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Susan Roberts-Dobie

University of Northern Iowa, susan.dobie@uni.edu

Mary E. Losch

University of Northern Iowa, mary.losch@uni.edu

Danielle Vsetecka

Center for Social and Behavioral Research, Cedar Falls, Iowa

Andrew Morse

Center for Social and Behavioral Research

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Sexuality Curriculum Policies: Rural is Not Always More Conservative

Susan Roberts-Dobie

University of Northern Iowa

Mary E. Losch

University of Northern Iowa

Danielle Vsetecka

Center for Social and Behavioral Research, Cedar Falls, Iowa

Andrew Morse

Center for Social and Behavioral Research, Cedar Falls, Iowa

This study examined sexuality education policies of school districts following the enactment of a law by the state of Iowa in 2007 requiring schools to include curriculum related to human growth and development education. The authors compared responses from superintendents in rural and urban areas in the state of Iowa regarding their districts' sexuality curriculum policies. All public school superintendents in Iowa (n=364) were mailed a survey; 131 (36%) responded. The sample was representative of the state both geographically and by size of district. Findings indicate that while rural states (or more-rural areas within rural states) may be publically perceived to be more conservative than urban areas, their sexuality education policies show little statistical difference. Additionally, Iowa's sexuality education policies were found to be equally or more inclusive in comparison to previously reported national results. Community opposition to sexuality education was not evident. Superintendents indicated that state directives were the most influential factor driving district policies on sexuality education.

Keywords: sexuality education, abstinence education, curriculum, rural

Although the teen pregnancy rate in the United States among girls aged 15-19, has decreased from approximately one in 11 females in the year 2000 (Henshaw, 2001) to one in 14 in 2006 (National Campaign to Prevent Teen Pregnancy, 2010), this number is still high. According to the 2007 Youth Behavior Risk Survey (YRBS) (Eaton et al., 2008), nationwide, 47.8% of students have ever had sexual intercourse and 35% of students are currently sexually active. Moreover, 50% of the 19 million new cases of sexually transmitted infections (STIs) are among teens (Weinstock, Berman, & Cates, 2000). In light of these data, all states, rural and urban, face the challenge of providing quality sexuality education to their students. However, while all students need the same essential information about growth and development and human sexuality, students in rural areas often face barriers to accessing professional help and advice. First, there are limited numbers of reproductive health care providers in rural areas; second, students may reside at geographic distance from available providers (Winstead-Fry & Wheeler, 2001), and third, due to close community ties in rural areas, there exists a real or perceived lack

of confidentiality when using those providers (Garside, Ayres, Owen, Pearson, & Roizen, 2002). Overlying these issues is the common public misperception that teen pregnancy is an urban, not rural, issue (Bennett, Skatrud, Guild, Loda, & Klerman, 1997; Levine & Coupey, 2003; Yawn & Yawn, 1993). In fact, rural teens are equally as likely to become pregnant as urban teens, and when White teens are considered alone, pregnancy rates are slightly higher in rural counties compared to urban counties. Additionally, after becoming pregnant, rural teens are less likely to have an abortion, resulting in higher birth rates for rural teens (Bennett et al.).

While studies comparing sexual activity between rural and urban teens are not common, data that do exist across rural and urban areas show rural adolescents have similar and sometimes higher rates of the high risk sexual behaviors that lead to adolescent pregnancy, early childbearing, and STIs. In an analysis of 1999 Youth Risk Behavior Survey data, Crosby, Yarber, Ding, DiClemente, and Dodge (2000) found that rural adolescent males were more likely than their urban counterparts to report ever

having sexual intercourse, not using a condom at last sexual intercourse, and to having used alcohol or drugs during their last sexual intercourse. While Crosby et al. found no statistical difference in sexual risk-taking behaviors between rural and urban females, in a study of rural African American teens, Milhausen and colleagues (2003) found that rural African American females were more likely than their urban counterparts to report having ever had sex, to initiate sex before age 15, to have had more than one sexual partner in the past three months, and to report having not used a condom during their last sexual encounter. Rural African American males in the sample were more likely to report having ever had sex and to report having not used a condom during their last sexual encounter than their urban peers. Levine and Coupley (2003) analyzed YRBS data comparing risk behaviors by metropolitan status. While they found no differences in risky sexual behavior among urban, suburban, and rural youth when controlled for race, they asserted that urban youths may actually experience an “urban advantage” due to the high density of health care providers, targeted youth services, and access to public transportation in urban areas.

The purpose of this study was to determine the status of sexuality education in Iowa’s urban and rural schools after the passage of the new law related to human growth and development education requiring sexuality education materials to be “research-based” (State of Iowa Legislature, 2008, para 4). Research questions included (a) What are the sexuality education policies of districts? (b) At what grade levels are schools delivering sexuality education? (c) Is the current policy identified as “abstinence-based” or “abstinence-only”? (d) How do these findings differ from an earlier national sample? (e) Do these findings differ in more rural areas vs. more urban areas of the state?

Sexuality Education Policy in Iowa

In an attempt to improve sexuality education, and thus limit unintended pregnancy and reduce the STI rates among teens, the Iowa legislature passed a law related to human growth and development education requiring all public and non-public schools to “incorporate age-appropriate and research-based materials into relevant curricula and reinforce the importance of preventive measures when reasonable with parents and students” (State of Iowa Legislature, 2008, para 4). Research-based was defined as:

[C]omplete information that is verified or supported by the weight of research conducted in

compliance with accepted scientific methods; recognized as medically accurate and objective by leading professional organizations and agencies with relevant expertise in the field, such as the American College of Obstetricians and Gynecologists, the American Public Health Association, the American Academy of Pediatrics, and the National Association of School Nurses; and published in peer-reviewed journals where appropriate. (2) Information that is free of racial, ethnic, sexual orientation, and gender biases. (State of Iowa Legislature, 2008, para 23)

Existing Iowa Code both prior to the new law (passed in April 2007) and continuing forward requires that human growth and development instruction include coverage of human sexuality, self-esteem, stress management, interpersonal relationships, domestic abuse, human papilloma virus (HPV) and the availability of the vaccine to prevent HPV, and Acquired Immune Deficiency Syndrome (AIDS) in grades one through twelve (State of Iowa Legislature, 2008, para 13). The state does not currently require or suggest that schools follow a designated curriculum and does not restrict any topic from inclusion. Iowa’s state policy mandates that schools teach health in grades K-8 and that high schools offer and teach one unit of credit in health education. The state does not require that students complete the high school health credit for graduation. In terms of sexuality/abstinence education (heretofore referred to as “sexuality education”), each district determines the specific curriculum, resources, and time dedicated to instruction based on community and school needs. Currently, the Iowa Department of Education endorses an abstinence-based approach and allows districts to adopt either an abstinence-based or an abstinence-only sexuality education curriculum.

