period, how HIV affects the immune system, and the prevention of the spread of HIV), teenage pregnancy, sexual orientation, gender stereotyping, decision making styles, risky behaviors and Sexually Transmitted Diseases (STDs).
- All units in the health education curriculum are based on building the following skills: assertive communication, empowered decision making, assessment of the impact of decisions on their future goals, stress management in healthy relationships and advocating for their personal values.
- Data and health information is constantly changing and is updated regularly using national and state resources.
- Student/parent communication is critical. The Health Department has a website to inform parents and they send out a syllabus that must be signed by parents at the beginning of the course.
- The "opt out" option is only allowed by NYSED regulations for the prevention of HIV/AIDS portion (this is one of the two day HIV/Aids lessons in the 10 day unit and students are still responsible for the content).

Health Advisory Council Process (continued)

Meeting 2 - March - Program assessment

Members broke into smaller groups to discuss four areas:

1. Reflecting on the teachers' description of the course outline, would you add, further clarify, or more thoroughly address any topics?
2. Look at establishing protocols on how to more effectively communicate with parents. Please provide suggestions for ways to effectively communicate with parents.
3. Parental engagement is critical to student success--becoming partners with parents and reinforcing what is taught at school. How can teachers engage parents so they reinforce what is being taught while incorporating their own values/beliefs?
4. What criteria would you suggest if we were to use guest speakers?

Among the comments/question:

- General endorsement of continuing the current content, particularly the repeated lessons on abstinence as the only totally safe health practice.
- Ensuring the comfort level of students. Shenendehowa is a diverse community in many ways. It is extremely important that curriculum is presented in a factual, clinical way and without judgment.
- Teachers should continue to encourage students to take what they have learned in class and talk about personal/family values and beliefs with parents or other adult family members.
- Bridging the gap in health education between 8th and 12th grades, the council agreed that there is a need for elementary health and 6th-grade education component.
- Consider separating boys and girls at the middle level for lessons on anatomy to make them more comfortable asking questions.
- It is critical that students understand the absolute meaning of the word abstinence in preventing Sexually Transmitted Diseases (STDs).
- Should be addressing sexual orientation/identity given the necessity to comply with the Dignity for All Students Act (DASA).
- Continue to address the psychological implications of sexual activity.
- Improved communications with parents through evening presentations, panel discussions, videos describing the sexual health curriculum, fact sheets and online resources.
- Concerns about reaching parents who do not/cannot access a computer.
- Given time constraints, the district must weigh the added value of an outside speaker against the expertise of the teachers and their established relationship with our students.
- Develop a process for selecting guest speakers.
- Guest speakers are important because they can provide information in a way that the regular classroom teacher can't due to the relationship of the teacher/student, a different perspective.
- Stay away from politically/religiously charged. Instead go with doctors, psychologists, nurse practitioners, etc.

Health Advisory Council Process (continued)

Prior to Meeting 3 - Independent analysis

Sexual health programs are typically defined or segmented according to two different approaches. Comprehensive information, largely research-based, was shared with council members to read and complete appropriate follow up for understanding prior to the next meeting.The goal was to facilitate and foster independent analysis on the two primary approaches to sexual health.

All council members were sent an e-mail explaining that the next meeting would be a review of the different types of sexual health programs.

The purpose for independent review of the programs was to avoid the perception of trying to "sell" or influence council members in any way.

The council was also provided the following questions to serve as a comparative lens, so that a cohesive discussion could take place at the following meeting.

1. Does the program (or parts of the program) help to provide a balanced approach? Specify?
2. Does the program (or parts of the program) offer clinical and scientific information rather than values and beliefs? Specify.
3. Is the program developmentally appropriate (8th and HS)?
4. How could this content be presented?
5. Should we engage experts to emphasize what is taught in this curriculum? How should they be involved?

Comprehensive Sex Education - Sexual risk prevention programs teach teenagers a range of information related to their own sexual anatomy, the act of sex, the use of contraceptives, and the risks of pregnancy and STDs associated with having sex.

Comprehensive Sex Education (Sexual Risk Prevention)

- http://www.plannedparenthood.org/resources/implementing-sex-education-23516.htm
- http://www.etr.org/tppi/products/reducingTheRisk.html
- http://recapp.etr.org/recapp/index.cfm?fuseaction=pages.ebpDetail&PageID=128

Abstinence education - Sexual Risk Avoidance (SRA) programs teach teenagers that abstinence from sex until marriage is the expected standard for all teens and it is the most effective means of avoiding the risk of pregnancy, STDs and harmful social/emotional effects.

Abstinence Sex Education (Sexual Risk Avoidance):

- http://healthyrespect.org/programs.shtml
- http://www.abstinenceandmarriage.com/store/aspire-grades-9-10

Both approaches have components that are vital to the provision of a balanced, clinically-sound, instructive and comprehensive health curriculum. Like many schools, Shenendehowa provides a program that is a combination of both approaches, commonly referred to as an Abstinence Plus program.

Council members knowledgeable in various sexual health programs were asked to submit examples of Sexual Risk Avoidance (SRA) programs and Comprehensive Sexual Health programs for members to review prior to the next meeting.

Health Advisory Council Process (continued)

Meeting 3 - April - In-depth program analysis

At the April meeting, different sex education programs were reviewed. The health education teachers provided an analysis of Comprehensive Sex Education programs and Sexual Risk Avoidance (SRA) programs (i.e. Healthy Respect, Aspire, Safer Choices, and Making Sense of Abstinence) compared them with Shenendehowa's current Abstinence Plus program. See Appendix C.

- The main differences between Comprehensive Sexual Education and Shen's curriculum are the subjects of abortion, masturbation and sexual dysfunction.
- The main differences between SRA programs and Shenendehowa's curriculum are the use of the word marriage, the inclusion of the effectiveness of contraception (as opposed to focusing on the failure rate only), and the acknowledgment that teens may become sexually active.

Questions/concerns about the two approaches:

- Abstinence-until-marriage programming having a religious perspective.
- The absence of topics such as masturbation at the middle school and abortion in our current programming is a concern.
- Losing sight of what is best for students in the face of political pressure.
- Our school is a public school that must serve the needs of all students, The district should not lose sight of what is best for students when under political pressure.
- Concern that we are "promoting sexual activity" in our students because we discuss contraception at the high school level.
- Canned curriculums are costly and take longer to implement than the 10 days set aside for sexual education.

Additionally, at the meeting, information was provided by council members (see appendix D and E) and by the health teachers (see appendix F) on the pros/cons of the two different approaches.

Health Advisory Council Recommendations

Meeting 4 - May - Developing and synthesizing recommendations

As per the Health Advisory Council Charge:

After thorough review and evaluation of the current program and other options for sexual health education, the Health Advisory Council has come to consensus on the following recommendations for content, implementation, evaluation and alternative options:

Content

- Continue to stress abstinence as the healthiest choice for teens overall mental and physical health.
- Continue to stress communication skills to help students know what/how to be ready to speak up/out when faced with difficult sexual situations.
- Be mindful that statistics are subject to change and interpretation. Instead, focus should be on the message (i.e., condoms are highly effective in preventing STIs only if used exactly as prescribed. However, studies show that most teenagers do not use condoms properly.)
- Teachers should continue to review the most up-to-date information available prior to the start of each semester and provide information in the course syllabus regarding their sources.
- As per Dignity for All Students Act (DASA) beginning July 1, 2012 , Sexual identity and orientation should be included in the curriculum (not necessarily the health curriculum only).

Implementation

- Keep lessons clinically and factually based and encourage parents to continue the discussions at home with regard to personal or family values.
- Continue to explore methods to make kids comfortable with topics that naturally make many adolescents (different levels of social/emotional development, different backgrounds and experiences) and some adults feel embarrassed or awkward.
- Teachers should continue to use varied instructional strategies to meet the needs and comfort level of a diverse class.
- Make best use of the district's website as an informational tool to share curriculum, practices and expectations and also as a link to outside resources for parents including SRA and Comprehensive Sexual Education Programs. Make every effort to provide information to parents who do not have access to a computer.

As per the Health Advisory Council Charge:

The Health Advisory Council is making recommendations concerning the:

- content
- implementation
- evaluation
- options/alternatives

of the Health Education instruction program, which includes AIDS instruction.

While the council has no responsibility whatsoever to direct district resources, such as funding or decisions regarding curriculum delivery (i.e. guest speakers), it is recommending options for discussion.

Health Advisory Council Recommendations (continued)

- Explore opportunities for the district to host evening workshops where representatives from Sexual Risk Avoidance and/or Comprehensive Sexual Education Programs (i.e., Planned Parenthood) can present information to parents, students and families that reinforces what is taught at Shen.

