Sexual Health in the Rio Grande Valley: A Description of Perceived Barriers from the Perspective of Youth Development Professionals

By

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Applied Research Project

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ABSTRACT

Purpose: The purpose of this research is to describe the perceived barriers to sex education program implementation in the Rio Grande Valley, from the perspective of youth development professionals. In 2009, there were approximately 4,476 births to female"s ages 15-19 years of age in the Rio Grande Valley (Texas Department of State Health Services, center for Health Statistics, 2011). The teen birth rates in the Rio Grande Valley are higher than the national average, as well as, the state average. However, less than two-thirds of Texas school districts have a sexual health education policy in place. Many Rio Grande Valley schools offer any type of sex education program at all. This research develops a conceptual framework based on four categories; parents, adolescent health providers, school administrators and school board members.

Methods: An electronic survey instrument was distributed to school districts and organizations in nine Rio Grande Valley cities. Responses were received from 65 participants. These responses were analyzed using simple descriptive statistics.

Findings: The findings suggest that, according to sex education professionals, parents have the greatest influence on whether or not a school offers sex education programs to students. Parents" lack of knowledge of sex education programs and this hinders the adoption of sex education programs in the Rio Grande Valley. Another important factor is fear of community opposition and the perception of the opposition to sex education programs in the community. In addition, this study finds that parents, adolescent health providers, school administrators and school board members do not communicate well on the issue.

About the Author

Crystal Starkey was born and raised in Jacksonville, Texas. She graduated with a Bachelor of Arts in Sociology and a minor in Philosophy from the University of Texas at Austin in 2005. Crystal will complete her Masters of Public Administration degree from Texas State University-San Marcos in May 2012. Crystal has invested her career in the area of youth development, with a focus on developing programmatic resources to enhance the effectiveness of policies and procedures surrounding youth programs. She currently works with the Department of State Health Services, monitoring state-wide adolescent health contractors, evaluating program initiatives and managing program media campaigns. Crystal is also a member of Pi Sigma Alpha, the National Political Science Honor Society.

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Chapter 1
Introduction

Introduction

In 2009, approximately 410,000 children were born to teen moms ages 15-19, in the United States (Centers for Disease Control and Prevention, 2012). Three in ten US, teen girls will become pregnant by the age of twenty (The National Campaign, 2011). Roughly 8.9 million Americans between the ages of 15-24 become infected with a sexually transmitted disease each year (Centers for Disease Control and Prevention, 2012). As one of the most powerful nations in the world, the United States lags far behind in developing effective policies for reducing teen pregnancy and sexually transmitted disease rates among youth.

With a teen birth rate of 42.1 per 1,000 girls aged 15-19, the United States has more births to teen moms than the Netherlands, Japan, France, Germany and Canada combined (Tortolero, 2011). One of the main contributors to this discrepancy in numbers of teen pregnancy among the developed nations is the lack of sex education being provided to youth in the United States (Tortolero, 2011). Sex education programs provide youth medically accurate information about sexually transmitted diseases, sexual intercourse and pregnancy, the programs also engage students in decision making skill building, increasing self-esteem, promotes goal setting and enhances communication skills (Kalmuss et al., 2003).

In the United Kingdom, where only four percent of births are to women 18 years or younger, there is national and local coordination on teen pregnancy reduction in addition to support of personal, social and health sex education programs (Baird and

Porter, 2011). These effective programs in the UK focus on peer education, teen emotions, self-esteem and informed decision making about sex (Baird and Porter, 2011). In addition, schools are encouraged to be active promoters of age appropriate sexual health education (Baird and Porter, 2011).

In the United States, sex education is a strongly debated political topic. In addition, there is little collaboration between federal, state and local governments to reduce teen pregnancy by increasing the availability of sex education to youth. Much of the responsibility for implementing sex education programs falls on local school board members, school administrators, adolescent health providers and parents (Peskin et al., 2011). Without federal direction, sex education programs vary wildly across the nation, resulting in a large discrepancy in the sexual health information youth are receiving. This information gap is important because research has found that a lack of sexual health information increases teenage pregnancy, sexually transmitted diseases among youth, poor school performance and poverty (Whitehead, 1994).

It is evident that increasing access to sex education programs for youth will reduce teen pregnancy and sexually transmitted diseases. However, in the US, in order for these programs to be adopted, collaboration between local school board members, school administrators, adolescent health providers and parents must occur in order. This collaboration contributes to long lasting, effective integrated sex education programs.

Sex Education in the United States

Sex education in the United States is tied to politics, morality and religion (Luker, 2006). Much of the debate among politicians on sex education involves the content included in sex education programs. Conservatives believe that sex education is better

left to parents or the church and that abstaining from sexual behavior is the only message that should be conveyed. Liberals advocate for fully integrated sex education programs in the schools, which discuss condom use and access to contraception. Continuous ideological debate on sex education limits the use and benefits of these programs.

The first school-based sex education programs emerged in the late 1800"s during urbanization. Youth were no longer working on the farm, but running the streets unsupervised instead. It was at this time that public officials began to take an interest in what was termed "morality education" (Comblatt, 2009). The National Education Association was the first to propose that morals based education be included within the school system (Holcomb, 2002). However, sex education of any kind failed to catch on, due to an uproar from the religious sector.

Due to the outbreak of syphilis among returning soldiers from World War I, the federal government first became involved in sexual health education. It was at this time, that sex education became linked to public health education. Though the federal monies were only allocated to sex education for soldiers, it prompted the 1919 report from the U.S. Department of Labor"s Children"s Bureau, which introduced the idea that adults could better benefit from sex education, if they received it at a younger age while in school (Comblatt, 2009). However, sex education programs failed to become integrated into the school day.

Throughout the 1920"s to the 1950"s sex education teacher training programs and curricula were being developed and implemented (Irvine, 2002). Yet, by the early 1970"s a religious movement against sex education diminished these efforts and sex education

lost its momentum (Luker, 2006). Political parties began using sex education as a platform, creating a barrier between sex education supporters and those in opposition.

When human immunodeficiency virus (HIV) emerged in the 1980‟s, a concern for the need of sex education grew. During this time, the federal government allocated millions of dollars to states, through the 1996 Personal Responsibility and Work Opportunity Reconciliation Act to develop abstinence sex education programs, which at the time seem to be the answer to educating youth on HIV and sexually transmitted diseases, while keeping morality education at its core (Hauser, 2012).

Due to a lack of collaboration, federal and state agencies fail to establish official requirements in the sexual health education of youth. With only 17 states implementing state-wide efforts to educate youth in sex education, it is critical that local sex education stakeholders become involved in the development of sex education programs (Alton, 2011).

Sex Education in Texas

Research surveying 825 United States school districts found that only two-thirds of school districts have a district-wide policy for sex education and thirty-one percent leave the decision up to each school principal (Landry et al., 1999). As Texas legislators gather to discuss adolescent health policies, sex education continues to be a concerning issue. Legislators usually derive at a consensus on whether Texas will provide abstinence-only, abstinence-plus or comprehensive sex education; however these decisions seldom have a direct impact on youth, as Texas does not require that sex education be taught in the schools (Alton, 2011).

In 1995, the 74th Texas Legislature passed Senate Bill 1, which for the first time amended the Texas Education Code to include state-wide sex education curriculum guidelines for Texas schools to follow (Texas Education Code, 1995). These guidelines can be found in *Table 1.1*. This appeared to be a step forward in a state-wide initiative to combat teen pregnancy. However, the failure to require sex education programs limited the progress of this effort. The new amendment to the Education Code continued to leave the decision of implementing integrated sex education programs and the content of the programs to the local school district and schools.

Since 1996, Texas has remained an abstinence-only sex education state, with roughly $500,000 of state general funds being allocated to sex education (Jamison, 2010). Sadly, Texas ranking 4th in the nation for birth rates to teen mothers and the funds appropriated to combat this issue does not provide for quality sex education for Texas youth. In 2010, the State of Texas received federal monies totaling $5 million dollars to provide direct sex education services and launch a state-wide sex education media campaign to reduce teen pregnancy (The Department of State Health Services, 2010).

Table 1.1
Texas Education Code Chapter 28, Section .004
Statutory requirements for sex education curriculum in Texas

- Must present abstinence from sexual activity as the preferred choice of behavior in relationship to all sexual activity for unmarried persons of school age;
- Must devote more attention to abstinence from sexual activity than to any other behavior;
- Must emphasize that abstinence from sexual activity, if used consistently and correctly, is the only method that is 100 percent effective in preventing pregnancy, sexually transmitted diseases, infection with human immunodeficiency virus or acquired immune deficiency syndrome, and the emotional trauma associated with adolescent sexual activity;
- Must direct adolescents to a standard of behavior in which abstinence from sexual activity before marriage is the most effective way to prevent pregnancy, sexually transmitted diseases, and infection with human immunodeficiency virus or acquired immune deficiency syndrome;
- Must teach contraception and condom use in terms of human use reality rates instead of theoretical laboratory rates, if instruction on contraception and condoms is included in curriculum content;
- A school district may not distribute condoms in connection with instruction relating to human sexuality.
- A school district that provides human sexuality instruction may separate students according to sex for instructional purposes.

As a direct result of the lack of state mandated integrated sex education programs in Texas, school board members, school administrators, adolescent health providers and parents at the local level often have the most influence on the sexual health education available (Wiley, 2011). Each stakeholder has different viewpoints on the type of sex education to be provided and the level of information that will be made available to the children. When considering each stakeholder‟s agenda in educating local youth of their sexual health, it is inevitable that conflicts arise over the controversial issue. And as these conflicts arise, as do barriers, often limiting the movement of sex education

implementation. With no state direction on sex education, local sex education advocates are left to battle the war alone.

Sex Education in the Rio Grande Valley

In 2009, the Texas Department of State Health Services (2010) identified 20 counties which had the highest numbers of births (exceeding 350) to women aged 15-19 and had a birth rate exceeding 45 per 1,000 births to women aged 15-19. The counties are identified in *Table 1.2*.

Table 1.2 Texas Counties with a Birth Rate that Exceeds 45 per 1,000 for Females Ages 15-19 and Have at a Least 350 births Within that County.

Counties	Number of births to females ages 15-19	Birth rate of females ages 15-19
Bell	651	71.9
Bexar	3,707	61.7
Brazoria	491	45
Cameron	1,383	79.8
Dallas	5,473	63.4
Ector	547	108.6
El Paso	2,308	75.6
Galveston	491	48.1
Harris	8,530	59.6
Hidalgo	2,739	76.9
Jefferson	498	56.5
Lubbock	704	66.3
McLennan	524	57.8
Midland	398	79.2
Nueces	780	67.7
Potter	429	104.9
Smith	408	56.1
Tarrant	3,379	51.7
Travis	1,564	51.1
Webb	999	93.9

From this data, El Paso county and Hidalgo county were identified as priority areas in reducing teen pregnancy numbers and increasing sex education accessibility, due to the counties lack of adolescent health services (Jamison, 2010).