Abstinence-Only vs. Abstinence-Based Approaches

While nationally 93% of public secondary schools teach sexuality education and most states have a policy to include the topic in public school curriculum (Lindberg, Ku, & Sonenstein, 2000), there is great variability among states’ sexuality education policies. Some states mandate that schools provide sexuality education or STI and/or HIV/AIDS education, some mandate both, and others simply make recommendations (Sexuality Information and Education Council of the United States [SIECUS], 2008a). Among the states with mandated sexuality education, some include specific requirements or

restrictions in terms of content and others leave these decisions up to local communities. Even in states that do not mandate sexuality education, some have requirements and restrictions for the schools that choose to provide sexuality education (SIECUS, 2008a). It is generally accepted that sexuality education falls into one of two categories, abstinence-only or abstinence-based. Abstinence-only programs encourage teens “to wait until marriage to have sex. If birth control is mentioned, the message says that no birth control is 100% effective at preventing pregnancy and avoiding sexually transmitted diseases” (Barnett & Hurst, 2003, p. 264). Abstinence-based programs “emphasize the benefits of abstinence [and] include information about sexual behavior other than intercourse as well as contraception and disease-prevention methods” (SEICUS, 2008b, para 4).

Sexuality education delivered to the nation’s adolescents is at the forefront of efforts to prevent unintended pregnancies and STIs. School-based instruction is the primary mode of this education and has been shown to reduce sexual risk behaviors by delaying age of first intercourse, reducing levels of sexual activity, and increasing contraceptive or condom use (Kirby, Short, Collins, Rugg, Kolbe, Howard, et al., 1994). In response to the ongoing debate about the most effective approach to sexuality education, there have been numerous studies comparing abstinence-based and abstinence-only approaches. In order to shed light on the effectiveness of each, Kirby (2001) performed a meta-analysis of articles reviewing both abstinence-based and abstinence-only programs. Of twenty-eight abstinence-based programs, nine were found to delay initiation of sexual intercourse, eighteen showed no impact, and one appeared to hasten the initiation of sex. In the evaluation of three studies reviewing the impact of five abstinence-only programs, no scientific evidence of effectiveness was found in delaying the initiation of sexual intercourse. Conclusions similar to Kirby’s were reached by Manlove, Romano-Papillo, and Ikramullah (2004) who evaluated different types of sexuality education programs. Compared to control groups they found that while six of the nine comprehensive sexuality education programs, five of seven HIV/STI prevention programs, and four of four youth development programs delayed the onset of sexual activity, none of the abstinence-only programs delayed onset of sexual activity. An exception to this pattern of findings is a study by Jemmot, Jemmot, and Fong (2010) comparing four curriculums (abstinence-only, safer sex-only, comprehensive, and a control curriculum) delivered to 12-year-olds. Two

years later, at age 14, fewer participants from the abstinence-only group were sexually active. The authors, however, noted that that the abstinence-only curriculum used did not: Stress waiting until marriage for sex, contain medically inaccurate information, portray sex in a negative light, or use a moralistic tone, which sets it apart from most abstinence-only curriculums.

While the majority of sexuality education programs in the U.S. take an abstinence-based approach, many school sexuality education policies do not reflect the preponderance of current research (Landry, Kaeser, & Richards, 1999). A Kaiser Family Foundation study (2000) reported that 58% of principals said that their school took a comprehensive (abstinence-based) approach to sex education, teaching that while young people should wait to have sex, they should use birth control and practice safer sex if they do not. An additional 34% of principals reported the main message of their sexuality education program was abstinence-only.

Federal Policy

Federal financial support for abstinence-only education began in 1982 with the Adolescent Family Life Act. In 1996, Congress authorized Section 501(b) of Title V of the Social Security Act which established an eight-point definition for abstinence education and provided \$50 million a year in funding for state initiatives with the exclusive purpose of “teaching the social, psychological, and health gains to be realized by abstaining from sexual activity” (Howell, 2007, para 6). The more restrictive Community-Based Abstinence Education funds, authorized in 2000, provided increased funding for abstinence-only education, while at the same time requiring that programs equally teach all components of the eight-point definition of abstinence-only education (Howell). Not surprisingly, as annual funding for abstinence-only programs increased, so did their delivery. For example, between 1995 and 2002, as annual funding increased from \$80 million to \$204 million, there was a corresponding increase in students receiving abstinence-only education from 9.3% to 23.8% (Lindberg, Santelli, & Singhas cited in Kohler, Manhart, & Lafferty, 2008).

At the time of writing, Title V funding has been renewed for another five years, until 2014, as part of the health care reform law. Annually, \$50 million will be provided to states to promote abstinence from sex outside of marriage. However, programs will no longer be required to meaningfully represent each component of the eight-point definition of abstinence-only education, which allows for much

more flexibility in the type of programming delivered (Boonstra, 2010a). In addition to Title V funding, \$114 million has been allocated in 2010 for the Teen Pregnancy Prevention Program, \$75 million of which will go to programs proven through rigorous evaluation to reduce teen pregnancy. An additional pool of federal money, the Personal Responsibility Education Program, allocated by the Administration on Children, Youth and Families, will provide \$55 million for proven programs to educate adolescents on both abstinence and contraception and prepare them for adulthood by teaching subjects such as healthy relationships, financial literacy, and parent-child relationships (Boonstra, 2010b). Thus, under the current presidential administration approximately \$190 million is available in annual federal funding for abstinence-based sexuality education and \$50 million is available for abstinence-only education via Title V funds.