Evaluation

- Continue to work with the Health Advisory Council to evaluate content and/or implementation on a periodic basis and address concerns as they arise.

Options/Alternatives

While the council has no responsibility whatsoever to direct district resources, such as funding or decisions regarding curriculum delivery (i.e. guest speakers), the following options were discussed as part of the evaluation:

- While it is the opinion of the council that Shen's health teachers plan for, and are experienced in, ensuring that all required topics are taught thoroughly, it is recommended that it remains the role of the teachers and administrators to determine whether or not guest speakers will be used to enhance the curriculum.
- While students may opt out of the one day that is the prevention of HIV/AIDs portion of the sexual health education curriculum, it is not recommended that students be allowed to opt out of other classes during Health. The council's concerns included:
    - The health/sex education curriculum is state mandated to enhance the knowledge, health and safety of students.
    - Ensuring that students experiencing sexual abuse are not absent for information that might be of immediate help to them.
    - As a public school district, it is important to support many, not fewer educational opportunities.
    - Avoiding setting a precedent for requests to opt out of other controversial topics.
- Use, as needed, internal resources including: Shen counselors, psychologists, social workers, nurses to enhance the health curriculum.
- Conduct training for teachers in other curricular areas about adolescent sexual health. It is important to take advantage of "teachable moments," but only with accurate and consistent information.
- Establish appropriate health curriculum to be integrated into elementary grades.
- Offer health/sex education to students earlier in their school careers, ideally 10th grade.
- Include 6th grade health in our curriculum again. (middle school counselors have noticed the difference in students lacking 6th grade health education).

It is hereby recommended that the Health Advisory Council report, in its entirety, be approved by the Board of Education and disseminated/shared with the community.

Appendix

Other Sources Reviewed:

National Sexuality Education Standards:

The National Sexuality Education Standards: Core Content and Skills, K–12 provides clear, consistent and straightforward guidance on the essential minimum, core content for sexuality education that is age-appropriate for students in grades K–12.The Standards are presented both by topic area and by grade level.
http://www.futureofsexed.org/documents/josh-fose-standards-web.pdf

NYS Guidance Document for Health Education

This guidance document provides local educational agencies with a framework for developing health curricula and implementing instructional and assessment strategies. Every attempt has been made to ensure that the information and resources contained in this document reflect best practice in health education.
http://www.p12.nysed.gov/sss/schoolhealth/schoolhealtheducation/GuidanceDocumentFinal1105.pdf

Appendix A

NYS Education Department Commissioner's Regulations - § 135.3 Health education

(a) Provision for health education. It shall be the duty of the trustees and boards of education to provide a satisfactory program in health education in accordance with the needs of pupils in all grades. This program shall include, but shall not be limited to, instruction concerning the misuse of alcohol, tobacco and other drugs.

(b) Health education in the elementary schools.

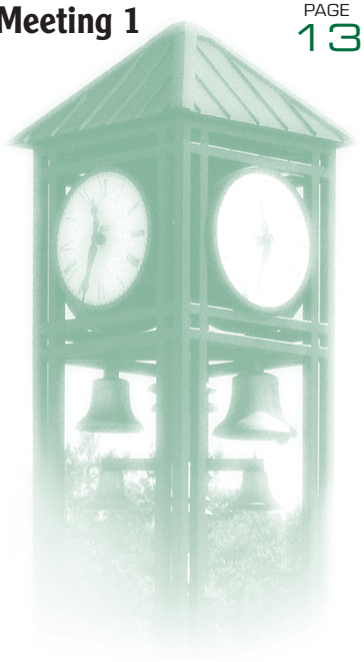
(1) The elementary school curriculum shall include a sequential health education program for all pupils, grades K-6. In the kindergarten and primary grades, the teacher shall provide for pupil participation in planned activities for developing attitudes, knowledge and behavior that contribute to their own sense of self-worth, respect for their bodies and ability to make constructive decisions regarding their social and emotional, as well as physical, health. Personal health guidance shall also be provided according to the individual needs of pupils. This guidance shall include the development of specific habits necessary to maintain good individual and community health.

In addition to continued health guidance, provision shall be made in the school program of grades 4-6 for planned units of teaching which shall include health instruction through which pupils may become increasingly self-reliant in solving their own health problems and those of the group. Health education in the elementary school grades shall be taught by the regular classroom teachers.

(2) All elementary schools shall provide appropriate instruction concerning the acquired immune deficiency syndrome (AIDS) as part of the sequential health education program for all pupils, grades K-6. Such instruction shall be designed to provide accurate information to pupils concerning the nature of the disease, methods of transmission, and methods of prevention; shall stress abstinence as the most appropriate and effective premarital protection against AIDS, and shall be age appropriate and consistent with community values. No pupil shall be required to receive instruction concerning the methods of prevention of AIDS if the parent or legal guardian of such pupil has filed with the principal of the school which the pupil attends a written request that the pupil not participate in such instruction, with an assurance that the pupil will receive such instruction at home. In public schools, such instruction shall be given during an existing class period using existing instructional personnel, and the board of education or trustees shall provide appropriate training and curriculum materials for the instructional staff who provide such instruction and instructional materials to the parents who request such materials. In public schools, the board of education or trustees shall establish an advisory council which shall be responsible for making recommendations concerning the content, implementation, and evaluation of an AIDS instruction program. The advisory council shall consist of parents, school board members, appropriate school personnel, and community representatives, including representatives from religious organizations. Each board of education or trustees shall determine the content of the curriculum and approve its implementation, and shall be responsible for the evaluation of the district's AIDS instruction program.

(c) Health education in the secondary schools.

(1) The secondary school curriculum shall include health education as a constant for all pupils. In addition to continued health guidance in the junior high school grades, provision shall also be made for a separate one-half year course. In addition to continued health guidance in the senior high school, provision shall also be made for an approved one-half unit course. Health education shall be required for all pupils in the junior and senior high school grades and shall be taught by teachers holding a certificate to teach health. A member of each faculty with approved preparation shall be designated as health coordinator, in order that the entire faculty may cooperate in realizing the potential health teaching values of the school programs. The health coordinator shall insure that related school courses are conducted in a manner supportive of health education, and provide for cooperation with community agencies and use of community resources necessary for achieving a complete school -community health education program.



EXPECTATIONS OF MEETING

- Begin and end on time
- Focus on curriculum
- Ensure everyone has a chance to speak
- Listen attentively and respectfully
- Be aware of the time (time keeper)
- Avoid personalizing
- Confidentiality

HEALTH ADVISORY COUNCIL

AS PER COMMISSIONER REGULATIONS, PART 135
THE HEALTH ADVISORY COUNCIL SHALL BE RESPONSIBLE FOR MAKING RECOMMENDATIONS CONCERNING THE CONTENT, IMPLEMENTATION AND EVALUATION OF AN AIDS INSTRUCTION PROGRAM.

POLICY 8211

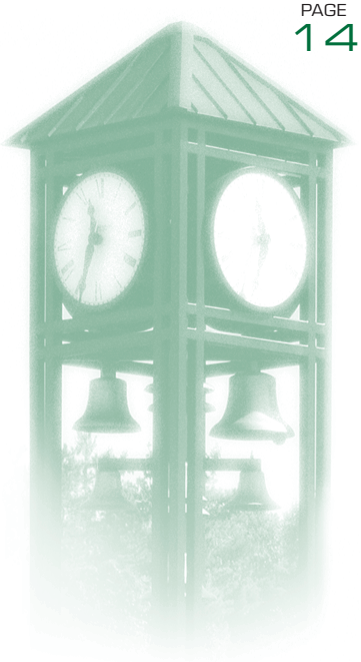
CONSENSUS

(In compliance with our District's Shared Decision Making Plan)

- Reaching Consensus

All members must agree to support or, at least, not undermine a decision. Reaching consensus **does not** mean the vote is unanimous, the result is everyone's first choice, or everyone agrees. Consensus lends to the development of the commitment and ownership necessary in collaborative decision making. Said in another way, consensus is reached when all members agree to one of the following statements:

"I'm all for this decision and I will be a leader."
"I'm all for this decision and I will give a lot of support."
"I can live with this decision; I will be supportive."
"I don't agree with this decision, but I will trust the opinion of the group."



HEALTH ADVISORY COUNCIL'S CHARGE

THE HEALTH ADVISORY COUNCIL SHALL BE RESPONSIBLE FOR MAKING RECOMMENDATIONS CONCERNING THE CONTENT, IMPLEMENTATION, AND EVALUATION OF THE HEALTH EDUCATION INSTRUCTION PROGRAM, WHICH INCLUDES AIDS INSTRUCTION.