The Rio Grande Valley is composed of four counties which include; Starr County, Hidalgo County, Willacy County and Cameron County. In 2009, there were approximately 4,476 births to females‟ ages 15-19 years of age in the Rio Grande Valley (Texas Department of State Health Services, center for Health Statistics, 2011). The Rio Grande Valley has a birth rate of approximately 80.4 births per 1000 females age 15-19 (Texas Department of State Health Services, center for Health Statistics, 2011). The need for sex education is critical in the Rio Grande Valley area, yet there are few sex education resources available to schools. Planned Parenthood, the Prevention Resource Center, Harlingen Department of State Health Services and the Valley AIDS are the only identified local providers of sexual health education material (Community Council of the Rio Grande Valley, 2012). Planned Parenthood is the only identified source for sexual health education presentations in the Rio Grande Valley (Community Council of the Rio Grande Valley, 2012). While roughly ninety percent of the Rio Grande Valley population is Hispanic, it cannot be assumed that this population is opposed to sex education (La Fe Policy Research and Education Center, 2012). Research shows that Hispanic parents overwhelmingly support integrated sex education programs and instruction on birth control, condoms and other types of protection against sexually transmitted infections and pregnancy (Constantine et al., 2007).

The implementation of integrated sex education programs in the Rio Grande Valley area is largely the responsibility of local school board members, school

administrators, adolescent health providers and parents. Limited knowledge of sex education programs, opposition to sex education community advocacy and strong personal attitudes towards sex education, have hindered the adoption of integrated sex education programs in the Rio Grande Valley schools.

Research Purpose

The purpose of this research is to describe the perceived barriers to sex education implementation in the Rio Grande Valley from the perspective of youth development professionals. Youth development professionals include any career directly involved in the mental, physical and emotional development of youth. By identifying the obstacles which prevent sex education in the Rio Grande Valley, strategies to overcome the barriers may become multi-faceted, to include all stakeholders in sex education such as, local government, local school districts, private industries, non-profit sectors and parents. Youth development professionals have careers in all employment sectors, which provide a more comprehensive vision of the sex education challenges in the Rio Grande Valley, as opposed to describing the barriers from a one dimensional viewpoint, such as parents, adolescent health providers, school administrators or school board members.

This research aims to discover the barriers to sex education program implementation in the Rio Grande Valley, to develop strategic plans for overcoming barriers and building collaborations among sex education stakeholders.

Description of the Chapters

This research is organized into five chapters. Chapter two discusses the scholarly literature regarding barriers to sex education program implementation in the United States. The literature is reviewed and the conceptual framework is developed connecting

the literature to descriptive categories. Chapter three discusses the research methodology used in this research, as well as, the statistical analysis and survey design. The conceptual framework is operationalized in Chapter three. Chapter four explains the survey results and data using descriptive statistics. Finally, chapter five provides a summary of the findings provides recommendations for strategies to overcome the barriers to implementing sex education programs in the Rio Grande Valley and gives recommendations for future research.

Chapter 2
Literature Review

Chapter Purpose

The purpose of this chapter is to provide an overview of the literature that focuses on perceived barriers that prevent sex education implementation in schools throughout the United States. The chapter first, identifies four primary stakeholders in sex education implementation and the categories of sex education barriers that befall effective sex education programming. The chapter then proceeds to discuss the specific barriers to implementing sex education programs, as they directly pertain to parents, adolescent health providers, administrators and school board members.

Conceptual Framework

Shields and Tajalli attribute successful Applied Research Projects to students‟ use of "intermediate theory or conceptual frameworks in the early stages of their papers." (Shields and Tajalli, 2006:313). The authors identify five types of conceptual frameworks, with are directly related to a research purpose (Shields and Tajalli, 2006).

The purpose of this research is to describe the perceived barriers to sex education implementation, from the perspective of youth development professionals. A review of sex education literature identified four primary stakeholders in the implementation of sex education programs; parents, adolescent health providers, which include those who have a direct role in sex education programming from non-profit organizations, state and local government departments and agencies, sex education instructors, school health professionals and adolescent health professionals, administrators, which include principals, superintendents, curriculum specialists and other educational specialists within

school districts and school board members. Each stakeholder has an unique role in perpetuating perceived barriers to sex education program knowledge, sex education community support and personal attitudes which all hinder sex education implementation. *Table 2.1* consists of the conceptual framework outlining the descriptive categories and the literature which supports each of these findings.

Table 2.1: Conceptual Framework

Categories	Supporting Literature
Parental Barriers to Sex Education Implementation	
Program Knowledge	Alexander, 1984; Bandura, 2004; Constantine et al., 2007; Croft and Asussmen, 1992; Donovan, 1998; Geasler et al., 1998; Ito et al., 2006; Lindau et al., 2008; Luker, 2006; Marsman and Herold, 1986; Russell et al., 2004; Scales and Kirby, 1983
Community Support	Alexander, 1984; Constantine et al., 2007; Donovan, 1998; Petty et al., 1997; Russell et al., 2004; Scales, 1981; Scales and Kirby, 1983; Tortolero et al., 2011; Zahne, 2006
Personal Attitudes	Alexander, 1984; Brown, 2009; Irvine, 2007; Luker, 2006; Marsman and Herold, 1986; Peskin et al., 2011; Sabia, 2006; Santelli et al., 2006; Scales, 1981; Scales and Kirby, 1983; Tortolero et al., 2011; Zelnick and Kim, 1982
Adolescent Health Providers Barriers to Sex Education Implementation	
Program Knowledge	Alexander, 1984; Alton, 2011; CSCU, 2011; Dailard, 2001; Darroch et al., 2000; Donovan, 1998; Evidence Based Practices and Curriculum, 2011; Halpert, 1969; Henry J. Kaiser Family Foundation, 2000; Kirby, 1989; Landry, 2003; Peskin et al., 2011; Scales, 1981; Scales and Kirby, 1983; Schultz and Boyd, 1984; Tortolero et al., 2011; Wiley, 2011; Wiley et al., 2011
Community Support	Alexander, 1984; Butterfoss, 1993; Donovan, 1998; Kirby, 1989; Landry et al., 1999; Scales and Kirby, 1983; Schultz and Boyd, 1984; Tortolero et al., 2011; Wiley, 2011
Personal Attitudes	Bleakley et al., 2006; Blinn-Pike et al., 2000; Bloch and Derryberry, 1971; Ito et al., 2006; Jemmot et al., 2010; Peskin et el., 2011; Petty et al., 1997; Scales and Kirby, 1981; Schultz and Boyd, 1984; Tortolero et al., 2011; Whitehead, 1994; Wiley, 2011; Wilson, 2000
Administrator‟s Barriers to Sex Education Implementation	

Table 2.1: Continued	
Program Knowledge	Alton, 2011; Bandura, 2006; Blinn-Pike, 2000; Bowden, 2003; Donovan, 1998; Fagen et al., 2010; Henry J. Kaiser FamilyFoundation, 2000; Kirby, 1989; Lindau et al., 2008; Peskin et al., 2011; Rose, 2005; Sabia, 2006; Scales, 1981; Scales and Kirby, 1983; Schultz and Boyd, 1984; Wiley, 2011
Community Support	Alexander, 1984; Alton, 2011; Blinn-Pike, 2000; Donovan, 1998; Giardino and Sanborn, 2011; Henry J. Kaiser Family Foundation, 2000; Irvine, 2007; Peskin et al., 2011; Scales and Kirby, 1983; Schultz and Boyd, 1984; Somerfield, 1970; Tortolero et al., 2011
Personal Attitudes	Allen et al., 1997; Dailard, 2011; Greenberg et al., 1983; Henry J. Kaiser Family Foundation, 2000; Irvine, 2002; Ito et al., 2006; Jemmot et al., 2010; Kalmuss et al., 2003; Kenny, 1987; Kirby, 1989; Klein, 2005; Koeske and Koeske, 1991; Markham et al., 2011; Peskin et al., 2011; Scales and Kirby, 1983; Tortolero et al., 2011
School Board Barriers to Sex Education Implementation	
Program Knowledge	Alton, 2011; Blinn-Pike, 2000; Croft and Asmussen, 1992; Donovan, 1998; Fagen et al., 2010; Henry J. Kaiser Family Foundation, 2002; Luker, 2006; Markham et al., 2011; National School Board Association, 2010; Peskin et al., 2011;
Community Support	Bock and Kim, 2002; Burdell, 1996; Crowson, 1998; Keith, 2008; Kuklinski and Quirk, 1998; Land, 2002; Lindevaldsen, 2011; Resnick, 2011; Sharp, 2002
Personal Attitudes	Argyris, 1991; Bandura, 2004; Bowden, 2003; Golden and Zajac, 2001; Henry J. Kaiser Family Foundation, 2000; Kuklinski and Quirk, 1998; Land, 2002; Luker, 2006; Merriam, 2011; Sharp, 2002; Tortolero et al., 2011; Wiley et al., 2011

Parental Barriers to Sex Education Implementation

Perception of parental opposition to integrated sex education programs is one of the greatest barriers to implementing effective programs (Scales and Kirby, 1983). Parent‟s belief that sex education undermines parental authority has been a central argument for sex education opposition groups since the 1960‟s (Scales, 1981). Yet, recent research has found that the majority of parents, almost one-hundred percent of those

involved in research studies, support some type of sex education (Constantine et al., 2007). In addition, a survey conducted in Houston, Texas, found ninety-three percent of the parents interviewed, supported that sex education should be a subject covered during the school day (Tortolero et al., 2011).

This discrepancy of information can be attributed to parental barriers that prevent sex education program knowledge, fail to engage in community support, and reflect personal attitudes rather than the whole population.

Program Knowledge

For parents to clearly communicate their desires for their children‟s sexual health education, they must first be aware of their own lack of sex education knowledge. Many parents are unaware that sex education programs encompass more than puberty, sex and condoms. Effective sex education includes medically accurate, scientific sexual health information, decision making skills, communication and refusal skills and personal responsibility (Lindau et al., 2008). Long passed are the days in which a simple "don‟t do it" is suffice.

Russell et al. (2004), stresses the need for parent education programs to help alleviate the perceived prejudice against sexual health programs and educate parents on what sex education programs actually encompass. Often parents associate sex education with controversial topics such as abortion and homosexuality, because they lack the program knowledge to understand that sex education covers medically accurate information and youth development skills to ensure behavior change, rather than just instruction of sex itself (Luker, 2006).