Community Pressure

Although national opinion polls show 90% of adult Americans believe it is very or somewhat important to teach sex education in schools (Dailard, 2001), adverse pressure from the community is still of concern to schools (Kirby, 2007). Worry about unfavorable community reaction has been associated with reduced odds of teaching multiple skills and topics related to pregnancy prevention (Landry, Darroch, Singh, & Higgins, 2003) and pressure or fear of pressure from parents, the community, or the school administration has been found to influence the inclusion of topics in sexuality education (Forrest & Silverman, 1989; Yarber & Torabi, 1997). Sexuality education teachers' personal views also influence the amount and depth of sexuality education that youth receives (Darroch, Landry, & Singh, 2000).

There has been pressure to standardize sexuality education curriculum through national, state, and district policies (Darroch, Landry, & Singh, 2000; Lindberg, Ku, & Sonenstein, 2000). These calls for a more standardized curriculum may be justified as great variability is seen in the depth and breadth of sexuality education programs within districts, and among districts, states, and the nation. Landry, Kaeser, and Richards (1999) found evidence of this disparity in a nationally representative sample of 825 public school district superintendents. They found that although more than two-thirds of school districts had adopted a district-wide sexuality education policy, the remainder left decisions up to the school principal or to teachers. Among school districts with a sexuality education policy, all required that abstinence be taught and 86% required that abstinence be promoted over other options.

Approximately 35% of those with a district-wide policy (23% of all school districts) required that abstinence be taught as the only option for unmarried people, while either prohibiting the discussion of contraceptives or allowing discussion only of their ineffectiveness; 51% required that abstinence be taught as the preferred option for young people, but also permitted discussion of contraception as an effective means of protecting against unintended pregnancy and the use of condoms in preventing STIs. An additional 14% presented abstinence as one option as part of a broad sexuality education program (see Table 1).

In light of this great differentiation both locally and nationally, we collected data to determine the status of sexuality education policies in Iowa which allowed for analysis to determine if the policies differ between the more rural and more urban areas of the state.

Methods

Following approval from the Institutional Review Board, all superintendents in public schools (N = 364) in the state of Iowa were sent a letter of invitation and a self-administered questionnaire (SAM) and asked to complete the questionnaire or ask a designee to do so. Because of the relatively small number of districts in the state, all superintendents were included in the sample frame. A four-page paper questionnaire addressed to "Superintendent" was mailed to the school district. To improve response, a postcard reminder and second questionnaire were also mailed to non-respondents. Data were collected August-October 2007.

Participants

A total of 131 school superintendents returned usable questionnaires for a response rate of 36%. The responding superintendents represented districts in 70% of the state's 99 counties. Respondents were geographically well-distributed throughout the state with 47 (35.9%) identified as being from the western third of the state, 40 (30.5%) from the central third of the state, and 41 (31.3%) from the eastern third. The sample was also representative by size of district. The Iowa Department of Education reported 480,609 students enrolled in 364 districts in 2007-2008 (Iowa Department of Education, 2008). When divided into tertiles based on district enrollment, 'small' districts were those with enrollments of 1-494 students; 'medium' districts were those with enrollments of 495-899 students; and 'large' districts enrolled 900 or more students. Of the respondents, 44 (34.4%)

represented small districts; 40 (31.2%) represented medium sized districts, and 44 (34.4%) represented large districts. The total enrollment of school districts responding to this survey was 183,785 students ($M = 1,435.8$, $SD = 2,072.29$), representing 38.2% of all students in the state of Iowa. The maximum value for district enrollment among survey respondents was 17,746 students and the minimum was 78. Although Iowa itself is a rural state, within Iowa, size of district enrollment can essentially be used as a proxy for more rural versus more urban locations. Larger school districts are more urban; while smaller districts are more rural.

Instrument

The instrument was based on a questionnaire included in an Alan Guttmacher Institute study conducted by Landry, Kaiser, and Richards in 1999. Two questions were added to the Guttmacher questionnaire to assess district policy and curricular changes in response to a new state law requiring research-based and medically accurate information be included in sexuality education. The questionnaire included 18 questions regarding the presence, type, and scope of policies related to sexuality education, factors influencing the establishment of current policy, the grades in which specific topics are covered, curriculum used, and community support. The question format required respondents to indicate the response that best described their school district's policy, either in a yes/no format or by choosing one sentence from a set of sentences (see example in Table 3). No scales were developed for the questionnaire. The items were designed to address dynamic policies and procedures and hence, no psychometric measures such as validity or reliability are applicable.

The questionnaire stated that the term, *sexuality/abstinence education*, incorporates any and all health education related to human sexuality, including family life, abstinence until marriage, postponing sexual involvement, and avoidance of sexually transmitted diseases (STDs)/HIV and unintended pregnancy, and the term, *policy*, includes any guidance that applies, district-wide, to such education in the schools in your district.

Analysis

Owing to the descriptive nature of the items, frequencies/percentages of responses were summarized to characterize responses and Chi-square statistics were used to assess group differences. Data analysis was performed using SPSS 15.0 for Windows.

Results

The results section is divided into two parts. The first part compares data with regard to sexuality education policies to data from the national survey conducted by Landry, Kaeser, and Richards (1999). The second part examines the data collected from this study more closely.