RESOURCES

SHENENDEHOWA POLICY AND REGULATIONS

NEW YORK STATE EDUCATION DEPT. REGULATIONS

DIGNITY FOR ALL STUDENTS ACT (2012)

NEW YORK STATE GUIDANCE DOCUMENT (2005)

NATIONAL HEALTH EDUCATION STANDARDS(JAN. 2012)

NEW YORK STATE HEALTH DEPARTMENT

CENTER FOR DISEASE CONTROL

NOTE: ADDITIONAL DATA/RESOURCES MAY BE PROVIDED

When is Health offered?

- Health is offered in 8th grade for 20 weeks and at the 11th and 12th grade for 20 weeks
- Summer school
- Various types of classes
  - On-line
  - Traditional

HEALTH EDUCATION PROGRAM

- STANDARDS – BASED
- SKILLS DRIVEN
- SCIENTIFICALLY RESEARCH-BASED
- LEARNER – CENTERED
- STRENGTH – BASED
- AUTHENTIC
- INTEGRATED INTO TOTAL EDUCATIONAL PROGRAM
- PROVIDED BY CERTIFIED, QUALIFIED AND SKILLED TEACHERS
- COORDINATED SCHOOL HEALTH MODEL FRAMEWORK
- CORE CURRICULUM

Our Philosophy – What Drives Us

- Health Education in NYS, and at Shenendehowa, from start to finish is all about learning the skills & information that are necessary for Personal Empowerment
- Students learn how to:
  - Be Assertive **Communicators** in all areas of their lives;
  - Be **Proactive Decision Makers**, considering consequences of actions and the impact of choices on their future;
  - **Plan & Set Goals** based on personal and family values and to consider the impact of decisions on their ability to achieve those goals;
  - **Manage Stress** effectively in their daily lives;
  - Be strong **Advocates** for their beliefs; and,
  - Use **Self-Management** to tie the skills together and live the healthiest life possible.
- Knowledge is Power

8TH GRADE – Sexual Health Unit Outline

- Healthy & Unhealthy Relationships
- Authentic Assessment
  - Linking all topics from this unit back to the Health Skills:
    - Assertive Communication
    - Empowered Decision Making
    - The impact of decisions on Goals for their future
    - Stress Management in healthy relationships
    - Considering and being an Advocate for your personal values
- Sexual Health Unit Test

Appendix B (Continued) - Presentation to the Health Advisory Council Meeting 1

High School – Sexual Health Unit Outline

- HIV/AIDS/STI/Decision Making Pre-Assessment
- IDEAL MODEL
- Decision making styles
- Personal limits thinking exercise
- Risky behaviors
- STI transmission activity & Abstinence activity
- Exposure chart
- Norming activity
- Sexually Transmitted Infections

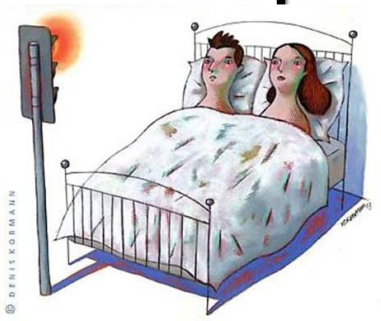
High School – Sexual Health Unit Outline

- Contraception
- Reflection
- HIV/AIDS: methods of transmission, the incubation period, how HIV affects the immune system, and the **prevention of the spread of HIV is also discussed**
- Teenage pregnancy
- Sexual orientation
- Gender stereotyping
- Review game
- Sexual Health Unit Test – 40 questions

8TH GRADE – Sexual Health Unit Outline

- Reproductive System – review of, and extension from, 7th grade science
- Abstinence
- Sexually Transmitted Infections (STIs)
- HIV/AIDS
- Teen Pregnancy
- Gender Stereotypes in the Media
  - Concerns:
    - Damage to Self-esteem
    - Implications for relationships
    - Encourages behavior that is not age-appropriate

Contraceptives



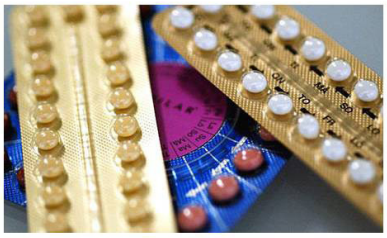
Hormonal versus Non-Hormonal Methods

A device, drug, or chemical agent that prevents conception.

Hormonal Methods

Birth Control Pill

1 pill each day at the same time of day * 3 weeks hormone, 1 week sugar



99% Effective

0% STI Protection

HOW IT WORKS

- Interferes hormonally
- Stops egg from being released
- Taking 1 pill everyday prevents forgetting

EFFECTS

- Headaches
- Mood swings
- Regulates period
- Decreases acne
- Blood clots*

Advantages

- Highly Effective
- Predictable, regular menstrual cycles
- Lighter menstrual bleeding, less cramping
- Protection from ovarian cysts and cancer and uterine cancer
- May improve acne

Disadvantages

- Need to remember to take a pill daily
- Breakthrough bleeding
- No protection against STI
- Breast tenderness, nausea, mood changes
- Blood clots
- Benign liver tumors
- Heart attack, stroke
- Once you stop taking the pill, it may take 3-6 months to return to regular ovulation
- Smoker: higher risk for medical complications

Adverse Reactions: severe abdominal, chest, head or leg pain; vision loss or blurring

Failure Rate

Typical Use	Perfect Use
8%	.3%

http://healthcenter.ucdavis.edu/topics/contraception/efficacy.html

Birth Control Patch

1 patch every week to shoulder, upper back, abdomen, or hip * 3 weeks on, 1 week off

99% Effective

0% STI Protection

HOW IT WORKS

- Interferes hormonally
- Stops egg from being released

EFFECTS

- Headaches
- Mood swings
- Regulates period
- Decreases acne
- Clots*

Advantages

- Highly Effective
- Predictable, regular menstrual cycles
- Protection from ovarian cysts and cancer and uterine cancer

Disadvantages

- Need to change patch weekly
- Difficult to conceal patch or get good skin adherence
- Spotting between periods
- No protection against STI
- Lower effectiveness for women over 198 lbs
- Benign liver tumors
- Heart attack, stroke
- Skin irritation at the site of patch
- Reversible darkening of the skin under patch
- Smoker: higher risk for medical complications

Adverse Reactions: severe abdominal, chest, head or leg pain; vision loss or blurring

Failure Rate

Typical Use	Perfect Use
8%	.3%

http://healthcenter.ucdavis.edu/topics/contraception/efficacy.html

Birth Control Shot

1 shot every 3 months

99% Effective

0% STI Protection

HOW IT WORKS

- Interferes hormonally
- Stops egg from being released

EFFECTS

- Headaches
- Mood swings
- Regulates period
- Decreases acne
- Clots*

Advantages

- Highly effective
- Effective for 12-13 weeks
- Decreases bleeding and cramping with period
- Does not contain estrogen
- Helps prevent cancer of the uterus

Disadvantages

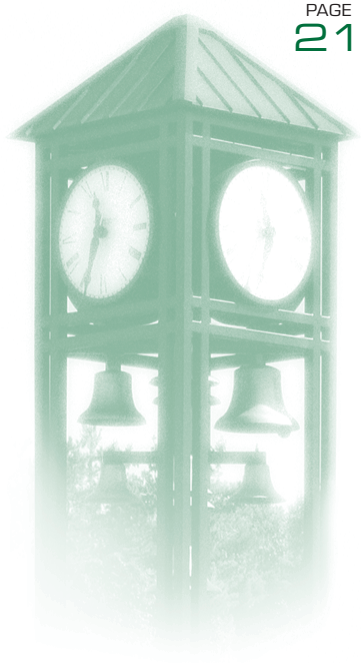
- Must receive shot every 12-13 weeks
- May cause irregular, light or eventually no bleeding
- No protection against STI
- May take 9-10 months to resume ovulation after discontinuing use
- May develop temporary and reversible decreased bone density
- Weight changes (weight gain)
- Exacerbate depression
- Irregular bleeding for the first 6-12 months
- After 12 injections, menstrual cycle stops for 50% of women

Adverse Reactions: severe abdominal, chest, head or leg pain; vision loss or blurring

Failure Rate

Typical Use	Perfect Use
3%	.3%

http://healthcenter.ucdavis.edu/topics/contraception/efficacy.html



NuvaRing

Once a month * Leave in for 3 weeks, leave out for 1 week

99% Effective

0% STI Protection

HOW IT WORKS

- Interferes hormonally
- Stops egg from being released

EFFECTS

- Headaches
- Mood swings
- Regulates period
- Decreases acne
- Clots*

Advantages

- Highly Effective
- Predictable, regular menstrual cycles
- Lighter menstrual bleeding, less cramping
- Protection from ovarian cysts and cancer and uterine cancer