Constantine et al. (2007), provides a great example of this unawareness, when asking parents their opinion on abstinence-only education. Parents‟ reactions were strongly opposed to abstinence-only education because it does not teach children about STI‟s and pregnancy prevention (Constantine et al., 2007). The reality is that evidence based abstinence programs cover the top three subjects parents want addressed in sex education; the transmission and prevention of STI‟s and HIV, what to do if a sexual assault occurs and the basics of reproduction (Ito et al., 2006). Parents lack of knowledge about sex education programs have lead them to oppose and support sex education programs of which they have inaccurate information on.

Without awareness of their own lack of sex education knowledge, parents are not able to increase their knowledge of sex education, thus creating a fear of the sexual health information their children are being exposed to. This creates another parental barrier to sex education program knowledge, which is the perception that parents should be the provider of sex education to their children.

The perception that parents feel that it is their right to determine the sex education of their children, not the schools, is one of the most common barriers to sex education implementation. Alexander found in a 1978 survey of parents, that an "overwhelming ninety-five percent favored themselves to be most responsible for teaching sex education to their children" (1984:253). Some parents, who are opposed to integrated sex education programs, believe that children are not "creatures of the state….parents have a fundamental right to direct their child‟s educational upbringing" (Alexander, 1984:109).

However, as the need for sex education has become more evident, parents are beginning to recognize the need for sex education in schools. Research has shown that

parents feel they should have a role in the sex education of their youth, but the majority is not comfortable being the sole provider of this information, due to a lack of sex education knowledge (Marsman et al., 1986). In focus group sessions conducted by Croft and Asmussen (1992), parents expressed a desire for their children to learn sex education at school, and then they could supplement the information at home as needed, since many were afraid they would provide inaccurate information. This concept is also supported in a study conducted by Geasler et al., which found that "parents need and want guidance about how and when to discuss sexuality with their children", because many parents do not have the specific sex education knowledge to know what topics are appropriate to address at what ages (1995:188).

Though parents may feel the school plays a role in the development of sexual education programs, they also feel they, too as parents, should have a say in the sexual health information their children are exposed to, however many become conflicted as to what extent they should be involved. Though parents want to be in control of what of sex education information their children receive, many parents lack the knowledge to be the primary provider of sex education to their children. Intimidated by the scientific aspect of sexual health, parents remain uninvolved and unsupportive.

If parents are not knowledgeable about the content of sex education programs are, they find difficulty in surrendering control over their child‟s sexual health education to the schools, especially when they are not provided with the appropriate resources to educate them on sex education programs (Bandura, 2004). This leads to the last parental barrier to sex education program knowledge; parents lack of participation in sex education program selection.

The lack of parental inclusion in sex education program development is a severe barrier to implementing sex education programs because it prevents parents from obtaining the program knowledge needed to support sex education (Scales and Kirby, 1983). Limited communication between parents and schools has created a greater divide between parents and the sex education knowledge they need to support sex education programs. Geasler et al., suggests that developing sexuality education for parents is "recommended to facilitate parents" development as sexuality educators" (1995:188). When parents are excluded from sex education program selection and from expanding their knowledge of sex education, sex education programs have a lower success rate (Russell et al., 2004).

Ito et al. (2006) found that ninety-five percent of parents felt they should be involved in the development of sex education programs and eighty-one percent felt school administrators should also have a role. A study completed in 2001, found that in order for sex education programs to be effective, they must involve parents and family in program efforts (Russell et al., 2005). Russell et al. continues to explain that when "parents understand and share the goals of the program, fewer conflicts arise" (2005:145). By failing to include parents in sex education program development, they will continue to lack sex education program knowledge, which will further perpetuate a lack of parental inclusion in sex education implementation.

Essentially by including parents in the development of sex education programs, they are increasing their knowledge of sex education and are able to make informed decisions regarding support of sex education programs, but they are in a sense retaining control over the sexual health information their children are being exposed to.

When parents are involved in sex education programs and become familiar with the language and content involved, they are much more likely to be in support of the program (Donovan, 1998). By not being engaged in the process of sex education curricula selection and learning more about sex education programs, it is difficult for parents to make an educated decision on whether they support sex education.

A lack of parental participation in sex education program development combined with their own lack of knowledge in the expertise of sex education programs increases the likelihood of parents being unsupportive of sex education programs.

Community Support

With ninety-three percent of parents surveyed in Houston, Texas supporting school based sex education in schools and only seven percent opposing it (Tortolero et al., 2011), common sense would imply that school board meetings, parent-teacher association meetings and the general community should be filled with vivid support of sex education for youth. However, the reality is the opposition.

Though parents may support sex education, they are unaware of the need to publicly advocate for sex education programs (Scales and Kirby, 1983). Parents assume if they are not fighting sex education programming, then it will be taught in the schools. However, community support of sex education is needed to counterbalance the sexual health education opposition. Research suggests "messages that use negatively framed arguments were more effective than messages that use positively framed arguments" (Petty et al., 1997:629). Findings of this nature make it critical that positive sex education information and support of sex education is vividly seen by the community, to

fight community opposition. This lack of awareness for the need of community advocacy supporting sex education is a crucial barrier in sex education implementation.

As Russell et al., reported, "[sex education] interventions need to move from being expert-led to community-led" (2004:147). One of the most powerful players in the sex education field are parents, yet without the awareness of the need for community advocacy for sexual health education, parents cannot join the effort that has for many years been monopolized by opposition groups.

Of those parents that are aware of a need for community based sex education advocacy, the strength of opposition groups often diminishes their desires to exhibit community support for sex education. Those parents who oppose sex education typically engage in organized advocacy and are vocal about their opposition (Alexander, 1984). Sex education opposition groups" strong activism combined with the lack of voices supporting sex education enable opposition groups to gather greater audiences at faster rates, creating a misperception of their actual strength. This misperception of the strength of sex education opposition groups is directly due to a lack of community support of sex education. As Donovan reports, "since 1990"s sex education opponents have brought increasing pressure on school officials and teachers" in addition, these groups have refocused their efforts to target local school boards and even state legislatures (1998:189). Though in sheer numbers, parents supporting sex education far exceed those who oppose, it is the vivid activism of parents who oppose that garner attention, because of the lack of parents in the community actively supporting sex education. This attention to sex education opposition groups is then misperceived as strength, creating a barrier for those who support sex education.

The only way to dispel this misperception of the strength of sex education opposition groups is for parents to actively engage in community support of sex education programs. However, a combination of the lack of awareness for the need of community support and the perceived strength of sex education opposition groups, have created a third barrier to community support for sex education; the lack of organized and vocal supporting parents (Donovan, 1998).

Scales (1981) reports that sex education opposition groups have utilized community organization and activism since the 1960ʺs. A review of major barriers to sex education in the 1960ʺs, found that most administrators have been more influenced by opposition groups, than by those in support (Scales, 1981). Opposition groups typically used tactics such as, name-calling, guilt and manipulation of research to advocate their point of view (Scales, 1981). Unfortunately, not much has changed in the past seventy years. Sex education opposition groups are still organized and vocal, whereas sex education supporting groups are just beginning to recognize the need for advocacy.

Etizoni states that "too often the dominant interests are not those of major segments of the population [but of] groups that represent narrow, self-serving goals (Zahne, 2006:1). This is representative of what is happening with sex education. Constantine et al. found that ninety-one percent of parents surveyed felt that “sex education should be a part of the school day curriculum” yet this small nine percent has a greater presence among the community, due to the lack of sex education supporters advocating their support in the community (2007:168).

It is the lack of organization among the parents that support sex education which hinders community support and advocacy for sex education from occurring. If the public

is not seeing parental support of sex education, the inaccurate beliefs and judgments against sex education in schools will continue to breed, further intensifying the existing barriers.

Personal Attitudes

In a study conducted by Scales and Kirby, researchers found that the top two perceived barriers to sex education program implementation in the category of "Community Beliefs about Sex Education and Sexual Behavior" are the misperception that sex education causes sexual engagement and that by teaching sex education, one is essentially teaching sexual techniques (1983:322). Though this survey was conducted nearly thirty years ago, parents" personal attitudes towards sex education create severe barriers to sex education implementation.

Zelnick and Kim (1982) conducted an evaluation of available data on youth participating in sex education, and found that there is no direct relationship between having participated in a sex education course and the initiation of sexual intercourse. Sabia (2006) used data gathered from the National Longitudinal Study of Adolescent Health, which focused on seventh, eighth and ninth graders in 1994-1995, to conduct an analysis determining the relationship between sex education and adverse health outcomes for adolescents. Sabia concluded that "the results of this study suggest little evidence that school-based sex education has measurable adverse health effects for teens" (2006:799).

Research proves that an overwhelming number of parents support sex education, so how do these negative personal attitude towards sex education prevail? As discussed earlier, sex education opposition groups have been active since the 1960"s, using what Irvine refers to as "sex panics"; "the concern over the expansion of power through

institutional mechanisms of regulation" as it relates to sexuality (2007:4). Luker (2006), discusses in her book, *When Sex Goes to School*, the impact personal attitudes of parents towards sex education can have on the actual implementation of sex education programs, especially when it comes to small towns. Because parents in small communities are generally acquainted, personal attitudes towards sex education tend to be similar towards sex education; with can prevent sex education implementation. Luker (2006) found this to be especially true when it came to connecting sexual health education to personal values or morals. While parents in general believe that sexual health information should be provided to youth, it is the fear of the content involved in sex education programs that concerns parents, due to their personal attitudes towards certain topics.

Marsman and Herold (1986) mention that while most research focuses on whether or not parents support sex education, it is actually an issue over what topics should be taught. Controversial topics such as abortion, counseling pregnant youth and contraception use are areas that can cause parental concern (Scales and Kirby, 1983).Comprehensive sex education includes topics of contraception and abortion, whereas abstinence sex education approaches the subject in terms of abstaining from sexual engagement until one is prepared for the consequences. While these programs do talk about condom use, it is in reference to the effectiveness in preventing sexually transmitted diseases (Santelli et al., 2006). Parents may support sex education, yet it is a perceived notion that parent"s personal attitudes are not supportive of do teachers providing information on how to use a condom, on masturbation or abortion (Alexander, 1984).

A study conducted of parents of seventh, eighth and ninth graders found that thirteen percent of the parents opposed discussion of masturbation and only nine percent did not agree with any discussions on abortion (Alexander, 1984). A more recent study of 1,201 parents in Houston, Texas, found that only eight percent felt that condom use and contraception should not be discussed (Tortolero, 2011). Parents personal attitudes towards certain sex education topics leads to a fear of sex education programs and the content they cover. While parents may oppose specific sexual content from being discussed, it is the values associated with the content that causes alarm.