Comparing Iowa and National Data

Compared to the most recent national data, this rural state is equally or less conservative regarding sexuality education (see Table 1). For example, compared to national data, Iowa school districts were more likely to have policies that portray contraception as effective in preventing pregnancy and STIs. Approximately 85% of Iowa districts reported presenting contraception in this context, compared to 65% nationally. Additionally, fewer Iowa districts seem to be highlighting contraception's ineffectiveness (14% compared to 35% nationally) (Landry et al., 1999). Nationally, the prevalence of district policy with regard to sexuality education is higher than in Iowa districts (68.8%: 51.2), suggesting that Iowa districts may give schools more autonomy. Neither the national data nor the data from this study indicate community opposition to sexuality curriculum in schools. However nationally there is more community support, whereas in Iowa the community is more silent. While the impact of state directives in influencing sexuality education is very similar nationally and in Iowa at just under 50%, school boards have more influence in Iowa.

Table 1

Comparison of Results from Landry et al.'s (1999) National Sample and Iowa Sample

	National Sample (n= 825)	Iowa Sample (n=131)
Source of Policy		
District-wide policy	68.8%	51.2%
Policy decisions made by schools or teachers	31.2%	48.8%
Presentation of abstinence in curriculum		
Abstinence is one option in a broader educational program to prepare adolescents to become sexually healthy adults.	14.4%	42.8%
Abstinence is the preferred option for adolescents; when contraception is discussed, it is presented as an effective means of providing protection against unintended pregnancy and STIs/HIV for sexually active individuals.	50.9%	42.8%
Abstinence is the only positive option outside of marriage; when contraception is discussed, its ineffectiveness in preventing pregnancy and STIs/HIV is highlighted. OR Abstinence is only option outside of marriage and all discussion of contraception is prohibited.	34.7% combined	14.3% combined
Community support for district's policy		
Strongly support	41.0%	25.0%
Generally silent	53.0%	73.4%
Divided	5.0%	1.6%
Generally opposed	<1%	0%
Most influential factors on the establishment of current policy		
State directives	48.2%	49.1%
Special advisory committee/Task Force	17.8%	9.4%
School board action	17.0%	28.3

Note. Comparisons were not made for all items in manuscript as results for all items were not reported for the national sample.

Sexuality Education Policies

Although the researchers anticipated that sexuality education policies might differ substantially between the more urban and more rural districts, few differences in policy were found in responses based on size of district. Thus, we discuss these results from the perspective of a rural state and do not differentiate between more and less rural areas within the state. In the two instances that a significant difference was found, differences will be indicated.

Slightly more than half of school superintendents (51.2%, n = 66) reported the presence of a district-wide sexuality education policy, while 48.8% (n = 63) reported leaving sexuality education policies up to individual schools or teachers. None of the school

districts reported a policy that prohibited teaching sexuality education. Significantly more large/urban school districts reported the presence of a district-wide sexuality education policy, while more small/rural districts reported leaving sexuality education policies up to individual schools or teachers ($X^2 = 6.15, p = .046$). Thirty-one percent (n = 41) of school districts reported teaching sexuality education in either 5th or 6th grades, 48.9% (n = 64) of school districts reported teaching sexuality education in 7th or 8th grades, and 49.6% (n = 65) school districts reported teaching sexuality education in high school (see Table 2). Of these, 24.4% (n = 34) of school districts reported teaching sexuality education

at all three levels and an additional 15.3% (n = 20) of school districts reported teaching sexuality education in both middle school and high school, but not the

elementary level. Eight districts reported delivering sexuality education in only one grade (5th grade = 2, 7th grade = 2, 8th grade = 2, 9th grade = 2).

Table 2

Number (and Percent) of Iowa Districts Teaching Sexuality Education at Each Grade Level

Grade	N (%)
5 th	30 (22.9%)
6 th	35 (26.7%)
7 th	48 (36.6%)
8 th	59 (45.0%)
9 th	57 (43.5%)
10 th	48 (36.6%)
11 th	41 (31.3%)
12 th	33 (25.2%)

Respondents were also asked to identify how abstinence is presented in the curriculum they deliver. The five options were:

1. *Abstinence is one option in a broader educational program to prepare adolescents to become sexually healthy adults.*

2. *Abstinence is the preferred option for adolescents.*
3. *When contraception is discussed, it is presented as an effective means of providing protection against unintended pregnancy and STIs/HIV for sexually active individuals.*
4. *Abstinence is the only positive option outside of marriage; when contraception is discussed, its ineffectiveness in preventing pregnancy and STIs/HIV is highlighted.*
5. *Abstinence is only option outside of marriage and all discussion of contraception is prohibited.*

Based on these descriptions, 85.6% of districts reported portraying contraception as effective in preventing pregnancy and the use of condoms in preventing STIs, while 14.3% highlighted contraception’s ineffectiveness or did not discuss contraception (see Table 3).

Table 3

Number (and Percent) of Iowa Districts Identifying How Abstinence is Presented in the District’s Curriculum

Abstinence is one option in a broader educational program to prepare adolescents to become sexually healthy adults.	33 (42.8%)
Abstinence is the preferred option for adolescents; when contraception is discussed, it is presented as an effective means of providing protection against unintended pregnancy and STIs/HIV for sexually active individuals.	33 (42.8%)
Abstinence is the only positive option outside of marriage; when contraception is discussed, its ineffectiveness in preventing pregnancy and STIs/HIV is highlighted.	10 (13.0%)
Abstinence is only option outside of marriage and all discussion of contraception is prohibited.	1 (1.3%)

Respondents were also asked to identify the most influential factor impacting the establishment of the current district policy. Nearly half of superintendents who responded to this item indicated state directives were the most important factor (49.1%, n = 26), 28.3% (n = 15) indicated school board action, 9.4% (n = 5) indicated a special school board advisory committee/task force recommendation, 9.4% (n = 5) indicated teachers’ or other school officials’ support for a broader sexuality education, and 3.8% (n = 2)

indicated teachers’ or other school officials’ support for a stricter abstinence education. None reported a formal complaint to the school board, litigation challenging the policy, organized community efforts in support of either stricter or broader sexuality education, federal abstinence-only funds, or CDC HIV prevention education funds as the most influential factor on policy change.