Disadvantages

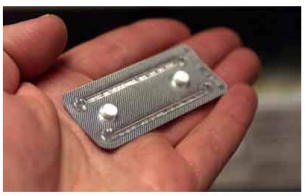
- Need to remember to (and be comfortable with) remove/insert ring monthly
- Breakthrough bleeding
- No protection against STI
- Increased vaginal discharge
- Vaginal irritation (yeast infections)
- Benign liver tumors
- Heart attack, stroke

- Smoker: higher risk for medical complications

Adverse Reactions: severe abdominal, chest, head or leg pain. Vision loss or blurring

Emergency Contraceptive

Morning after pill * High dose hormone * Take up to 3-5 days after intercourse * Sometimes 2 pills are taken together



99% Effective

0% STI Protection

HOW IT WORKS

- Stops egg from implanting

INFORMATION

- Four FDA-approved products on the market
- Plan-B, Next Choice & Levonorgestrel tablets are approved for preventing pregnancy when taken within 72 hours after unprotected sex
- Adults may purchase the aforementioned methods without a prescription. Individuals younger than 17 will need a prescription.
- The fourth product, Ella can be taken up to 5 days after unprotected sex; it is only available by prescription

Failure Rate

Typical Use **Perfect Use**

8% **.3%**

http://healthcenter.ucdavis.edu/topics/contraception/efficacy.html

Failure Rate

Treatment initiated within 120 hours of intercourse

11-25%

http://healthcenter.ucdavis.edu/topics/contraception/efficacy.html

Intrauterine Device-IUD

The IUD appears to work primarily by preventing fertilization of the egg. *The ParaGard IUD contains copper and can be left in place for up to 12 years and the Mirena IUD contains the hormone progestin and can be left in place for up to 5 years.

99% Effective

0% STI Protection

HOW IT WORKS

- IUDs affect the motility of the sperm or egg
- Thickens the cervical mucus
- The copper in the ParaGard impairs sperm function

EFFECTS

- Headaches
- Mood swings
- Regulates period
- Decreases acne
- Clots*
- PID
- Ovarian Cysts

Advantages

- Highly effective
- Typically very safe
- Long lasting (up to 5-12 years)
- The ParaGard IUD contains no hormones
- The Mirena IUD contains no estrogen
- Cost-effective
- The Mirena IUD can decrease menstrual bleeding

Disadvantages

- Some women experience heavier and longer menstrual bleeding and cramping with the ParaGard IUD and this usually decreases by 2-3 cycles
- Irregular bleeding in early months with either IUD
- Cramping and pain at insertion (lasts about 10-15 minutes)
- There is a 2-10% chance of expelling the IUD in the first year
- No protection from sexually transmitted infections

Adverse Reactions: severe abdominal, chest, head or leg pain. Vision loss or blurring

Failure Rate

ParaGard	Mirena
Typical use: 0.8%	Typical use: 0.2%
Perfect use: 0.6%	Perfect use: 0.2%

http://healthcenter.ucdavis.edu/topics/contraception/efficacy.html

Appendix B (Continued) - Presentation to the Health Advisory Council Meeting 1

Non-Hormonal Methods

Male Condoms

Latex, Polyurethane or Sheepskin * Need to be stored and put on properly (read directions) * Available OTC

98% Effective

98% STI Protection

Sheepskin effective ONLY against pregnancy

HOW IT WORKS

- Barrier Method
- Covers erect penis, prevents sperm from entering vagina and fertilizing egg
- LATEX and POLYURETHANE ONLY: prevent exchange of body fluids/viruses

EFFECTS

- Skin irritation and rashes from either condom or lubricant
- LATEX allergy in either partner

After this was presented at the first meeting of HAC, health teachers informed the council that this slide was replaced with this slide in health classes

Male Condoms

Latex, Polyurethane or Sheepskin * Need to be stored and put on properly (read directions) * Available OTC

98% Effective

in preventing pregnancy when used properly

Latex condoms, when used consistently and correctly, are highly effective in preventing the sexual transmission of HIV, and can also reduce the transmission of other sexually transmitted diseases (STDs).

Sheepskin effective ONLY against pregnancy

HOW IT WORKS

- Barrier Method
- Covers erect penis, prevents sperm from entering vagina and fertilizing egg
- LATEX and POLYURETHANE ONLY: prevent exchange of body fluids/viruses

EFFECTS

- Skin irritation and rashes from either condom or lubricant
- LATEX allergy in either partner

Advantages

- Readily available without prescription
- Condoms provide protection from STIs including HIV, with the exception of natural skin condoms
- Can help protect future fertility
- Used only when needed

Disadvantages

- Possible allergic reaction to latex. Non-latex condoms are available for anyone with a latex allergy
- Must have them at disposal

Adverse Reactions: severe abdominal, chest, head or leg pain. Vision loss or blurring

Failure Rate

Typical Use	Perfect Use
15%	2%

http://healthcenter.ucdavis.edu/topics/contraception/efficacy.html

Female Condoms

A soft, loosely-fitting polyurethane sheath with two flexible rings designed to hold the condom in place * Need to be stored and inserted properly (read directions) * Available OTC

95% STI Protection & Pregnancy

HOW IT WORKS

- Barrier Method
- Inserted into vagina, prevents sperm from entering cervix and fertilizing egg
- POLYURETHANE ONLY: prevent exchange of body fluids/viruses

EFFECTS

- Skin irritation and rashes from either condom or lubricant
- Not as effective in preventing pregnancy as hormonal methods or male condom
- Expensive and not readily available

Advantages

- Provides contraception similar to most other forms of non-prescription birth control
- Provides protection against many sexually transmittable infections and covers a larger genital area than a male condom
- Can be inserted up to 8 hours before intercourse

Disadvantages

- Initial test results appeared to have a higher failure rate than male condoms, however the female condoms may have been held to higher standards than male condoms. There is debate over the testing requirements for the female condoms
- Currently, female condoms cost more than male condoms and are not available in as many locations

Adverse Reactions: severe abdominal, chest, head or leg pain. Vision loss or blurring

Failure Rate

Typical Use	Perfect Use
21%	5%

http://healthcenter.ucdavis.edu/topics/contraception/efficacy.html

Spermicides

"Cide" = Kills * Chemicals that kill sperm * Applied internally by female partner before sex *Available OTC

82% Effective (Careful use)
71% Effective (Not careful)
0% STI Protection

HOW IT WORKS

- Kills sperm
- Barrier Method

EFFECTS

- Allergy to chemicals used
- Usual component is Nonoxynly-9

Advantages

- Available without a prescription
- Can be purchased at pharmacies and supermarkets
- Can be easily carried by a woman or partner

Disadvantages

- High failure rate
- Possible allergic reaction to nonoxynol-9

Adverse Reactions: severe abdominal, chest, head or leg pain. Vision loss or blurring

Failure Rate

Typical Use	Perfect Use
29%	18%

http://healthcenter.ucdavis.edu/topics/contraception/efficacy.html

Diaphragm

Latex rubber cap that covers cervix * Layer of spermicide applied to side that is against cervix * Must be prescribed and fitted by a doctor

94% Effective (Careful use)
84% Effective (Not careful)
Minimal STI Protection

HOW IT WORKS

- Inserted by woman up to 2 hours prior to sex
- Must leave in for 4-6 hours after sex

EFFECTS

- Latex allergy
- Increases incidence of UTI and bladder infections
- Small chance of Toxic Shock Syndrome (TSS)if left in place too long
- Woman must be comfortable with idea of insertion

Advantages

- Contains no hormones
- Immediately effective
- Used only when needed

Disadvantages

- Spermicidal cream or jelly may cause irritation
- Some individuals are allergic to latex or silicone
- No protection from STIs
- Increased risk of urinary tract infections
- Efficacy is lower than other types of contraception

Adverse Reactions: severe abdominal, chest, head or leg pain. Vision loss or blurring

Failure Rate

Typical Use	Perfect Use
16%	6%

http://healthcenter.ucdavis.edu/topics/contraception/efficacy.html

Withdrawal in accordance with Natural Family Planning Methods (no sex during ovulation)

The withdrawal method of birth control, also known as coitus interruptus, involves the man withdrawing his penis from the vagina before ejaculation.