Concern over the values associated with sex education program content is a major parental barrier in sex education implementation. Sex education is a controversial topic because it lingers on the line of being a moralistic issue rather than an educational one. Brown reports that when "a school advocates a message that conflicts with a parent"s message; it undermines that parent"s ability to direct their child"s upbringing" (2009:135).

Parents lack of knowledge on sexual education programs, leads them to depend heavily on their personal attitudes towards sex education. Since many equate sex education with morality, parents become concerned over the values their children are exposed to in sex education programs. The truth is that evidence-based sex education programs provide medically accurate and scientifically based information when it comes to the actual content on sex (Peskin et al., 2011). In addition, research has found positive values related to sex education, such as, self-esteem and communication and assertiveness (Scales, 1981). However, as parents continue to experience a lack of knowledge of sex education programs, parents" personal attitudes towards sex education

will continue to be the driving factor in their decisions to support or oppose sex education, as opposed to their knowledge on the needs of sex education and the content covered with youth.

Adolescent Health Providers Barriers to Sex Education Implementation

Though parents play one of the largest roles in implementation of sex education programs, they do not carry the entire burden. Adolescent health providers have a role in educating the public on the benefits of sex education, just as much as parents have a responsibility to ensure their children are receiving adequate sex health information. However, lack of sex education knowledge, failure to engage in community support and adolescent health providers own personal attitudes toward sex education create barriers to sex education implementation.

Program Knowledge

Prior to program development and implementation, it is critical for adolescent health providers to feel they have the support of their environment (school, organization and students‟ parents) to ensure that when opposition arrives, adolescent health providers are not fighting alone. Adolescent health providers are believed to be the most critical factor in sex education; yet when they fail receive support from peers and superiors it has detrimental effect on a sex education instructor‟s ability to perform (Schultz and Boyd, 1984).

A study conducted by Scales and Kirby (1983), found that a perceived lack of commitment to sex education is one of the greatest barrier to sex education. Much of this lack of support comes from teachers, administrators or parents who lack knowledge in sexual health education (Schultz and Boyd, 1984). And while adolescent health

providers are the most knowledgeable in the delivery of sex education, failing to educate the public on sex education programs, hinders public support for sex education. Without perceived sex education support, adolescent health providers are not able to effectively teach youth about sexual health (Kirby, 1989).

Peskin et al. (2011), conducted a study of 604 professional school staff, administrators included, which found that only one-third of the staff felt administrators supported sexual health education. This same study found only thirty-six percent of middle school teachers reported feeling they had the support of parents to implement sexual health education (Peskin et al., 2011). In addition, Landry (2003) reported that sex education instructors who perceived low support of sex education were less likely to teach about controversial topics and were more inclined to "highlight their failure rates", thus condemning sex education as ineffective (Peskin et al., 2011:28). Due to a lack of sex education knowledge among those not involved in sex education, adolescent health providers experience feelings of disapproval among their professional peers and feel a sense of fear in being able to effectively do their jobs (Donovan, 1998).

Halpert (1969) discusses the necessity in increasing knowledge on issues to gain public understanding and favorable attitudes in order to provide optimal services for vulnerable populations. Adolescent health providers" failure to educate their fellow professionals on sex education programs enables the perception of a lack of support to prevail, limiting adolescent health providers" ability to educate the students (Schultz and Boyd, 1984).

Though a majority of adolescent health providers agree that sex education should include comprehensive information (Landry, 2003), the inclusion of controversial sex

education information, is a perceived barrier that hinders the implementation of sex education programs. However, this barrier is largely due to the lack of knowledge among adolescent health providers on district sex education policies (Scales and Kirby, 1983).

Research conducted by the Henry J. Kaiser Family Foundation, shows that not only do parents support sex education, but they believe it should also "prepare children to use birth control and practice safe sex" (2000:30). Yet, there is "a large gap between what teachers think should be taught and what they actually teach" (Dailard, 2001:9).

A large part of this is due to limitations placed on adolescent health providers by school administrators and school boards, however some of the discrepancy between what sex education topics should be taught in classrooms and what actually is, comes from adolescent health providers' lack of sex education policy knowledge. Peskin et al. (2011), report that only seventy-three percent of 604 school professionals interviewed were aware of a school districts policy towards sexual health education.

Research conducted by Darroch et al. (2000), shows that while approximately eighty-one percent of teachers believe condom use should be taught, only roughly fifty-three percent actually instruct on the topic. Dailard found that teachers may avoid sensitive topics, even if they have permission to discuss them, out of "fear of adverse community reaction" (Dailard, 2001:11). Due to adolescent health providers' lack of knowledge of sex education policy for the schools, they ignore controversial topics or fail to address the topics as they arise during sex education class time (Donovan, 1998). Landry et al. found that "teaching in a school without a district or school level sex education policy" had a positive relationship to what sex education topics were discussed during sex education programs (2003:265). This positive relationship is largely due to the

perception of adolescent health providers that inclusion of controversial information hinders sex education implementation (Scales and Kirby, 1983).

Due to adolescent health providers lack of knowledge about what topics they can and cannot discuss during sex education programs, adolescent health providers run the risk of providing inaccurate, incomplete or misguided education to youth. Among the sex education world, there is a perception that sex education curricula often contains no scientific basis to its content and provides inaccurate information on condom use, sexually transmitted diseases or pregnancy rates (Scales, 1981). Many adolescent health providers utilize the available sex education curricula tools, there is a continued failure to utilize sex education evidence-based curricula, due to a lack of knowledge of evidence-based sex education programs available (Wiley, 2011).

An evidence-based curriculum is defined as curriculum that has been through a "rigorous research, demonstrated success, undergone an evaluation procedure which has been published in a peer reviewed journal" (Evidence Based Practices and Curriculum, 2011). The Texas Department of State Health Services offered a selection of 12 evidence-based abstinence only sex education curricula"s in their FY 2010 request for Proposal (CSCU, 2011). By using evidence-based sex education curricula, adolescent health providers have scientific data supporting the information they are providing and prevent the occurrence of providing youth with misguided information (Tortolero et al., 2011).

Alexander (1984) reports one of the prejudices against sex education programs stems from content being taught inappropriately for the age of the students. A report from the Texas Freedom Network found that "some Texas classrooms mix religious

instruction into sexuality programs" (Wiley et al., 2009:39). Tortolero et al. report that "forty-one percent of school districts used sex education materials that contained factual errors about condoms and STI's" (2011:6). Instances similar to this finding can be eliminated by only using evidence-based sex education. As adolescent health providers' continue to lack of awareness of evidence-based programs, medically inaccurate and controversial curricula continue to be used for sex education programs. When using evidence based sex education curriculum, the program includes materials and scripts on exactly what should be said to the students, in what order and at what ages. This protects the instructors and provides a sense of security for parents.

Due to many adolescent health providers lack of knowledge regarding evidence-based curricula for sex education, Alton (2011) stresses that advocating for evidence-based sex education as one of the three critical areas of need for implementing effective sex education in Texas.

While program knowledge is a key responsibility for adolescent health providers, they also have a large role in community advocacy for sex education programs. These are the instructors, after school staff and sex education teachers that work side by side the students, observing the students' needs and desire for this information, yet without their visual support the success of sex education programs is impossible.

Community Support

It is critical when implementing sex education programs, to build relationships with other organizations, agencies, departments and individuals who share a vested interest in the sexual health of students, to instill a stronger force of community support for sex education.

Kirby reports that "[sex education] programs may be more effective if they incorporate community-wide strategies that are both multi-faceted and mutually reinforcing" (1989:170). In a report on the sexual education movement California has recently experienced, one of the key lessons Texas should learn from California is the need for public-private partnerships to increase funding and support for sex education programs (Tortolero et al., 2011).

Adolescent health providers that have the capacity to build institutional relationships among providers of sex education to combat against community opposition to sex education, however they often fail to formalize any of these relationships. Evidence supports that effective sex education programs must develop partnerships with other organizations to increase community support of sex education and raise awareness to policymakers, yet this is not happening in Texas (Tortolero et al., 2011 and Wiley, 2011).

In order for sex education programs to be effectively implemented, adolescent health providers must overcome their failure to formalize relationships with community organization to increase public support of sex education programs and to combat against community opposition.

Scales and Kirby (1983) note one of the greatest barriers to sex education programs in a factor analysis research is the lack of sex education coalitions in the community. Coalitions are "an organization of individuals representing diverse organizations…who agree to work together in order to achieve a common goal" (Butterfoss et al., 1993:316). By establishing these coalitions, the groups can provide

visual sex education advocacy in the community and combat against community opposition to sex education.

Prior to establishing sex education coalitions, sex education stakeholders, partners and leadership must first be identified, and then a strategic plan for the group must be developed. The lack of ability for adolescent health providers to build partnerships with other sex education supporters greatly inhibits their ability to organize effective sex education coalitions to publicly advocate for sex education programs. If coalitions are not being formed, the organized advocacy for sex education in the community is not taking place at the level of sex education opposition groups, thus allowing sex education opposition groups to continue to gain recognition.

The development of organized, advocacy is one of the advantages opposition groups have over those supporting sex education programs (Donovan, 1998). A survey conducted in 825 United States school districts, reported that three-quarters of superintendents reported that tasks forces or advisory committees were one of the three most important factors influencing their current sex education policy (Landry et al., 1999). However, adolescent health providers‟ lack of ability to formalize sex education coalitions creates a severe barrier to sex education program implementation.

It is only natural that adolescent health providers have a vested interested in promoting community advocacy for sex education programs, however it has been reported that a lack of visual support of sex education programs, hinders professionals abilities to generate the needed support for sex education to combat community opposition (Schultz and Boys, 1984).

Studies report a large number of sex education supporters among parents, teachers and youth development workers, but there is a continued lack of visible sex education support in communities (Alexander, 1984, Tortolero et al., 2011 and Scales and Kirby, 1981). It is a responsibility of adolescent health providers to overcome the barrier of community opposition and lack of visual community support of sex education programs by engaging in relationship and coalition building with other supporting community organizations (Butterfoss et al., 1993). To do this effectively, adolescent health providers often have to put aside their own personal attitudes towards sex education to better reach the goal of increasing community support of sex education.

Personal Attitudes

Sex education supporters want to see youth receiving the education needed to make healthy choices for themselves, yet adolescent health providers‟ personal attitudes towards sex education implementation can often be a barrier to getting the appropriate information to students. Petty et al. (1997), report that according to Roese and Olson (1994), a relationship between the importance of an attitude and the mere number of times a person expresses the attitude. This means that as one continues to vocalize a personal attitude, the more important that attitude is perceived to be. This is why it is crucial that adolescent health providers keep their personal attitudes towards sex education separate from the sexual health information they provide youth.