Twelve respondents (9.2%) indicated that their curriculum was currently under review due to

changes needed to comply with new state requirements to provide “research-based and medically accurate information”. One quarter of the respondents (25.2%, n = 33) reported their districts’ most recent policy had been adopted since 2000. However, 6.1% (n = 8) responded that their most recent policy was adopted in the 1990s. Three percent (n = 4) reported that their most recent policy adoption was in the 1980s and nearly a quarter did not know when their most recent sexuality education policy was adopted (23.7%, n = 31).

Opt-Out Policy

Of 107 respondents, 84.1% (n = 90) reported giving parents the option of removing their child from a sexuality education course or class; 2.8% (n = 3) reported requiring parents to give specific permission for their child to attend a sexuality course or class, and 10.3% (n = 11) reported not having a policy on this issue. For those students whose parents opt their children out of, or do not opt them into, the offered sexuality education course or class, 7.5% (n = 8) districts reported the students must attend an alternative course/class that is offered by the school that is directly related to sexuality education; 45.6% (n = 41) of districts reported students must complete coursework or a project related to health; 30.8% (n = 33) of districts reported students are not required to complete any health-related coursework or project, and 7.5% (n = 8) of districts reported ‘other’ requirements must be met.

Curriculum

Forty-eight (38.4%) school districts reported adopting a standardized curriculum on sexuality

education and 77 (61.6%) districts reported not using a standard curriculum. Of those districts who reported adopted a standardized curriculum, 45 reported use of an internally developed curriculum. However, many identified the use of standardized curricula within their internally developed curriculum. The most common standardized curriculums were *Reducing the Risk*, *Sex Respect*, and *Postponing Sexual Involvement*. Significantly more large/urban school districts reported the use of a standardized curriculum, ($X^2 = 16.50$, $p < .0001$).

Respondents were asked a series of questions specific to curriculum delivery including any topics prohibited from inclusion, use of outside experts for delivery, and whether or not students were divided by gender for delivery of curriculum. Respondents were first asked to identify whether or not teachers were prohibited from teaching or discussing certain topics. Most districts did not prohibit either teaching about or the discussion of condoms to prevent STIs/HIV, contraceptives, masturbation, homosexuality, or abortion. Some schools prohibited the teaching of these topics, but allowed the discussion of them, while others prohibited both teaching and discussion (see Table 4). Although there was a significant difference in the use of a standardized curriculum, there were no differences between urban and rural districts regarding inclusion or prohibition of teaching on specific topics. More than half of all districts (55.7%) allowed outside experts/educators to deliver their sexuality education curriculum. Although division of students by gender was more common at lower grade levels, one district still separated students by gender up to 11th grade (5th grade = 24, 6th grade = 14, 7th = 5, 8th = 3, and 11th grade = 1).

Table 4

Number of Iowa Districts that Allow/Prohibit Teaching and Discussion of Specific Topics in Sexuality Education

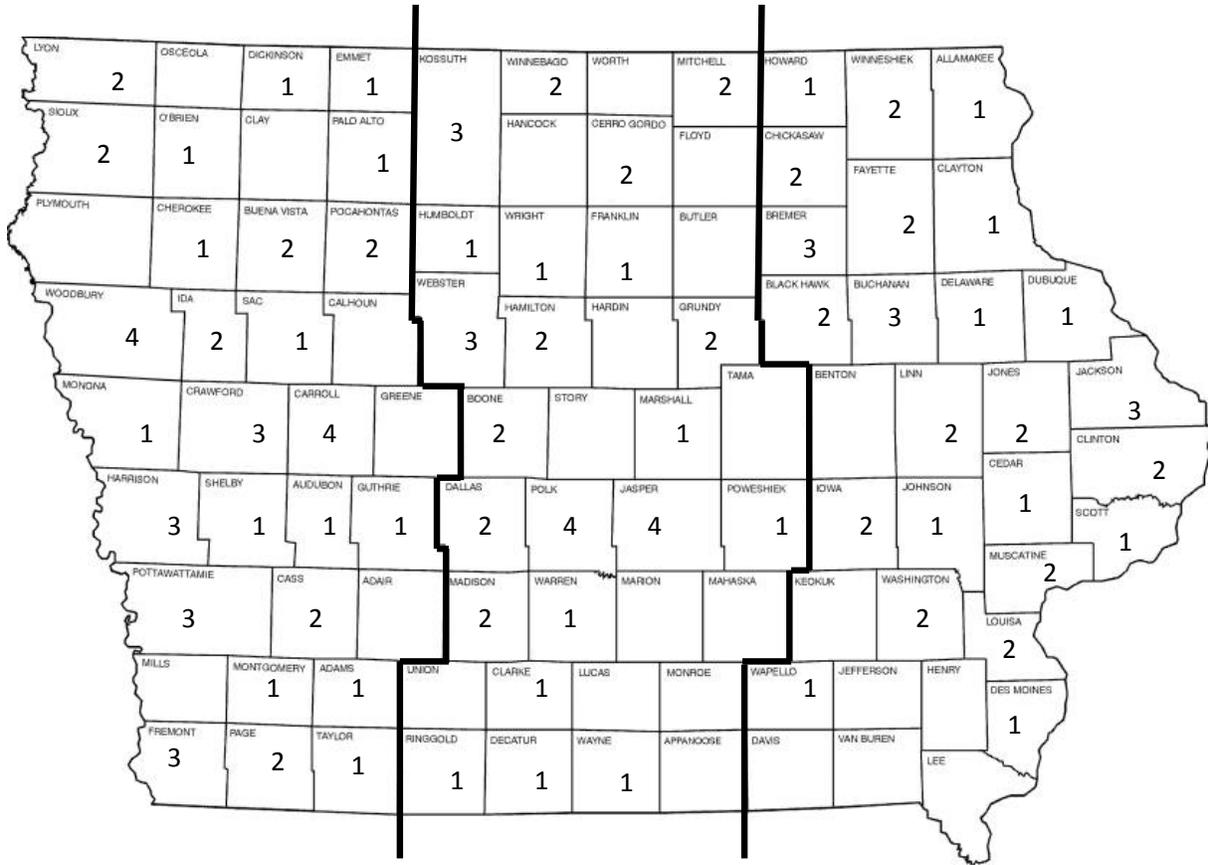
Topic	Allow #	Prohibit #	Prohibit in Grade level #									
			K-4	5	6	7	8	9	10	11	12	
Condoms to prevent STIs/HIV	77	15										
Teaching			9	10	7	4	6	3	3	3	3	
Discussing			3	3	2		1					
Contraceptives	77	14										
Teaching			9	11	7	5	8	3	3	3	3	
Discussing			3	4	2	2	2					
Masturbation	71	16										
Teaching			9	10	9	6	9	5	6	6	5	
Discussing			3	3			2		2	2	1	
Homosexuality	74	16										