96% Effective (Careful use)

73% Effective (Not careful)

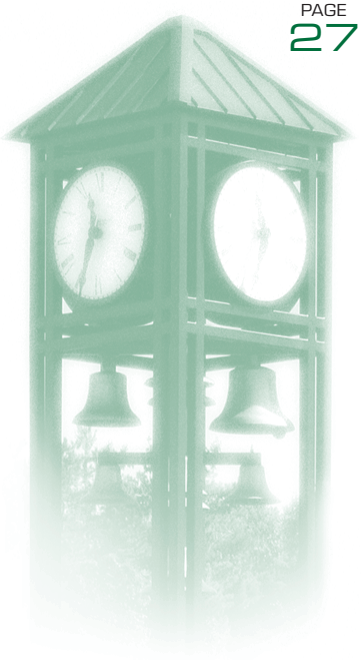
No STI Protection

HOW IT WORKS

- Prevents sperm from being deposited in the vagina and subsequently fertilizing an ovum

EFFECTS

- Pregnancy
- Infection
- Worry
- Regret



Advantages

- No cost
- No chemicals or devices
- Always available
- No side effects

Disadvantages

- High failure rate
- No protection from STIs

Adverse Reactions: severe abdominal, chest, head or leg pain. Vision loss or blurring

Failure Rate

Typical Use	Perfect Use
27%	4%

http://healthcenter.ucdavis.edu/topics/contraception/efficacy.html

Resources

Health topics: Methods of contraception. (n.d.). Retrieved from http://healthcenter.ucdavis.edu/topics/contraception/methods.html

Birth control: The female condom. (n.d.). Retrieved from http://www.ourbodiesourselves.org/book/excerpt.asp?id=25

Guttmacher institute state policies in brief: Emergency contraception. (2012, JANUARY 1). Retrieved from http://www.guttmacher.org/statecenter/spibs/spib_EC.pdf

Health topics: Efficacy chart. (n.d.). Retrieved from http://healthcenter.ucdavis.edu/topics/contraception/efficacy.html

Appendix B (Continued) - Presentation to the Health Advisory Council Meeting 1

Effectiveness of Sex Education Programs

Information from the Guttmacher Institute, December 2011

- In 2010, Congress created PREP
- Congress renewed Title V abstinence-only program
- Comprehensive Approach
- Abstinence Only programs

RECOMMENDATIONS

- CONTENT RECOMMENDATIONS
- PARENTAL COMMUNICATION RECOMMENDATIONS
- STUDENT AND PARENT EVALUATION OPPORTUNITIES
- GENERAL EVALUATION OF THE SUB COMMITTEE PROCESS AND CONCLUSIONS

MEETING DATES

MARCH 1ST 4:00-5:15
APRIL 5TH 4:00-5:15
MAY –10TH 4:00 – 5:15
JUNE - RECOMMENDATION TO SUPERINTENDENT AND BOE

HEALTH ADVISORY COMMITTEE

- Rebecca Carman (Chair/Facilitator- Member of Health and Wellness Committee)
- Kelly DeFeciani (Public Information Officer for the Shen School District)
- Nicole Holehan (Health Education Teacher-Member of Health and Wellness Committee)
- Amy Preston (Health Education Teacher- Member of Health and Wellness Committee)
- Carol Funyak (Health Education Teacher- Member of Health and Wellness Committee)
- Jean Botillo-Paulisi (parent - Member of Health and Wellness Committee)
- Penny Thompson (parent and school nurse)
- Maureen Silfer (parent -Shen Parents' Choice Coalition)
- Gretchel Hathaway (parent- Planned Parenthood Board)
- Idalia Sepulveda (parent-clergy)
- Dee Lowman (Clergy- Shenendehowa United Methodist)
- Sister Rose Caselerno (Clergy – St. Edwards)
- Annette Morere (community member- Member of Health and Wellness Committee)
- Laraine Longhurst (community member)
- Bill Casey (community member)
- Andrew McCarty (BOE- waiting for confirmation - Member of Health and Wellness Committee)
- Rick Mincher (BOE-waiting for confirmation)
- Dr. Marinello (School Physician)
- Jeanne Ann Dahl (Physician's Assistant)

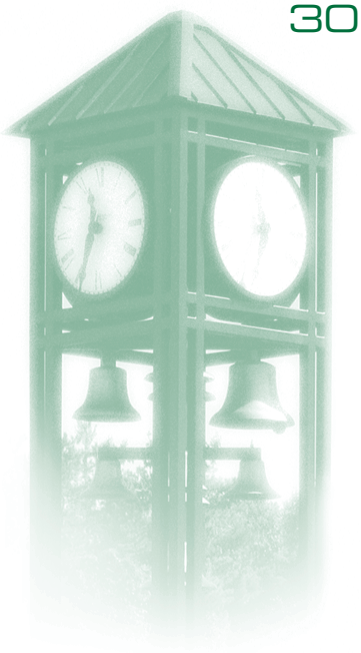
Appendix C -
Presentation to the Health Advisory Council Meeting 3

	Types of Sex Education Programs: Characteristics and Philosophical Principles		
	Abstinence Only & SRA Programs (Sexual Risk Avoidance Programs)	**Abstinence Plus Programs**	**Comprehensive Sex Education (Generally broken into 6 Key Concepts)**
Skills	Discussions of values, character building, & refusal skills. Some include Decision-Making and Goal Setting Skills.	Discussions of Values, Character Building, Refusal skills, Decision-Making, & Goal Setting	**Key Concept: Personal Skills** Values, Decision-making, Communication, Assertiveness, Negotiation, Looking for Help **Key Concept: Relationships** Families, Friendship, Love, Romantic Relationships and Dating, Marriage and Lifetime, Commitments, Raising Children
Reproductive System & Identity	May teach about Reproductive System	Teaches about Reproductive System Anatomy & Physiology, Puberty, & Reproduction	**Key Concept: Human Development** Reproductive and Sexual Anatomy and Physiology, Puberty, Reproduction, Body Image, Sexual Orientation, Gender Identity
Abstinence & Sexual Behavior	Promote Abstinence from sex outside of marriage	Promote Abstinence as the top choice in a hierarchy of sexual choices	**Key Concept: Sexual Behavior** Sexuality Throughout Life, Masturbation, Shared Sexual Behavior, Sexual Abstinence, Human Sexual Response, Sexual Fantasy, Sexual Dysfunction
Sexually Transmitted Diseases, Sexual Health, & Contraception	-May teach about contraception with the goal of pointing out the failure rate -Do not teach about condom use -Avoid discussions about abortion -Discusses sexually transmitted diseases and HIV as reasons to remain abstinent	-Teach about contraception -Teach about condom use -May discuss abortion - Discusses sexually transmitted diseases and HIV to provide students with accurate information to keep them safe	**Key Concept: Sexual Health** Reproductive Health, Contraception, Pregnancy and Prenatal Care, Abortion, Sexually Transmitted Diseases, HIV and AIDS, Sexual Abuse, Assault, Violence, and Harassment
Teen Sexual Behavior	Do not acknowledge that many teenagers will become sexually active	Acknowledge that many teenagers will become sexually active	Acknowledge that many teenagers will become sexually active
Society and Sexuality	Addresses the impact of the media on sexual behavior	Addresses the impact of media on sexual behavior. May address gender roles & diversity.	**Key Concept: Society and Culture** Sexuality and Society, Gender Roles, Sexuality and the Law, Sexuality and Religion, Diversity, Sexuality and the Media, Sexuality and the Arts

***Green text indicates what we do at Shenendehowa – including sexual orientation and gender identity as they are being added to the curriculum

***Red text indicates what we do not do at Shenendehowa

Appendix C (Continued) - Presentation to the Health Advisory Council Meeting 3



Comprehensive Sex Education Programs Alignment with Shenendehowa Curriculum

- Black text includes the principles of Comprehensive Sex Education Programs such as Making Proud Choices & Reducing the Risk
- Green text explains how we align with those program principles in terms of what we have in common
- Red text is where we differ

General Programming Information

- Most Comprehensive Sex Education programs are based on cognitive behavior theories - Social Learning Theory, Social Influence Theory, Social Learning Theory, and Cognitive-Behavioral Thec - (which is how health education in NYS is structured)
- There are no Comprehensive Sex Education programs that fully meet all of the Siecus recommended criteria, so most districts who decide to go with a canned Comprehensive Sex Ed curriculum use an existing program and add to it to meet missed criteria.