Exhaustive amounts of research support both evidence based abstinence-only and comprehensive education, yet there still continues to be a strong bias against abstinence education among adolescent health providers. This personal bias towards sex education material is a major barrier for sex education program implementation.

With approximately ninety-six percent of Texas school districts implementing abstinence-only curricula, adolescent health providers risk failure when attempting to implement comprehensive education (Tortolero et al., 2011). Though research confirms that parents and educators overwhelmingly support comprehensive education over abstinence-only education, yet roughly $104 million were spent in 2005 on abstinence only programs (Bleakley et al., 2006). According to three articles in Family Planning Perspectives, sixty percent of the public believe abstinence programs are unrealistic, yet research has found that using evidence based abstinence programs are proven to be effective in reducing teen pregnancy and increasing sexual health knowledge among youth (Wilson, 2000; Jemmot et al., 2010). In fact, both abstinence and comprehensive sex education programs have been proven ineffective when not evidence-based (Whitehead, 1994).

Dr. Wiley (2011) suggests, instead of focusing on whether a program provides comprehensive or abstinence-only information, the concern should be on whether evidence-based practices are being utilized, thus requiring adolescent health providers to put their personal attitudes towards sex education aside when it comes to instructing the youth. If a curriculum has been peer-reviewed and empirical evidence proves its effectiveness, then it should be supported (Wiley, 2011).

When adolescent health providers allow their personal attitudes towards particular sex education programs, they are creating a barrier to implementing any type of sexual health education. Both abstinence and comprehensive sex education programs can be effective and provide some factual sex education information that otherwise youth would not receive (Bleakly et al., 2006; Ito et al., 2006 and Tortolero et al, 2011). However, if

adolescent health providers allow their personal attitudes to influence sex education curricula selection, they risk alienating supporting organizations and schools.

When adolescent health providers allow their personal attitudes narrow their focus to implementing sex education in the school as the only avenue, they create another barrier preventing sex education implementation (Scales and Kirby, 1981). While the ideal location for sex education programs is in the schools, during the school day, after school programs, enrichment classes, health programs, churches and youth development programs are all great environments for provide sex education. Though schools should be the main arena for sex education, when adolescent health providers ignore external sex education providers, they allow their personal attitudes to interfere in providing sex education information to the public. When adolescent health providers become fixated on winning administrators and school boards support, they miss the opportunity to implement the program in welcoming places.

Planned Parenthood Affiliates, National Youth Organizations, Local Youth Organizations, School District Clubs, Religious Organizations, State and Local Government Departments and Hospital Programs have all been proven to provide effective sex education programs to youth (Scales and Kirby, 1981). Not only are these entities welcoming sex education programs, they often have less administrative requirements to overcome in order to implement the programs. Scales and Kirby, report that "evidence of organization opposition to non-school [sex education] efforts is rare." (1981:244). With the youth choosing to participate at will, this typically means the parents of the youth support sex education, since a waiver has to be completed by a parent before youth can receive sex education (Blinn-Pike et al., 2000). This provides a

great opportunity for adolescent health providers to begin creating organizational relationships, in order to develop a coalition providing visual community support of sex education. Adolescent health providers‟ perceptions of schools being the only avenue for sex education creates a barrier to sex education implementation because it allows for personal attitudes towards sex education to be determining factor in sex education program site locations rather than on the organizations capacity to get sexual health information out to the youth

While adolescent health providers may support sex education implementation in schools or community organizations, the personal attitude that the community does not support sex education creates a barrier to program implementation.

Fearing opposition to their programs, adolescent health providers may omit certain schools, school districts or organizations. In addition, when professionals perceive negative support from others, they may neglect to implement programs at these locations (Peskin et al., 2011). Often times, a school or organization may very well support sex education, but due to an outside influence or a recent event, will have to pass on the program (Bloch and Derryberry, 1971). This occurrence can lead to adolescent health providers‟ personal attitudes to be perceived as unsupportive of sex education, and thus not be willing to consider them a partner in the initiative to bring sex education to youth.

Blinn-Pike et al. (2000), found that adolescent health providers often fail to attempt sex education instruction for fear school administrators will not support them. Schultz and Boyd (1984) found similar results from a study conducted with sex education instructors. However, Peskin et al. found that of the 120 administrators surveyed more than one-third reported “support of sex education programs and instruction of condom

use" (2011:28). Yet only one-third of the rest of the staff surveyed felt administration supported sex education instruction (Peskin et al., 2011). It is critical that adolescent health providers not allow fear of a perceived lack of sex education support intervene with their job of providing sex education to the public. If assumptions continue to prevail, the barrier, of adolescent health providers" perceived notion of a lack of community support will ultimately prevent the movement of sex education implementation from occurring.

School Administrator Barriers to Sex Education

Blinn-Pike et al. (2000), illustrate that school administrators have the ultimate say in whether a sex education program is implemented. The first step in developing a sex education program needs to include the approval of key administrators. However, school administrator barriers such as, lack of program knowledge, community opposition and personal attitudes often prevent school administrator support of sex education from occurring.

Program Knowledge

School administrators must recognize the need for integrated sex education programs, yet most are unaware of what this would entail. Sex education cannot be adequately covered in one or two class sessions. Rather, sex education needs to be addressed as an on-going learning objective, much like traditional courses. Schools play an important role in health education because of the accessibility to children and the atmosphere encourages self-management skills (Bandura, 2004).

Only five percent of schools cover sex education for a semester or longer (Henry J. Kaiser Family Foundation, 2000). As Kirby (1989) reports, for sex education

programs to be effective, they must do more than increase sexual health knowledge. Sex education programs should "improve decision-making skills, communication skills, increase their motivation to delay sex and reduce risk-taking behaviors" (Kirby, 1989:169). To improve these skills among youth, more time must be allocated to sex education. However, for this to happen, school administrators must be knowledgeable about the need for integrated sex education.

If school administrators" lack knowledge of the need for integrated sex education, they cannot provide staff with clear expectations for the programs. The most effective sex education programs are those with specific and clear goals (Sabia, 2006). Since so few districts adopt sex education policies, it is critical that school administrators provide leadership for how that program should be implemented (Rose, 2005).

Lack of knowledge among school administrators about the need for sex education to be integrated into the school day, limits effective implementation of sex education curricula, sue to the lack of school administrators participation in program development (Blinn-Pike, 2000). In one case, the principal made it clear that the program should not be "made visible to him and to refer to the class as youth development" even though he supported the curricula (Blinn-Pike, 2000). This sends mixed signals to adolescent health providers in regards to whether they are receiving the support of their administrators and inhibits school administrators from becoming educated in the need for integrated sex education programs.

When school administrators lack the knowledge for the need of integrated sex education programs, they fail to provide the leadership and support to adolescent health providers. In order for sex education programming to be implemented successfully, a

team composed of teachers, youth development professionals, parents, school administrators, community members and other sex education supporters must join to develop the plans, goals and timeline for program implementation (Wiley, 2011). The leadership for developing and organizing sex education strategic planning committees should come from the administrators, however due to school administrator"s lack of knowledge in the need for integrated sex education, they fail to provide the leadership for sex education planning sessions (Scales and Kirby, 1983).

Schultz and Boyd report that a "step-by-step strategy for sex education programs needs to be developed" in order for programs to be successful (1984:540). By failing to provide leadership for sex education planning, school administrators" create a barrier to sex education implementation.

Due to a lack of knowledge of the need for integrated sex education programs, school administrators often fail to allocate adequate resources to sex education programs, such as training, supplies and staff (Scales and Kirby, 1983 and Peskin et al., 2011). For any type of education program to have an impact of youth behavior, the school must provide adequate "personnel, incentives, resources and operational control" (Bandura, 2004:158).

The availability of sex education resources, have an influence on the sex education topics sex education instructors will cover and to the extent of their medical accuracy (Lindau et al., 2008). Fagen et al. (2010), report similar findings, stating that lack of sex education curricula, textbooks and handouts, in addition to lack of training for sex education instructors are major barriers to implementing sexual health education policies.

Donovan (1998) found that most teachers received only one training course on sex education and have very little opportunity to receive additional sex education training once hired on. Teachers are sometimes penalized or have to use personal vacation hours if they want to attend sex education trainings (Donovan, 1998). Yet, well-trained instructors have the largest behavioral effects on sexual engagement (Sabia, 2006).

Peskin et al., (2011) state the need for adequate training for sex education instructors as one of the top barriers preventing sex education programs from being effective. Because many school administrators lack the knowledge of the needs for successful sex education programming, they often fail to hire the best personnel to provide sex education. Hiring the right teacher has been described as the most important factor to program success for the past thirty years (Scales, 1981). Strategies for developing successful sex education programs often stress the "importance of hiring the right person" (Wiley, 2011:2). A sex education instructor needs to have a passion for sex education, not someone who is placed into the role expectantly (Alton, 2011). Bowden (2003), reports that teacher"s attitudes about sex education directly affect the integrity of sex education programs.

School administrator"s lack of knowledge of sex education programs limits their ability to integrate sex education into the regular school day, prevents them from providing the appropriate leadership for planning sessions to implement sex education and contributes to the lack of resources available to adolescent health providers.

Community Support

When surveyed, school administrators often report being highly supportive of sex education programs, yet they fail to participate in sex education coalitions and sex

education support committees (Peskin et al., 2011 and Schultz and Boyd, 1984). School administrators‟ failure to participate in sex education coalitions is a barrier to sex education implementation due to their lack of participation in community wide efforts to support sex education.

Roughly fifty-nine percent of principals surveyed by the Henry J Kaiser Family Foundation (2000) report school administrators as having the greatest influence on sex education programs. Research has shown that it is the local stakeholders who have the capacity to make lasting changes in sex education. When school administrators fail to participate in sex education coalitions working to create a change among the delivery of sex education in the community, it sends a message of sex education opposition to the community instead (Alton, 2011).

School administrators‟ lack of participation in sex education coalitions prevents administrators from taking a role in the development of sex education programs. When these sex education coalitions move to make sex education program suggestions to school boards and the public, a lack of school administrator participation is viewed as being unsupportive of sex education to the community.

The role of school administrators is to provide opportunity for collaboration among stakeholders to develop a strategy that will work for the community. However, when leadership refuses to provide support for these programs, the entire effort is diminished, preventing collaborations between schools and external providers from uniting to provide community advocacy supporting this movement. Without the community activism supporting sex education, opposition groups will continue to monopolize sex education policy decisions.