Teaching			9	11	10	7	10	6	6	5	5
Discussing			2	3			2	1	1	1	1
Abortion	77	13									
Teaching			8	9	9	6	8	5	5	5	5
Discussing			2	2	2	2	1				

Community Support

Out of 128 responses to this item, 97.7% reported sexuality education was not raised as a major issue during recent school board elections (n = 123) and 2.3% reported they did not know (n = 3) if sexuality education was a major issue during recent elections. No districts reported that sexuality education was raised as a major issue during recent school board elections. Regarding the attitude of the

community at large about the districts' policies, 25% reported the community strongly supports the district's policy on sexuality education (n = 31), 1.6% reported the community is divided regarding the current policy (n = 2), and 73.4% reported the community is generally silent on this issue (n = 91) (see Figure 1). No districts reported that the community is generally opposed to the current policy.



Area of Iowa		
Western Iowa (n = 47)	Community is generally silent on this issue	78.7% (37/47)
	Community strongly supports current policy	21.3% (10/47)
	Community is divided regarding current policy	0% (0/47)
Central Iowa (n = 39)	Community is generally silent on this issue	61.5% (24/39)
	Community strongly supports current policy	33.3% (13/39)
	Community is divided regarding current policy	5.1% (2/39)
Eastern Iowa (n = 38)	Community is generally silent on this issue	78.9% (30/38)
	Community strongly supports current policy	21.1% (8/38)
	Community is divided regarding current policy	0% (0/38)

Figure 1. Location of respondents by county and perception of community attitude toward sexuality education

Discussion

While rural states may be characterized as more conservative than their urban counterparts, compared to the most recent national data, this rural state is equally or less conservative regarding sexuality education (see Table 1). For example, compared to national data, Iowa school districts were more likely to have policies that portray contraception as effective in preventing pregnancy and STIs.

Approximately 85% of districts reported presenting contraception in this context, compared to 65% nationally. Additionally, fewer Iowa schools seem to be highlighting contraception's ineffectiveness (14% compared to 35% nationally) (Landry et al., 1999). Additionally, within our rural state, while the population centers are often characterized as having more liberal views; we found no statistical difference in the policies, curriculum, or opposition encountered by the districts based on metropolitan status. The

differences found indicate a greater likelihood of the presence of a district wide policy regarding the teaching of sexuality education in large/urban districts as opposed to leaving the decisions to individual schools and teachers. Additionally, and most likely a reflection of the presence of a district wide policy, large/urban districts were more likely to adopt a specific curriculum for sexuality education. However, it is important to note that these two differences are not a reflection on the type of curriculum, but merely standardization, which would be necessary in larger districts to ensure a more uniform delivery across multiple school buildings and teachers as opposed to smaller rural districts with singular buildings and possibly singular teachers.

While there is often a public perception of a vocal and active opposition to sexuality education, this was not found to be true. No districts reported sexuality education being a major issue in the last school board election and no districts reported that the community was generally opposed to the current policy. In fact, teachers and other school officials were cited as influential factors in the establishment of current policy, but parents were never mentioned as the most influential factor. "Largely silent on this issue" is how most administrators described their community. This is consistent with the national finding that most parents want schools to be involved in sexuality education (Dailard, 2001). Interestingly, Orr (1982) reported that when parents were involved in the development of the sexuality education curriculum, a greater number of topics were included in the curriculum, especially the most controversial topics. This reinforces the notion that parents are more likely to be allies than enemies when it comes to the delivery of sexuality education in schools. However, the perception of opposition is quite powerful and affects what information is delivered in the classroom. Landry, Darroch, Singh, and Higgins (2003) reported that teachers who were concerned about the potential of adverse community reaction were almost twice as likely as other teachers to emphasize ineffectiveness of contraceptive methods or not to discuss preventive methods.

One point of concern raised by the findings is the number of districts (10.3%) with no policy regarding the notification of parents of sexuality education. Iowa has long had a parental notification law and opt-out policy. This type of notification is both appropriate and important to build trust with parents and to continue the lack of opposition sexuality education reportedly faces in this state.

The new state law's requirement for medically accurate and research-based materials may push more districts toward the adoption of standardized or

nationally-recognized curriculum. Most schools reported internally developed curriculum which may or may not reach this standard. However, the use of curriculum known to meet the standard would allow for easy identification and evaluation by the state Department of Education. In addition to standardized curriculum, it is possible that the new law may affect the current censorship on some topics. A medically accurate education would likely include discussion of contraception, condoms to prevent HIV and other STIs, masturbation, homosexuality, and abortion. While all of these topics must be approached in an age-appropriate manner, it is difficult to imagine a research-based medically accurate curriculum without the discussion of contraception or use of condoms to prevent HIV and other STIs.