Siecus (Sexuality Information and Education Council of the United States) Guidelines for Comprehensive Sex Education	
6 Key Concepts	**Included Elements**
Human Development	Topic 1: Reproductive and Sexual Anatomy and Physiology Topic 2: Puberty Topic 3: Reproduction Topic 4: Body Image Topic 5: Sexual Orientation Topic 6: Gender Identity
Relationships	Topic 1: Families Topic 2: Friendship Topic 3: Love Topic 4: Romantic Relationships and Dating Topic 5: Marriage and Lifetime Commitments Topic 6: Raising Children
Personal Skills	Topic 1: Values Topic 2: Decision-making Topic 3: Communication Topic 4: Assertiveness Topic 5: Negotiation Topic 6: Looking for Help
Sexual Behavior	Topic 1: Sexuality Throughout Life Topic 2: Masturbation Topic 3: Shared Sexual Behavior Topic 4: Sexual Abstinence Topic 5: Human Sexual Response Topic 6: Sexual Fantasy Topic 7: Sexual Dysfunction
Sexual Health	Topic 1: Reproductive Health Topic 2: Contraception Topic 3: Pregnancy and Prenatal Care

Healthy Respect Sex Education Program (SRA Abstinence Program) Alignment with Shenendehowa Curriculum

- Black text is the Healthy Respect Curriculum Overview
- Green text explains how we align with that program in terms of what we have in common
- Red text is where we differ

<table>
<tr><th colspan="2">Healthy Respect Student Topics</th></tr>
<tr><td>Communication Skills
• Foundation for healthy relationships
-We teach about this throughout our entire Communication unit in the context of all relationships, students practice these skills throughout the entire semester, and we revisit these skills and practice applying them within this unit. They have to demonstrate the use of communication skills in the Authentic Assessment at the conclusion of this unit.
• The importance of using Communication Skills to stick to personal values and to refuse sexual activity
-We teach about personal values and the importance of sticking to them throughout the entire semester with regard to all topics we teach. Students are asked throughout the course to examine personal & family values, and within this unit we reexamine this issue using Communication, Decision Making, and Planning & Goal Setting Skills to maintain their personal values. They have to demonstrate how they can do this, as well as how they can use the support of their friends and family to help them to do this, in the Authentic Assessment at the conclusion of this unit.</td><td>Sexually Transmitted Diseases
• Abstinence is the only 100% effective way to prevent them
-The definition of Abstinence that we use is as follows:
ABSTINENCE = refraining from any sexual activity that leads to an exchange of body fluids. Abstinence is only <u>100% effective</u> in preventing STIs and Teen Pregnancy, if you abstain from <u>ALL Risky Sexual Behavior</u>."
-We stress that Abstinence is the <u>best</u> choice for them at this point in their lives.
• Abstinence is defined to include the terminology of "premarital" sexual activity
-Our definition of Abstinence does not include the word "premarital" because when you use a definition for abstinence that alienates or excludes some of your students (due to reasons such as sexual orientation or students who have no intention of marrying in the future) they feel that what you are teaching does not apply to them.
• Information is provided about STDs and the dangers associated with them
-We teach about all major STDs, signs/symptoms, dangers, short- and long-term consequences, and that Abstinence is the <u>only</u> 100% effective way of preventing them. We mention protection to them at the middle school level within the context of saying that protection such as condom use is <u>not</u> 100% effective. Contraception is not addressed again until the high school.
• Abstinence helps you to achieve personal goals
-We teach Planning & Goal Setting skills for an entire unit during the semester during which students learn about how the decisions they make today can affect the ability to reach their goals in the future. Predicting this is a skill they practice and demonstrate with regard to many topics we teach, and it is revisited again in this unit. They have to demonstrate this in their Authentic Assessment at the conclusion of the unit as well.</td></tr>
<tr><td>Human Growth & Development
-We teach a review of the Reproductive system Anatomy & Physiology from 7th grade science.</td><td>Emotional Health & Character Formation
• The physical, mental/emotional, and social consequences of sexual activity</td></tr>
</table>

Appendix D -
Information provided by a council member on sexual risk avoidance programs

The Effectiveness of SRA Education
Jemmott Study

A groundbreaking study published in the February 2010 Archives of Pediatric and Adolescent Medicine, provides strong evidence that abstinence-only sex education is more effective than comprehensive sex education (also known as "abstinence-plus"). The Jemmott study was the first to compare the abstinence approach to several alternatives using a random assignment of study subjects, a methodology considered to be the gold standard in research. A research team led by John B. Jemmott III, professor at the University of PA, conducted the federally funded research with 662 African American students from 4 public middle schools in the Northeast. The study found that only the abstinence intervention significantly reduced sexual initiation, when compared with the control group (32.6% that had received the abstinence intervention initiated sex vs. 51.8% that received "safer sex" and 41.8% that received "comprehensive" sex education.) 46.6% of the control group initiated sex. Neither the "safe sex" nor the two "comprehensive" sex education interventions significantly increased condom use. The abstinence intervention did not negatively impact condom use among those participants who became sexually active.(Jemmott Study of Inner City Youth. State: Pennsylvania. Study: Jemmott, J. B., Jemmott L. S.,Fong G.T. (2010).)

The author cites the value of a single focused abstinence approach for encouraging sexual delay, as opposed to a mixed "comprehensive" message. (AP article 2/2/10: "Jemmott said the single focus may have been better at encouraging abstinence than the other approaches in his study. 'The message was not mixed with any other messages,' said Jemmott.)

"This new study is game-changing," said Sarah Brown of the National Campaign to Prevent Teen and Unplanned Pregnancy, in a statement. "For the first time, there is strong evidence that an abstinence-only intervention can help very young teens delay sex and reduce their recent sexual activity as well. Importantly, the study also shows that this particular abstinence-only program did not reduce condom use among the young teens." (http://www.nytimes.com/2010/02/03/education/03abstinence.html)

Further Evidence SRA More Effective Than CSE

Evaluations of "abstinence only programs" have shown them to be more successful than comprehensive sex education programs (Torolero, et.al. 2010,Weed, et.al.2008, Jemmott, et.al., 2010). Students in comprehensive sex education programs were anywhere from 30% more likely, to twice as likely, to initiate sex sooner than those in "abstinence only" programs.

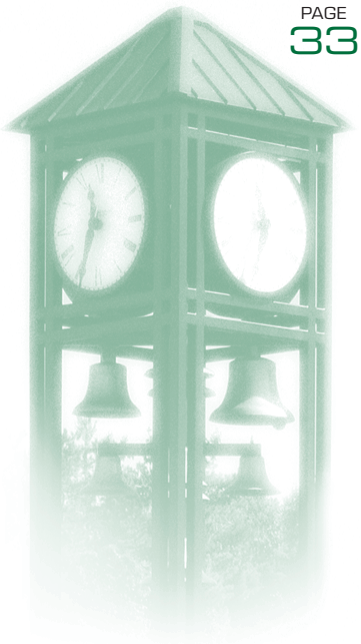
Abstinence Works 2011

In the introduction to Abstinence Works 2011, a compendium of research demonstrating that abstinence centered education works, Valerie Huber, the executive Director of the National Abstinence Education Association explains:

"This edition identifies 22 abstinence-centered education programs evaluated by independent researchers that demonstrate statistically significant results in reducing teen sex or affecting other important behavioral indicator in teen sexual decision-making."

Choosing the Best is one of the 22 studies in Abstinence Works 2011 that was shown successful in reducing teen sex. A 2005 US Department of Health and Human Services study showed a 47% decrease in the initiation of teen sex between students participating in Choosing the Best and those in the control group using the health textbook curriculum. (http://www.choosingthebest.org/docs/CTB_2005_Research_Study.pdf) Additionally, a 2010 independent research study found students who received Choosing the Best were nearly 1.5 times more likely to delay the onset of sexual behavior than the control group. (http://www.choosingthebest.org/docs/CTB_Published_Research-SAGE_Publications.pdf)

Appendix D - Information provided by a council member on sexual risk avoidance programs (continued)



Dear Health Advisory Council,

I am a family physician whose primary concern is for the health and safety of the teens in Clifton Park. I believe we have that in common. Last week, a high school student at Shen brought home a chart with inc rect information regarding the effectiveness of condoms in protecting them from STDs. Last September, it brought to the school's attention that incorrect rates of protection for the condom were being taught to stu dents. In spite of assurances that these rates were corrected and that the school was constantly updating tl information, misinformation is still being given to students. The chart in question indicates that teens, wher using a condom, are 98% protected from STDs. I am very concerned that the misinformation on condom effectiveness has not yet been corrected. Our teens are growing up in an age with a sexually transmitted disease (STD) crisis that the Centers for Disease Control (CDC) has called a "multiple and hidden" epidemi For example:

1. About 9.5 million youth are diagnosed with a sexually transmitted disease every year.2
2. Teen girls are more vulnerable to STD's due to their immature cervical lining.3
3. 1 out of 4 teens has at least one STD.4
4. HPV can cause cancer including oral, cervical and anal types. The HPV vaccine can protect against mos cancer causing strains of the virus (70%), but not all.5 The vaccine cannot protect those who have been vaccinated.
5. At least 24,000 women discover they are infertile due to undiagnosed and untreated STD's every year
6. 34% of newly diagnosed cases of HIV occur in those 13-29 years of age.7
7. STDs can result in irreparable lifetime damage for infants infected by their mothers during gestation or birth, including blindness, bone deformities, mental retardation, and death.8