When school administrators fail to provide community support for sex education programs, it is often assumed they do not approve of integrated sex education. This hinders sex education supporters efforts against sex education opposition groups in the community because it provides no voice for school administrators on the issue. The attitudes of a crowd tend to influence the attitudes of those observing the crowds. If sex education opposition groups are the only ones voicing their opinion at school board meetings, then eventually the attitudes of those being vocal will begin to infiltrate the attitudes of those observing (Irvine, 2007).

Peskin et al. (2011), reports that for sex education programs to be delivered to the community effectively, school administrators must convey their support for the programs. When a community sees that a change needs to occur, they often look to leaders to act in the best interest of the community (Giardino and Sanborn, 2011). The leaders on sex education programs are school administrators. Without school administrators‟ support for sex education, community opposition groups will continue to assume this means that school administrators do not support sex education and use this misperception to their advantage. Until administrators vocalize their support of sex education programs, community opposition will continue to be a barrier to sex education implementation.

School administrators‟ fear of public opposition is the reason for administrator‟s lack of public support against sex education opposition groups (Scales and Kirby, 1983 and Peskin et al., 2011). Due to fear of controversy, many school administrators decline to take a public position on sex education implementation, due to community opposition to sex education (Alexander, 1984).

A study conducted in 1960, found that school administrators are "more influenced by the opposition, real and anticipated…than by the demands of those seeking curriculum expansion in sex education" (Somerfield, 1970:221). Due to school administrators fear of community opposition many refuse to "go on the record" as sex education advocates (Blinn-Pike, 2002). By publically advocating for integrated sex education programs, many school administrators believe they are inviting controversy (Donovan, 1998). A majority of US parents support sex education, so it is a minority sex education opposition group that generates this fear among school administrators (Tortolero et al., 2011). Until sex education supporters become more organized and vocal, the perception of community opposition will continue to exist.

School administrators' failure to participate in sex education coalitions limits their public support of sex education programs, allowing fear of controversy and community opposition to sex education to prevail.

Personal Attitudes

School administrators' lack of commitment to sex education is a barrier to sex education among school administrators' beliefs and attitudes of sex education (Scales and Kirby, 1983).

Peskin et al. reports school administrators perceive a "high level of negative parental support for comprehensive sex education programs", which deters them from implementing sex education programs (2011:28). Many times school administrators feel sex education is too big of an issue to even bother with (Irvine, 2002).

Tortolero et al. (2011) reports that around ninety-three percent of parents surveyed in Houston, Texas support sex education in schools. In fact, parents feel that

schools should be providing more in depth sex education, rather than limiting sex education content (Ito et al., 2006). Yet, teachers are often instructed, by school administrators, to avoid sensitive sex education topics, due to school administrators own personal attitudes that integrated sex education is not supported by parents (Dailard, 2001).

School administrators often limit sex education programs to "minimize publicity and controversy" (Alexander, 1984:251). School administrators" personal attitudes towards parental support of sex education, disables the development of sex education programs and often fails parents" expectations of their children"s sex education experience. Henry J. Kaiser Family Foundation, reports that eighty-two percent of parents feel that "all aspects of sex education, including birth control and safer sex", should be covered in secondary school (2000: 32). This report also found that ninety-two percent of teachers and eighty-eight percent of youth support comprehensive coverage of sex education materials (Henry J. Kaiser Family Foundation, 2000).

Personal attitudes of school administrators towards the perceived belief that parents do not support sex education prevents students from receiving sexual health information they need to keep their bodies and minds healthy.

School administrators often maintain that schools should focus primarily on those subjects which will increase students" academic knowledge and performance, without realizing the impact the sexual health education can have on students" performance. By the 10^{th} grade, approximately fifty-four percent of students have engaged in vaginal, oral or anal sex (Markham et al., 2011). Most youth are unprepared for the physical, emotional and mental changes that occur with sexual relationships. Due to school

administrators‟ personal beliefs that sex education is not related to academic performance, leaves many youth unknowledgeable of these changes, causing them to experience severe stress and anxiety, creating an adverse effect on their academic performance (Koeske and Koeske, 1991).

Donovan (1998), reports that school administrators often want to focus on academic standards of which the state holds them accountable, not on low priority topics, such as sex education. Yet, research has shown teen pregnancy has a direct relationship to poor academic performance (Klein, 2005). Of teens giving birth prior to age 17, roughly fifty percent graduate from high school, with fifty percent of those teens only acquiring a General Equivalency Diploma (Kenny, 1987). In addition to leaving many youth uneducated, Allen et al. (1997), reports that teen pregnancy costs the nation somewhere between $9 and $29 billion annually.

Not only do school administrators need to recognize the need for sex education to be integrated into the school day to enhance students‟ academic achievements, but sex education programs need to begin in earlier grades to target younger adolescents (Kalmuss et al., 2003).

School administrators‟ failure to acknowledge that sex education has a direct impact on academic performance of student is a major barrier to implementing sex education programs that have a lasting impact on sexual health knowledge and behavior of students.

Due to school administrators‟ personal attitudes towards sex education, many administrators feel one shot sex education programs are sufficient for educating students on sexual health, rather than an integrated sex education program (Scales and Kirby,

1983). From 1978 to 1981, one school district reported that the only sex education provided to students was one film shown during the 5th grade (Greenberg et al., 1983). The Henry J. Kaiser Family Foundation (2000) found that seventy-four percent of students surveyed reported that sex education classes lasted about one to three class meetings. This same report found that fifty-five percent of administrators felt that schools allocated enough time to sex education already. Yet, parents want sex education programs to consist of half a semester to a full semester (Henry J. Kaiser Family Foundation, 2000).

In order for sex education programs to be effective, they must increase sexual health knowledge and have an effect on youth sexual behavior (Jemmot et al., 2010). To have an effect on behavior, sex education programs must include components on esteem building, communication skills, conflict resolution and decision making (Kirby, 1989). These skills cannot be mastered with one-shot sex education programs. School administrators" personal attitudes that one shot sex education programs are suffice, "pose an enormous obstacle" to reducing risky behavior (Kalmuss et al., 2003:90).

Until school administrators recognize that their personal attitudes towards sex education are detrimental to the development of youth, there will be limited movement in developing lasting strategies to combat teen pregnancy.

School Board Members Barriers to Sex Education Implementation

Parents, adolescent health providers and administrators have a direct hand in the development of sex education programs, advocating for sex education existence and strategizing collaborations to develop an appropriate approach to integrated sex education that will include the whole community. However, it is school board members that hold

the power in regards to sex education implementation. Yet, school board members‟ lack of sex education knowledge, community opposition to sex education and school board members‟ personal attitudes towards sex education prevent sex education movement from occurring in schools.

Program Knowledge

Administrators reported local school board members as having the greatest influence on sex education curriculum provided in a district; however few of the school board members are aware of their need to establish a clear consensus on sex education policy (Henry J. Kaiser Family Foundation, 2002).

Eleven states in the U.S. do not have a state mandated sex education requirement for schools, which means the school boards have complete discretion as to what sex education programs will be implemented in their districts (Alton, 2011). Of the remaining states, many do not provide strict guidelines for sex education programs, creating astronomical variances in sex education programs. School board members‟ failure to provide unanimous consensus creates disparities among schools in regards to the sex education students are receiving.

School board members‟ lack of sex education knowledge prompts many school boards to leave the decision of sex education program content up to individual school administrators. A survey conducted by the Alan Guttmacher Institute found that only two thirds of U.S. school districts adopt a sex education policy, with one thirds leaving the decision up to the individual schools themselves (Kaiser Family Foundation, 2000). The failure of the school board to enforce mandated sex education programs hinders the ability of schools to adequately provide programming. Without the guidance of school

board members, sex education instructors fear providing youth with controversial sex education information and school administrators refuse to publically support sex education programs. In fact, rather than providing schools with control over sex education programs, this lack of guidance on sex education programs among school board members actually prevents integrated sex education from occurring.

A survey of 604 school staff in southeast Texas, found one quarter of the staff interviewed in Texas reported not knowing if their school boards supported comprehensive sex education (Peskin et al., 2011). School boards must document unified, clear goals for their sex education policy and clear subjects which are to be or not to be discussed, so those providing sex education to youth can work in confidence knowing they the content being covered is within school district policies (Peskin et al., 2011 and Croft and Asmussen, 1992). The National School Board Association stresses the when school districts have established policies that support student health, student absenteeism declines, student performance improves, schools report fewer student behavioral issues and students adopt healthier behaviors (National School Board Association, 2010). School board members‟ lack of awareness for the need of sex education program consensus and sex education guidelines for adolescent health providers and administrators creates a disparity among students sex education knowledge and negatively impacts the success of sex education programs in schools.

Even when decisions are made by school board members on sex education, the information rarely gets passed down to the adolescent health providers teaching the students. The failure to disseminate sex education policy changes prevents the success of sex education programs (Fagen et al., 2010). Peskin et al. (2011) report the lack of

dissemination of sex education policies is a major flaw to sex education program implementation. Due to school board members failure to inform appropriate administrators of sex education program decisions, adolescent health providers remain in constant fear that they are providing information that will somehow end up getting them fired (Donovan, 1998). School board members‟ failure to disseminate sex education information to school district professionals, few sex education instructors and administrators will elect school board involvement in the sex education programs being implemented on their campuses (Blinn-Pike, 2000). This is a tremendous barrier to gaining sex education support of school boards, since they will not be knowledgeable of the efforts campuses are making for sex education and the need for more attention to be spent on sex education programs. Failure to disseminate sex education decisions to school administrators and adolescent health providers, school board members continue to lack knowledge of the need for sex education and of the sex education program efforts occurring in their district.

When school board members do provide guidance for school districts, they rarely require evidence-based sex education curricula to be used in sex education programs (Peskin et al., 2011). In order to eliminate instructors fear of being individually targeted for providing information on controversial sex education issues, school board members must require evidence-based sex education programs to ensure all students receive similar medically accurate sexual health information. However, due to school board members‟ lack of knowledge on evidence based sex education programs and the member‟s lack of knowledge for the need of evidence based sex education programs, very few district make it a requirement for schools (Markham et al., 2011).

By requiring evidence based sex education programs, schools are ensured to have a positive impact of students‟ sex education knowledge and sexual behavior. This also ensures school board members that funds being allocated towards evidence based sex education have measurable outcomes and are cost effective. Due to school board members‟ lack of knowledge of the benefits of evidence based sex education, schools fail to provide adequate sex education to youth, by relying on instructors‟ personal experiences and beliefs rather than medically accurate, peer reviewed information (Luker, 2006).

Due to school boards lack of awareness for the need of sex education program consensus, disseminated sex education program policies and required evidence based sex education practices, many board members continue to lack knowledge of the need for integrated sex education for youth to better protect their sexual health.