In the near future, the new law may also alter districts' approaches to how curriculum is chosen. In almost half of all cases (48.8%), the policy regarding sexuality education is made at school or teacher levels, rather than at district level. This is lower than national data which estimates two-thirds of districts have district-wide policies (Landry, Kaeser, & Richards, 1999). This discrepancy may be due to the long history in Iowa of local control, even to the point of school-specific policy as opposed to a district-wide policy. However, state directives do seem to be important in the district decisions, as they were found to be the most influential factor in the district policies. Time will reveal if movement toward research-based means more decisions at the district-level and fewer at the school and teacher level. Additionally, as these data were collected soon after the passage of the law, they form a baseline for future comparison of how school districts may alter their policies in reaction to the law.

While this law is certainly a step in the right direction, an additional legal step that is needed is comment on the depth of coverage of specific health topics. There is currently no language within the Iowa Code identifying how this information should be covered, for how many minutes, or how many times. In fact, the law can be read to indicate that as long as human growth and development is addressed in one lesson plan, one time, between first and fifth grades, the state requirement is met. The authors also wonder, given the strong case against the effectiveness of abstinence-only education, how much longer it will be allowed to be delivered in a state requiring research-based sexuality education. A decade ago, the Consensus Panel on AIDS of the National Institutes of Health stated that the abstinence-only approach "places policy in direct conflict with science because it ignores overwhelming evidences that other programs are

effective” (National Institutes of Health, 2008, p. 15) in delaying initiation of intercourse among adolescents, in reducing the number of partners, and in increasing the use of condoms among those already sexually active. Perhaps clarification on how abstinence-only sexuality education fits within the research-based framework and recommendations for time allotted to sexuality education will be included in future legislation. However, the refusal of federal funding for abstinence-only education by Iowa’s Governor in 2008, soon after the adoption of the research-based and medically accurate sexuality education law (Waddington, 2008), is perhaps a signal of the State’s recognition of the incompatibility of abstinence-only education with the requirement that sexuality education be research-based and medically accurate. Furthermore, the appropriation of federal funding for abstinence-based education under President Obama’s Administration (Boonstra, 2010a) may lead to further movement away from abstinence-only education in states previously accepting Title V funds.

Conclusion

While the data reveal the status of sexuality education in Iowa schools, some limitations should be noted. First, the response rate was typical, but low enough to generate possible concerns about non-response bias. While the sample was representative geographically and by district size, results may not reflect the population as well as a larger sample may have. Second, as this study was a replication of a

previous national survey, few changes were made to allow comparison to the original survey. This restricted the ability of the research team to ask more specific questions about classroom practice. Also, these data reflect sexuality education policies as reported by the district superintendent (or designee), rather than what classroom teachers responsible for sexuality education report happening in the classroom. Thus these results pertain to district policy on sexuality education delivery rather than to actual classroom practice.

The status of sexuality education policies in Iowa is positive overall. It is encouraging that, compared to national data, school districts in this rural state are more likely to have policies that portray contraception as effective in preventing pregnancy and the role of condoms in helping protect against STIs. The lack of community opposition to sexuality education is also a cause for optimism. The new law continues to move Iowa in the right direction, protecting our youth and improving their opportunities for a healthy future. However, future legislation addressing time allotted, content, and depth of coverage would greatly improve the status of this state’s and all states’ sexuality education status. In the meantime, it is important for school leaders and those involved in sexuality education to recognize that the need for sexuality education is no less dire in rural areas than it is in urban areas and the curriculum and policy related to sexuality education need not be more conservative in rural areas than in urban counterparts.

References

- Barnett, J. E., & Hurst, C. S. (2003). Abstinence education of rural youth: An evaluation of Life’s Walk Program. *Journal of School Health, 73*(7), 264-268.
- Bennett, T., Skatrud, J. D., Guild, P., Loda, F., & Klerman, L. V. (1997). Rural adolescent pregnancy: A view from the South. *Family Planning Perspectives, 29*(6), 256-260.
- Boonstra, H. D. (2010a). *Lemonade from lemons: The Obama Administration’s plan for implementing the Title V abstinence education program*. Retrieved September 1, 2010, from <http://www.guttmacher.org.pubs/gpr/13/3/gpr130324.html>
- Boonstra, H. D. (2010b). *Sex education: Another big step forward and a step back*. Retrieved September 1, 2010, from <http://www.guttmacher.org.pubs/gpr/13/2/gpr130227.html>
- Crosby, R. A., Yarber, W. L., Ding, K., DiClemente, R. J., & Dodge, B. (2000). Rural and non-rural adolescents’ HIV/STD sexual risk behaviors: Comparisons from a national sample. *The Health Education Monograph Series, 18*(1), 45-50.
- Dailard, C. (2001). Sex education: Politicians, parents, teachers and teens. *The Guttmacher Report on Public Policy, 4*(1), 9–12.
- Darroch, J. E., Landry, D. J., & Singh, S. (2000). Changing emphases in sexuality education in U.S. public schools, 1988-1999. *Family Planning Perspectives 32*(5), 204-211.
- Eaton, D. K., Kann, L., Kinchen, S., Shanklin, S., Ross, J., et al. (2008). *Morbidity and Mortality Weekly Report, 57*(SS04), 1-131. Retrieved October 8, 2010, from