8. What's more, many of those infected do not show any symptoms.9

Condoms cannot fully protect against STD's and antibiotics cannot cure them all, nor reverse the damage that has already occurred. There is no 98% effective in any of the literature concerning STDs. The truth, according to the CDC, is that condoms, even when used consistently and correctly, can only reduce the risk of transmission of HIV/AIDS by 80%10 This is referred to as "highly effective" which is the best "protection" that condoms are well documented to offer. Is this an unrealistic expectation for teens since consistently and correctly means 100% of the time? Nowhere does the CDC claim 98% effectiveness rates. Actual protection rates are in dispute so that the most precise advice they offer is that condoms, when "used consistently and correctly, reduce the risk of transmission" of some STDs. With other STDs, condoms may (or may not) reduce the risk of transmission at all.11

The CDC states:

> Consistent and correct use of latex condoms reduces the risk for many STDs that are transmitted by genital fluids (STDs such as chlamydia, gonorrhea, and trichomoniasis).
>
> Consistent and correct use of latex condoms reduces the risk for genital ulcer diseases, such as genital herpes, syphilis, and chancroid, only when the infected area or site of potential exposure is protected.
>
> Consistent and correct use of latex condoms may reduce the risk for genital human papillomavirus (HPV) infection and HPV-associated diseases (e.g., genital warts and cervical cancer).12

In addition, the following data concerning the amount of protection condoms confer has been reported in authoritative peer reviewed journals: If used consistently and correctly, condoms may offer only 30% lower risk for herpes transmission13, 50% lower risk for chlamydia, gonorrhea and syphilis14, and some studies show condoms may not provide any protection for preventing HPV among women15. None of these numbers comes close to 98%. "Consistently and correctly" appears repeatedly in the literature but is also not included in the chart. Who is reviewing the material to make sure that it is medically accurate? From where are they obtaining their information? What qualifications do they have? As you can see, this information is very difficult to understand and maybe even more difficult to present. Any misperception on the students' part about the level of protection condoms offer can have the devastating health consequences mentioned above including infection with lifelong diseases which could cause cancer, infertility, or even death or be passed to their children as fatal infections.

In the handout containing the condom effectiveness information, the definition of abstinence is also incomplete. It defines abstinence as "refraining from any activity that leads to an exchange of body fluids." This definition should also include refraining from skin-to-skin contact. STDs can be transmitted not only through bodily fluids but also through direct skin-to-skin contact without an exchange of bodily fluids. The CDC states that: "genital ulcer diseases (such as genital herpes, syphilis, and chancroid) and human papillomavirus (HPV) infection are primarily transmitted through contact with infected skin or mucosal surfaces."16 Infection with these pathogens can be serious and lifelong. Therefore, a complete definition of abstinence should include refraining from skin-to-skin contact with the genitals. Students should be informed

Appendix D - Information provided by a council member on sexual risk avoidance programs (continued)

that this kind of contact can spread disease.

Another concern is that in an exercise on the same handout, students define abstinence themselves. During that exercise students reportedly became confused thinking that "acceptable" definitions of abstinence included oral sex, anal sex and other sexual activities. All of these put students at high risk for STD's. Who is making sure that this information is presented in a way that is not confusing to our teens? Misperception can be as dangerous as misinformation.

In another area, information is also incomplete. Little to no information was apparently given on the emotional and psychological consequences of multiple sexual partners, unplanned pregnancies, and STDs. Teen sex is linked to depression and attempted suicide17, especially among those who contract an STD.18 Suicide is the third leading cause of death among youth.19

Correct medical information is crucial to our students regarding their sexual health. Misinformation, incomplete information, and misperception could result in devastating and lifelong consequences for our teens. Please make sure that these changes are made to the handout. And maybe even more importantly, please consider implementing a curriculum that has been studied by medical professionals for accuracy.

Sincerely,

Jan L. Patterson M.D.

References:

1. http://www.cdc.gov/std/stats98/STD_Trends.pdf
2. http://www.cdc.gov/std/stats10/trends.htm
3. http://www.mayoclinic.com/health/sexually-transmitted-diseases-stds/DS01123/DSECTION=risk-factors
4. http://www.cdc.gov/stdconference/2008/press/release-11march2008.htm
5. http://www.cdc.gov/std/HPV/STDFact-HPV.htm http://www.cdc.gov/mmwr/pdf/rr/rr5602.pdf
6. http://www.cdc.gov/nchhstp/newsroom/docs/2008STDSurveillanceRpt-Women-MediaFactSheet-FINAL.pdf
7. http://www.cdc.gov/nchhstp/newsroom/docs/Fact-Sheet-on-HIV-Estimates.pdf
8. http://www.cdcnpin.org/scripts/std/std.asp (infants)
9. http://www.health.ny.gov/diseases/communicable/std/
10. http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5912a1.htm Weller, S.C., and K. Davis-Beaty. "Condom Effectiveness in Reducing Heterosexual HIV Transmission". Family Planning Perspectives 31.6 (1999): 272-79.
11. http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5912a1.htm
12. http://www.cdc.gov/condomeffectiveness/brief.html
13. http://archinte.ama-assn.org/cgi/content/abstract/169/13/1233 Emily T. Martin, et al. "A Pooled Analysis of the Effect of Condoms in Preventing HSV-2 Acquisition." Archives of Internal Medicine 169.13 (2009):12331240.
14. Baeten, J.M., P.M. Nyange, B.A. Richardson, et al. "Hormonal contraception and risk of sexually transmitted disease acquisition: Results from a prospective study. American Journal of Obstetrics and Gynecology 185.2 (2001):380-385
15. http://cebp.aacrjournals.org/content/15/2/326 http://www.niaid.nih.gov/about/organization/dmid/documents/condomreport.pdf, http://www.ncbi.nlm.nih.gov/pubmed/12438912
16. http://www.cdc.gov/condomeffectiveness/latex.htm
17. http://www.pire.org/detail2.asp?core=16988&cms=408 Hallfors, D.D., Waller, M.W., Ford, C.A., Halpern, C.T., Brodish, P.H., & Iritani, B. (2004). Adolescent depression and suicide risk: association with sex and drug behaviors. American Journal of Preventive Medicine, 27:224–230.
18. http://archpedi.ama-assn.org/cgi/reprint/156/6/599.pdf
19. http://www.cdc.gov/ViolencePrevention/pdf/Suicide-DataSheet-a.pdf

NOTE:

Concerned with inaccuracies in this letter, council member Dr. Anthony Marinello provided the following links for the council to review:

The Centers for Disease Control and Prevention (http://www.cdc.gov).

STD Trends in the United States, 2010 http://www.cdc.gov/std/stats10/trends.htm

This was discussed at the April meeting.

Appendix E -
Information provided by a council member on sexual risk prevention programs

Effectiveness of a Comprehensive Sexual Education Pr

• Although only 13% of U.S. teens have had sex by age 15, most initiate sex in their late teen y
seven in 10 teen men and teen women have had intercourse.[1]

EFFECTIVENESS OF SEX EDUCATION PROGRAMS

• There is no evidence to date that abstinence-only-until-marriage education delays teen sexual
shows that abstinence-only strategies may deter contraceptive use among sexually active teens,
tended pregnancy and STIs.[23]

• A 2007 congressionally mandated study found that federally-funded abstinence-only progran
young people's sexual behavior.[23]

• Leading public health and medical professional organizations, including the American Medica
Nurses Association, the American Academy of Pediatrics, the American College of Obstetricians a
Public Health Association, the Institute of Medicine and the Society for Adolescent Health and M
sive approach to educating young people about sex.[23]

ALTERNATIVE SOURCES OF SEX INFORMATION

• Adolescents consider parents, peers and the media to be important sources of sexual health information.[16]

• Seventy percent of male teens and 79% of female teens report talking with a parent about at least one of six sex education topics: how to say no to sex, methods of birth control, STIs, where to get birth control, how to prevent HIV infection and how to use a condom.[11]

• Girls are more likely than boys to talk with their parents about birth control or "how to say no to sex."[11]

• Even when parents provide information, their knowledge about contraception or other sexual health topics may often be inaccurate or incomplete.[17]

• More than half (55%) of 7th–12th graders say they have looked up health information online in order to learn more about an issue affecting themselves or someone they know.[18]

• The Web sites teens turn to for sexual health information often have inaccurate information. For example, of 177 sexual health Web sites examined in a recent study, 46% of those addressing contraception and 35% of those addressing abortion contained inaccurate information.[19]

• Exposure to high levels of sexual content on television is associated with an increased risk of initiating sexual activity, as well as a greater likelihood of involvement in teen pregnancy.[20]

TEENS' REPORTS OF FORMAL SEX EDUCATION

• In 2006–2008, most teens aged 15–19 had received formal instruction about STIs (93%), HIV (89%) or abstinence (84%). However, about one-third of teens had not received any formal instruction about contraception; fewer males received this instruction than females (62% vs. 70%).[11]