Community Support

There is no denying that sexual health education is political. Not only do state level political agendas have an effect on sexual health education, but local level politics play a large role as well.

School board members are elected officials who‟s primary goal is to enhance the educational experience for its‟ students, however due to a lack of community support school board members are failing to fulfill their goal by ignoring sex education instruction as a role of the school system (Land, 2002). Perception of the strength of sex education opposition groups in the community; often intimidate school board members from providing adequate attention sex education issues (Sharp, 2002). When sex

education is not treated as a vital part of student‟s education, school board members fail to enforce sex education policies and retreat from community opposition (Burdell, 1996).

In fact, Lindevaldsen (2011) reports that when school board members‟ fail to acknowledge sex education for youth, for fear of adverse community reaction, they make students vulnerable to unhealthy sexual decisions because of their lack of sexual health knowledge.

School board members are in a position to enforce change in school districts and ensure that programs exist to enhance student achievement and health development (Keith, 2008). However, rather than allocating efforts to increase student‟s sexual health knowledge, they resort to repression tactics, such as deferring sex education issues or delaying in making any definite rulings on sex education issues, to avoid potential aversion from the public (Sharp, 2002). School board members‟ failure to acknowledge sex education programs as a need for schools, due to possible community opposition, prevents effective sex education implementation at the campus level.

School board members‟ fear of sex education opposition groups is a critical barrier in developing movement for sex education programs. Though school board members may support sex education, the context of how to deal with sex education opposition groups when making policy decisions hinders the adoption of sex education programs (Sharp, 2002).

Sharp (2002), further explains that community pressures tend to hold more weight when it comes to elected representatives. Because school board members risk losing citizen votes for their election to the board by taking strong positions on controversial issues, members place greater concern on community opposition to sex education than

those with non-elected positions. In fact, school board members‟ relationships with special interest groups are a major barrier in the school boards success in improving student achievement (Land, 2002).

According to the economic exchange theory, a person‟s behavior is dependent on their expectant awards and costs incurred by their behavior (Bock and Kim, 2002). This means that only if the expected rewards outweigh the considered costs, will a person engage in a particular behavior. In regards to sex education, this means if school board members‟ gains from implementing sex education programs outweigh the costs of community opposition, will they enforce sex education implementation.

Resnick (2011) describes a four step approach to addressing health threats which include; naming the threat, identifying the causes, understanding prevention methods and mobilizing resources and political will to make the changes. Though school board members have accomplished three of the four, they lack the motivation to make change in sex education policies and fail to utilize powerful resources to help school board members implement supported integrated sex education programs.

School board members‟ failure to consider sex education expertise from external organizations prevents school boards from gaining sex education allies to assist in program development (Land, 2002).

Crowson (1998) discusses a major shift in the paradigm of education, which includes a broadened mission for school districts to include a strong community-school relationship. In order to fully educate children, school boards and school professionals must recognize the need for “interdependencies” among families, schools and outside agencies (Crowson, 1998:60).

External providers such as; community health centers, nonprofit organizations, physicians, medical researchers, private sector corporations and sex education curricula developers should all have a role in developing sex education policies with school board members. By collaborating with others who have specialized sex education knowledge, school board members are equip with strong tools to fight against sex education community opposition. School board members‟ failure to consider expert opinions on sex education from outside sources hinders the establishment of relationships among these outside agencies and school boards to overtake sex education opponents.

Kuklinski and Quirk (1998), report that when attention and motivation are high, people utilize a systematic approach resolving issues, however when attention and motivation of a subject are low, people exert less resources in devising a solution. School board members lack of acknowledgement of sex education and failure to consider expert opinions on sex education, combined with their lack of motivation for establishing sex education policies due to fear of community opposition, results in limited mental resources allocated to developing a strategy for implementing sex education programs.

Personal Attitudes

Though school board members‟ primary function is to develop policies by assessing the interests and values of the community, they often allow their personal attitudes to influence their judgment on community interests (Land, 2002).

School board members‟ personal belief that sex education does not have a place in schools goes against what parents and the communities want. Not only do parents want sex education to be part of the school day, they want more time and resources allocated to increasing students‟ knowledge of sexual health (Tortolero et al., 2011). Students report

needing sex education during school, to help them learn how to protect themselves against HIV and what to do when sexual assault occurs (Henry J. Kaiser Family Foundation, 2000). School board members‟ personal attitude that sex education is not public education‟s responsibility preventing youth from gaining the knowledge of sexual health that they need.

Attitudes towards sex education have a direct relationship with ones confidence on the subject. When people are not in agreement with sex education, they are skeptical to the influence sex education can have on students (Bowden, 2003). By allowing their personal attitudes towards sex education, school board members hinder the development of sex education programs by instilling doubt about the effectiveness of sexual health programs.

Allowing their own personal attitudes influence sex education policies, school board members fail to take a socially oriented approach to the improvement of adolescent health (Bandura, 2004). Rather than embracing sex education as a means of raising public awareness of teen pregnancy and building community capacity to encourage advocacy, school board members approach sex education as being one‟s own responsibility. Allowing their personal attitudes that sex education is not the responsibility of schools, school board members fail to uphold their responsibilities.

Sex education has historically been considered morality and values based education in the United States, compared with other countries who consider sex education as scientific information (Luker, 2006). School board members personal attitudes towards sex education as morality based education, prevents members from

developing sex education policies for the district, due to fear of prosecution for prophesying in the public school system (Merriam, 2011).

School districts face risk of breaking the law when instructors introduce morality curricula into the classroom. Sex education has historically used methods of shamming or religion to instill fear into students to prevent them from engaging in sexual behavior (Luker, 2006). Sex education instructors must be vigilant in removing any religious, shaming, and negative context from sex education curricula.

Because morality based topics, such as sex education, typically cause "uncompromising clashes over values, while non-morality policy involves conflicts …where compromise comes more easily", school board members opt to avoid all morality based subjects within the context of public education (Sharp, 2002:863). Sex education is highly critiqued among the public because personal values and threats to those values are at stake when school board members are develop morality policy to handle youth sexual health (Sharp, 2002).

Due to the sensitivity of sex education, school board members often feel it is safest to remove sex education from schools, to ensure schools are not sued for introducing inappropriate material. However, in doing this school board members prevent students from receiving sexual health knowledge and dismiss parents‟ expectations.

School board members‟ failure to consider recommendations from outside expertise due to personal attitudes towards collaboration with other entities that support sex education, greatly hinders the ability for schools to provide adequate sex education programs. Golden and Zajac describe one of the factors that hinders board‟s ability to

impact performance is the "withholding of resources that are essential to successful implementation" (2001:1106). By failing to consider sex education recommendations from committees, health professionals or sex education campaigns, school board members prevent sex education information from being disseminated to stakeholders.

One of the characteristics describing effective school boards include good relations to campuses, outside agencies, state and local government, local organizations and the public in general (Land, 2002). Research has shown that people tend to hold high opinions of groups to which they belong to, and place a lower value on those groups which they do not participate in (Kuklinski and Quirk, 1998). This sometimes leaves school board members with the personal attitude that they know what is best for the students and district, without considering outside professionals who could provide valuable resources to the school board. When school districts fail to consider the recommendations for sex education from external providers to develop effective sex education for the community, they fail to establish working relationships with community allies.

Researchers suggest that school board members work with the community, parents, local agencies, nonprofits and even the faith based communities to develop effective sex education strategies for the community. Rather school board members often alienate the community by failing to consider their sex education expertise due to school board members" personal attitudes towards collaboration with outside entities. A recent study conducted in Texas, found that sixty-six percent of school districts failed to consider recommendations for health curricula from School Health Advisory Councils, a council developed of parents, school professionals, community members and youth

development professionals, which research effective health curricula for students and provide formal recommendations to school board members (Texas Education Code, 2011 and Wiley et al., 2009). Personal attitudes of school board members towards collaboration with outside adolescent health providers hinders the development of effective integrated sex education, prevent stakeholders from receiving valuable sex education material and harms students by withholding crucial information from them.

Until school board members overcome their personal attitudes towards sex education, limited movement can be expected towards integrated sex education programs. If school board members cannot forgo their personal attitudes to become open to a new sex education movement, students will continue to miss out on valuable education (Argyris, 1991).

Conclusion

The Henry J. Kaiser Family Foundation (2000), reports that students want more information on sexual and reproductive health (Dailard, 2001). Parents want sex education in the schools and want more sex education topics and time dedicated sex education programs (Tortolero et al., 2011). Adolescent health providers report that leadership on sex education program implementation, more training on sex education and the visible support of administrators would enable sex education programs to have a lasting behavioral impact on youth (Peskin et al., 2011 and Sabia, 2006).

Yet, there is still an astronomical lapse in what the public desires for sex education and the information our youth are receiving. As the literature reports, each stakeholder has a role in the barriers preventing sex education implementation. Until parents, adolescent health providers, administrators and school board members can

overcome their lack of sex education program knowledge, fear of community opposition and personal attitudes towards sex education the barriers preventing sex education implementation will remain, preventing students from receiving sexual health education that can help keep them healthy.

Chapter Summary

The literature finds parents, adolescent health providers, administrators and school board members as the key stakeholders in the implementation of sex education programs. Three categories of barriers; program knowledge, community support and personal attitudes are identified to better understand why sex education programs are not being implemented in schools. These specific barriers are analyzed using descriptive statistics and content analysis, which will be discussed in the methodology section of this research.

Chapter 3
Methodology

Chapter Purpose

This chapter discusses the quantitative research methods used to describe the perceived barriers to implementing sex education programs in the Rio Grande Valley, from the perspective of youth development professionals. Four key stakeholders; parents, adolescent health providers, school administrators and school board members in sex education implementation were identified through a review of the literature on sex education. Furthermore, three descriptive categories of barriers; program knowledge, community opposition and personal attitudes were identified through the review of sex education literature.

This study utilizes survey research to determine the barriers to implementing sex education programs in the Rio Grande Valley. Survey questions directly address specific areas of each descriptive barrier category to determine the degree of relativity to implementing sex education programs in the Rio Grande Valley area (see *Appendix A*). By utilizing a survey tool, the specific barriers to implementing sex education programs in the Rio Grande Valley, from the perspective of youth development professionals can be better determined and described.

Variables

Table 3.1 illustrates how each descriptive barrier category is operationalized to measure the effect the barrier category has on sex education program implementation in the Rio Grande Valley area. The survey questions illustrated in the conceptual framework were developed specifically for this study.