- <http://www.cdc.gov/mmwr/preview/mmwrhtml/ss5704a1.htm>
- Forrest, J. D., & Silverman, J. (1989). What public school teachers teach about preventing pregnancy, AIDS, and sexually transmitted diseases. *Family Planning Perspectives, 21*(2), 65-72.
- Garside, R., Ayres, R., Owen, M., Pearson, V. A. H., & Roizen, J. (2002). Anonymity and confidentiality: Rural teenagers' concerns when accessing sexual health services. *The Journal of Family Planning and Reproductive Health Care, 28*(1), 23-26.
- Henshaw, S. K. (2001). *U.S. teenage pregnancy statistics*. New York: Alan Guttmacher Institute.
- Howell, M. (2007). *The history of federal abstinence-only funding*. Retrieved September 1, 2010, from <http://www.advocatesforyouth.org/storage/advfy/documents/fshistoryabonly.pdf>
- Iowa Department of Education. (2008). *Certified enrollment*. Retrieved May 30, 2008, from <http://iowa.gov/educate/content/view/123/1355/>
- Jemmott, J. B., Jemmott, L. S., & Fong, G. T. (2010). Efficacy of a theory-based abstinence-only intervention over 24 months: A randomized controlled trial with young adolescents. *Archives of Pediatric and Adolescent Medicine, 164*(2), 152-159.
- The Kaiser Family Foundation. (2000). *Sex education in America: A view from inside the nation's classrooms*. Menlo Park, CA: The Henry J. Kaiser Family Foundation.
- Kirby, D. (2001). *Emerging answers: Research findings on programs to reduce teen pregnancy*. Washington, DC: National Campaign to Prevent Teen Pregnancy.
- Kirby, D. (2007). *Emerging research findings on programs to reduce teen pregnancy and sexually transmitted diseases*. Washington, DC: National Campaign to Prevent Teen and Unplanned Pregnancy.
- Kirby, D., Short, L., Collins, J., Rugg, D., Kolbe, L., Howard, M., Miller, B., Sonenstein, F., & Zabin, S. (1994). School-based programs to reduce sexual risk behaviors: A review of effectiveness. *Public Health Reports, 109*(3), 339-360.
- Kohler, P. K., Manhart, L. E., Lafferty, W. E. (2008). Abstinence-only and comprehensive sex education and the initiation of sexual activity and teen pregnancy. *Journal of Adolescent Health, 42*(4), 344-351.
- Landry, D. J., Darroch, J. E., Singh, S., & Higgins, J. (2003). Factors associated with the content of sex education in U.S. public secondary schools. *Perspectives on Sexual and Reproductive Health, 35*(6), 261-269.
- Landry, D. J., Kaeser, L., & Richards, C. L. (1999). Abstinence promotion and the provision of information about contraception in public school district sexuality education policies. *Family Planning Perspectives, 31*(6), 280-286.
- Levine, S. B., & Coupey, S. M. (2003). Adolescent substance use, sexual behavior, and metropolitan status: Is "urban" a risk factor? *Journal of Adolescent Health, 32*(5), 350-355.
- Lindberg, L., Ku, L., & Sonenstein, F. (2000). Adolescents' reports of reproductive health education, 1988 and 1995. *Family Planning Perspectives, 32*(5), 220-226.
- Manlove, J., Romano-Papillo, A., & Ikramullah, E. (2004). *Not yet: Programs to delay first sex among teens*. Washington, DC: National Campaign to Prevent Teen Pregnancy.
- Milhausen, R. R., Crosby, R., Yarber, W. L., DiClemente, R. J., Wingood, G. M., & Ding, K. (2003). Rural and nonrural African American high school students and STD/HIV sexual-risk behaviors. *American Journal of Health Behavior, 27*(4), 373-379.
- National Campaign to Prevent Teen Pregnancy. (2010). *Teen pregnancy rates in the United States, 1988-2006*. Retrieved October 8, 2010, from http://www.thenationalcampaign.org/resources/pdf/Briefly_TeenPregRates_1988-2006.pdf
- National Institutes of Health. (2008). *NIH Consensus Statement: Interventions to prevent HIV risk behaviors*. Retrieved May 24, 2010, from <http://consensus.nih.gov/1997/1997PreventHIVRisk104.pdf>
- Orr, M. T. (1982). Sex education and contraceptive education in U.S. public high schools. *Family Planning Perspectives, 14*(6), 304-313.
- Sexuality Information and Education Council of the United States (SIECUS). (2008a). *Sexuality education in the United States*. Retrieved April 15, 2010, from <http://www.siecus.org/siecusreport/volume29/29-6.pdf>
- Sexuality Information and Education Council of the United States (SIECUS). (2008b). *Sexuality education definitions*. Retrieved September 9, 2009, from <http://www.communityactionkit.org/index.cfm?pageId=886>
- State of Iowa Legislature. (2008). *House File 611-Enrolled*. Retrieved May 8, 2010, from <http://coolice.legis.state.ia.us/Legislation/82ndGA/enrolled/HF611.html>
- Waddington, L. (2008, March 6). Iowa 17th state to refuse federal ab-only funds. *RH Reality Check*. Retrieved July 23, 2010, from <http://www.rhrealitycheck.org/blog.2008/03/06/iowa-becomes-17th-state-to-refuse-federal-abstinence-only-sex-education-funds>
- Weinstock, H., Berman, S. & Cates, W. (2004). Sexually transmitted diseases among American youth: Incidence and prevalence estimates, 2000.

Perspectives on Sexual and Reproductive Health
36(1), 6-10.

Winstead-Fry, P., & Wheeler, E. (2001). *Rural women's health*. In S. Loue, & B.E. Quill (Eds.), *Handbook of rural health* (pp. 135-156). New York: Kluwer Academic/Plenum.

Yarber, W., & Torabi, M. (1997). Comprehensive sexuality education in Indiana secondary

schools: Instruction topics, importance ratings, and correlates with teacher traits. *American Journal of Health Studies*, 13(2), 65-74.

Yawn, B. P., & Yawn, R. A. (1993). Adolescent pregnancies in rural America: A review of the literature and strategies for primary prevention. *Family and Community Health*, 16(1), 36-45.

Dr. Susan Roberts-Dobie susan.dobie@uni.edu is Associate Professor of Health Promotion and Education and the University of Northern Iowa and is a researcher with the Iowa Initiative to Reduce Unintended Pregnancies.

Dr. Losch is Professor of Psychology and Assistant Director of the Center for Social and Behavioral Research at the University of Northern Iowa. She is also the Research Director of the Iowa Initiative to Reduce Unintended Pregnancies.

Danielle Vsetecka was previously a Graduate Research Assistant with the Center for Social and Behavioral Research at the University of Northern Iowa and is currently employed at the Brigham and Woman's Hospital in Boston.

Andrew Morse was previously a Research Assistant with the Center for Social and Behavioral Research at the University of Northern Iowa and is currently a graduate student at University of Tennessee-Knoxville.