• Many sexually experienced teens (46% of males and 33% of females) do not receive formal instruction about contraception before they first have sex.[12]

• About one in four adolescents aged 15-19 (23% of females and 28% of males) received abstinence education without receiving any instruction about birth control in 2006–2008[12], compared with 8–9% in 1995.[13]

• Among teens aged 18–19, 41% report that they know little or nothing about condoms and 75% say they know little or nothing about the contraceptive pill.[14]

Appendix E - Information provided by a council member on sexual risk prevention programs (continued)

SOURCES:

1. Abma JC et al., Teenagers in the United States: sexual activity, contraceptive use, and childbearing, National Survey of Family Growth 2006–2008, Vital and Health Statistics, 2010, Series 23, No. 30.
2. Martinez G et al., Teenagers in the United States: sexual activity, contraceptive use, and childbearing, 2006-2010 National Survey of Family Growth. Vital and Health Statistics, 2011, Series 23, No. 31.
3. Kost K and Henshaw, U.S. Teenage Pregnancies, Births and Abortions 2008: National Trends by Race and Ethnicity, 2012, <http://www.guttmacher.org/pubs/USTPtrends08.pdf>, accessed February 6, 2012.
4. Santelli JS et al., Explaining recent declines in adolescent pregnancy in the United States: the contribution of abstinence and improved contraceptive use, American Journal of Public Health, 2007, 97(1):1–7.
5. Finer LB and Zolna MR, Unintended pregnancy in the United States: incidence and disparities, 2006, Contraception, 2011, doi: 10.1016/j.contraception.2011.07.013.
6. Ventura SJ and Hamilton BE, U.S. teenage birth rate resumes decline, NCHS Data Brief, 2011, No. 58.
7. Santelli J et al., Transnational comparisons of adolescent contraceptive use: What can we learn from these comparisons? Archives of Pediatric Adolescent Medicine, 2008, 162(1):92–94.
8. McKay A et al., Trends in teen pregnancy rates from 1996–2006: a comparison of Canada, Sweden, USA and England/Wales, Canadian Journal of Human Sexuality, 19(1–2):43–52.
9. Weinstock H et al., Sexually transmitted diseases among American youth: incidence and prevalence estimates, 2000, Perspectives on Sexual and Reproductive Health, 2004, 36(1):6–10.
10. Darroch JE et al., Teenage sexual and reproductive behavior in developed countries: Can more progress be made? Occasional Report, New York: The Alan Guttmacher Institute, 2001, No. 3.
11. Martinez G, Abma J and Casey C, Educating teenagers about sex in the United States, NCHS Data Brief, 2010, No. 44.
12. Unpublished tabulations of data from the 2006–2008 National Survey of Family Growth.
13. Lindberg LD, Changes in formal sex education: 1995–2002, Perspectives on Sexual and Reproductive Health, 2006, 38(4):182–189.
14. Kaye K et al., The Fog Zone: How Misperceptions, Magical Thinking, and Ambivalence Put Young Adults at Risk for Unplanned Pregnancy, Washington, DC: National Campaign to Prevent Teen and Unplanned Pregnancy, 2009.
15. Department of Health Services, Center for Disease Control and Prevention (CDC), School Health Policies and Programs Study 2006 Pregnancy Prevention, Atlanta: CDC, 2007.
16. Brown J, ed., Managing the Media Monster: The Influence of Media (From Television to Text Messages) on Teen Sexual Behavior and Attitudes, Washington, DC: National Campaign to Prevent Teen and Unplanned Pregnancy, 2008.
17. Eisenberg ME et al., Parents' beliefs about condoms and oral contraceptives: Are they medically accurate? Perspectives on Sexual and Reproductive Health, 2004, 36(2):50–57.
18. Rideout VJ et al., Generation M2: Media in the Lives of 8- to 18-Year-Olds, Menlo Park, CA: Kaiser Family Foundation, 2010.
19. Buhi ER et al., Quality and accuracy of sexual health information web sites visited by young people, Journal of Adolescent Health, 2010, 47(2):206–208.
20. Chandra A et al., Does watching sex on television predict teen pregnancy? Findings from a national longitudinal survey of youth, Pediatrics, 2008, 122(5):1047–1054.
21. Guttmacher Institute, Sex and STD/HIV education, State Policies in Brief, October 2011, <http://www.guttmacher.org/statecenter/spibs/spib_SE.pdf>, accessed Oct. 19, 2011.
22. Committee on Government Reform—Minority Staff, United States House of Representatives, The content of federally funded abstinence only education programs, 2004, <http://democrats.oversight.house.gov/images/stories/documents/20041201102153-50247.pdf>, accessed Aug. 18, 2011.
23. Boonstra H, Sex education: another big step forward—and a step back, The Guttmacher Policy Review, 2010, 13(2):27–28.
24. Kirby D, Emerging Answers 2007: Research Findings on Programs to Reduce Teen Pregnancy and Sexually Transmitted Diseases, Washington, DC: National Campaign to Prevent Teen and Unplanned Pregnancy, 2007.
25. Jemmott III JB et al., Efficacy of a theory-based abstinence-only intervention over 24 months: a randomized controlled trial with young adolescents, Archives of Pediatric Adolescent Medicine, 2010, 164(2):152–159.

Appendix F

Presentation at April meeting by health teachers

Why We Do What We Do

WHAT RESEARCH TELLS US

Kirby: 4 Key Conclusions

1. Several abstinence programs, including abstinence-until-marriage programs, have been *rigorously* evaluated with large experimental designs and found to have **no overall impact** on delay in initiation of sex, age of initiation of sex, return to abstinence, number of sexual partners, or condom or contraceptive use.

Our Program: "Abstinence Plus"

As an "Abstinence Plus Program," our program takes the components of both approaches to sex education that have been **proven** to effect change & leaves out approaches and components that haven't been proven to do so:

- Does not exclude any students from definitions because that can cause them to believe none of this applies to them
- Teaches Abstinence as the **best choice** in a hierarchy of choices
- Teaches effective use of contraception (at the high school level)

Kirby: 4 Key Conclusions - continued

2. Moreover, research shows that abstinence only until marriage strategies **may deter contraceptive use among sexually active teens**, increasing their risk of unintended pregnancy and STIs.
   - They haven't received the instruction so they don't know how to use it correctly
   - It may cause a feeling of stigmatization about the use of contraception

Our Program: "Abstinence Plus" contd

- On the other hand, does **not** teach about things traditionally included in Comprehensive Sex Education programs, such as abortion, because it has not been shown to effect change
- Infuses concepts from this unit throughout the semester – for example, substance use and sexual behavior with ATOD unit, consequences of teen pregnancy with Planning & Goal Setting unit
- Encourages reflection on and maintenance of family values – without teaching family values

Appendix F - Presentation at April meeting by health teachers (continued)

Our Program: "Abstinence Plus" contd

- Does not shame students, or instill fear, about what will someday be a normal part of a healthy life
  - **Instead our program focuses on these concepts:**
    - Self-efficacy – You can successfully make positive and healthy choices
    - Social norms – "not everyone is doing this" – may reduce internal pressure to engage in activity
    - Empower people through Skills

Our Program: "Abstinence Plus" contd

- Teaches foundational skills necessary to be healthy, confident, self-empowered individuals.
  - By the time we get to this unit, students have had **many** days of skills instruction and practice **which is then extended into this unit**:
    - **70 days** at the middle school & **70 days** at the high school level (plus what they already had in middle school)
  - This skills instruction and practice teaches students to:

- Be Assertive **Communicators** in all areas of their lives;
- Be **Proactive Decision Makers**, considering consequences of actions and the impact of choices on their future;
- **Plan & Set Goals** based on personal and family values and to consider the impact of decisions on their ability to achieve those goals;
- **Manage Stress** effectively in their daily lives;
- Use **Self-Management** to tie the skills together and live the healthiest life possible.

Kirby: 4 Key Conclusions - continued

4. Teaching young people about sex and contraception does **not** lead to early sexual activity or experimentation.
   - In other words, emphasizing abstinence and the use of protection for those who do have sex in the same program is not confusing to young people; rather, it is realistic and effective.

Kirby: 4 Key Conclusions - continued

3. Sexual health education that at least provides information about abstinence **and** how to use contraception can:
   - delay the onset of sexual activity among teens
   - reduce their number of partners
   - increase safer sex practices
   - increase contraceptive use when they do become sexually active

Why is this a Realistic Approach?

- Although only 13% of U.S. teens have had sex by age 15, most initiate sex in their late teen years. By their 19th birthday, seven in 10 teen men and teen women have had intercourse. *(Vital and Health Statistics*, 2010)