Table 3.1 Operationalization of the Conceptual Framework

Categories	Survey Questions*
Parental Barriers to Sex Education Implementation	
Program Knowledge	Parents" lack of knowledge about integrated sex education programs prevents their adoption in the Rio Grande Valley area. Parents" lack of awareness for the need of sex education programs hinders the adoption of integrated sex education programs in the Rio Grande Valley area. Parents belief they can provide adequate sex education to their children, hinders the adoption of integrated sex education programs in the Rio Grande Valley area. Parents" lack of involvement in the development of sex education programs hinders the adoption of integrated sex education programs in the Rio Grande Valley area.
Community Support	Parental opposition to integrated sex education programs is a barrier to sex education program implementation in the Rio Grande Valley area. Parents" opposition to sex education community advocacy is a barrier to the adoption of integrated sex education programs in the Rio Grande Valley area. Parents" perceptions of the strength of community sex education opposition groups, is a barrier to the adoption of integrated sex education programs in the Rio Grande Valley area. Parents" lack of community sex education support is a barrier to the adoption of integrated sex education programs in the Rio Grande Valley area.
Personal Attitudes	The personal attitudes of parents towards integrated sex education programs prevent the adoption of sex education programs in the Rio Grande Valley area. Parents" perception that sex education should not be covered during school hinders the adoption of integrated sex education programs in the Rio Grande Valley area. Parents" fear of the content covered during sex education programs hinders the adoption of integrated sex education programs in the Rio Grande Valley area. Parents" concern over what values are covered during sex education programs hinders the adoption of integrated sex education programs in the Rio Grande Valley area.
Adolescent Health Providers Barriers to Sex Education Implementation	
Program Knowledge	Adolescent health providers" knowledge of sex education programs, in the Rio Grande Valley areas, is a barrier to the adoption of integrated sex education programs. Lack of adolescent health providers experience in community education, hinders the adoption of integrated sex education programs in the Rio Grande Valley area. Adolescent health providers" lack of knowledge of school

Table 3.1: Continued

	district sex education policies hinders the adoption of integrated sex education programs in the Rio Grande Valley area. Adolescent health providers" lack of awareness of evidence-based sex education curricula hinders the adoption of integrated sex education programs in the Rio Grande Valley area.
Community Support	Adolescent health providers fears of community opposition to sex education has become a barrier to the adoption of integrated sex education programs in the Rio Grande Valley area. Adolescent health providers inability to develop functioning sex education coalitions, serves as a barrier to the adoption of integrated sex education programs in the Rio Grande Valley area. Adolescent health providers inability to organize sex education stakeholders for advocacy, serves as a barrier to the adoption of integrated sex education programs in the Rio Grande Valley area. Adolescent health providers lack of sex education community advocacy, serves as a barrier to the adoption of integrated sex education programs in the Rio Grande Valley area.
Personal Attitudes	The personal attitudes of adolescent health providers towards sex education programs has become a barrier to the adoption of integrated sex education programs in the Rio Grande Valley area. Adolescent health providers" bias or favor towards particular sex education programs hinders the adoption of integrated sex education programs in the Rio Grande Valley area. Adolescent health providers" failure to consider outside sources for sex education programs, such as after school programs or community organizations, hinders the adoption of integrated sex education programs in the Rio Grande Valley area. Adolescent health providers" perception that the local community opposes sex education programs hinders the adoption of integrated sex education programs in the Rio Grande Valley area.
School Administrator's Barriers to Sex Education Implementation	
Program Knowledge	School administrators" lack of sex education program knowledge, in the Rio Grande Valley areas, is a barrier to the adoption of integrated sex education programs. School administrators" failure to acknowledge the need for sex education programs, hinders the adoption of integrated sex education programs in the Rio Grande Valley area.

Table 3.1: Continued

	School administrators" failure to provide leadership in development of sex education programs hinders the adoption of integrated sex education programs in the Rio Grande Valley area. School administrators" failure to provide adequate resources for sex education programs, hinders the adoption of integrated sex education programs in the Rio Grande Valley area.
Community Support	School administrators" perceptions of sex education program opposition in the community have become a barrier to the adoption of integrated sex education programs in the Rio Grande Valley area. School administrators lack of participation in community sex education coalitions, serves as a barrier to the adoption of integrated sex education programs in the Rio Grande Valley area. School administrators lack of community support for sex education programs, serves as a barrier to the adoption of integrated sex education programs in the Rio Grande Valley area. School administrators fear of community opposition to sex education programs, serves as a barrier to the adoption of integrated sex education programs in the Rio Grande Valley area.
Personal Attitudes	The personal attitudes of school administrators towards sex education programs has become a barrier to the adoption of integrated sex education programs in the Rio Grande Valley area. School administrators" belief that parents do not support sex education programs, hinders the adoption of integrated sex education programs in the Rio Grande Valley area. School administrators" belief that sex education programs are not academia, hinders the adoption of integrated sex education programs in the Rio Grande Valley area. School administrators" belief that sex education can be fully covered in minimal class meetings, hinders the adoption of integrated sex education programs in the Rio Grande Valley area.
School Board Members' Barriers to Sex Education Implementation	
Program Knowledge	School board members" lack of sex education program knowledge, in the Rio Grande Valley areas, is a barrier to the adoption of integrated sex education programs. School board members failure to provide consensus on a sex education policy for the district , hinders the adoption of integrated sex education programs in the Rio Grande Valley area School board members failure to disseminate sex

Table 3.1: Continued

	education policy information to appropriate leadership, hinders the adoption of integrated sex education programs in the Rio Grande Valley area School board members failure to require evidence based sex education programs be used in schools that provide sex education, hinders the adoption of integrated sex education programs in the Rio Grande Valley area
Community Support	School board members perceptions of sex education program opposition in the community has become a barrier to sex education program implementation in the Rio Grande Valley area. School board members failure to acknowledge the need for sex education programs, serves as a barrier to the adoption of integrated sex education programs in the Rio Grande Valley area. School board members fear of sex education program community opposition, serves as a barrier to the adoption of integrated sex education programs in the Rio Grande Valley area. School board members failure to consider sex education expertise from outside organizations, serves as a barrier to the adoption of integrated sex education programs in the Rio Grande Valley area.
Personal Attitudes	The personal attitudes of school board members towards sex education programs has become a barrier to the adoption of integrated sex education programs in the Rio Grande Valley area. School board members‟ belief that sex education is not a responsibility of the public school system hinders the adoption of integrated sex education programs in the Rio Grande Valley area. School board members‟ belief that sex education is morality education rather than health based education hinders the adoption of integrated sex education programs in the Rio Grande Valley area. School board members‟ bias towards collaborations with outside organizations hinders the adoption of integrated sex education programs in the Rio Grande Valley area.

* Response scale: strongly agree, somewhat agree, neutral, somewhat disagree, strongly disagree

Parental Barriers to Sex Education Programs

Program knowledge

To determine whether youth development professionals find that parents‟ knowledge of sex education programs is a barrier to the adoption of integrated sex education programs in the Rio Grande Valley, survey participants were asked to rank

their feelings on a scale of strongly agree, somewhat agree, neutral, somewhat disagree or strongly disagree in reference to the following question, "Parents lack of knowledge about integrated sex education programs prevents their adoption in the Rio Grande Valley area". This is an effective measurement of the degree to which youth development professionals find parents lack of sex education program knowledge to affect the adoption of sex education programs because it allows the survey respondent to gauge how impactful this particular barrier has been in the Rio Grande Valley.

The literature suggests that a lack of parental awareness for the need of sex education programs is a major barrier to program adoption (Russell et al., 2004). The question, "Parents lack of awareness for the need of sex education programs, hinders the adoption of integrated sex education programs in the Rio Grande Valley," measures the extent that respondents believe that parents knowledge about sex education programs is a barrier to sex education program implementation. Parents" lack of awareness for the need of sex education programs is important because prior to being able to lend support and community advocacy to integrated sex education programs parents need to become aware of what these programs provide for the youth and the benefits schools gain from implementing sex education.

Parent"s belief that they should be the sole provider of sex education to their youth is a barrier to the adoption of sex education programs (Geasler et al., 1995). The question, "Parents belief they can provide adequate sex education to their children, hinders the adoption of integrated sex education programs in the Rio Grande Valley area.", measures the extent to which youth development professionals find that parents belief they obtain the sex health knowledge to effectively educate their children on sexual

health and to what extent this serves as a barrier to implanting sex education programs. Literature has found that while parents believe they can provide sex education to their children, they often lack the scientific health knowledge to be able to adequately educate their children (Geasler et al., 1995). If parents are aware of the medically accurate information and decision making skill building which are built into sex education programs, they can better understand the benefits of the programs.

Excluding parents from the development of sex education programs is a barrier to adopting the programs (Scales and Kirby, 1983). The question, "Parents lack of involvement in the development of sex education programs, hinders the adoption of integrated sex education programs in the Rio Grande Valley area" measures the extent which parents" lack of involvement in the development of sex education programs is a barrier to adopting integrated sex education programs. Parental involvement in the development of these programs is necessary to gain support of the parents, school administrators and community.

Community Support

To determine whether youth development professionals find that parents" aversion to community advocacy for sex education programs is a barrier to the adoption of integrated sex education programs in the Rio Grande Valley, survey participants were asked to rank their feelings on a scale of strongly agree, somewhat agree, neutral, somewhat disagree or strongly disagree in reference to the following question, "Parental opposition to advocacy for integrated sex education programs is a barrier to sex education program implementation in the Rio Grande Valley area ". This question measures the degree to which youth development professionals find parents" opposition to advocating

for sex education programs affect the adoption of sex education programs because it allows the survey respondent to gauge how impactful this particular barrier has been in the Rio Grande Valley.

Literature suggests that while parents may support sex education programs, they rarely engage in community advocacy to gain support for the programs (Scales and Kirby, 1983). The question, "Parents opposition to sex education community advocacy is a barrier to the adoption of integrated sex education programs in the Rio Grande Valley", measures the degree to which aversion to community advocacy prevents the adoption of sex education programs. Parental advocacy for sex education programs is critical for the success and adoption of programs because without the vivid support from parents, school officials will continue to assume that sex education opposition groups represent the entire community opinion and therefore, will not adopt sex education programs.

One of the most common barriers to sex education program implementation is the misperception of sex education opposition groups. The question, "Parents perceptions of the strength of community sex education opposition groups is a barriers to the adoption of integrated sex education programs in the Rio Grande Valley", measures the extent to which youth development professionals find the perceived strength of sex education opposition groups to impact the adoption of sex education programs. While sex education program supporters far exceed the number of those in opposition, the fear of the strength of the opposition groups hinders supporters from advocacy. This is a critical barrier that must be dispelled by encouraging community advocacy for sex education programs to increase the visual support in the community.

In addition to parental aversion to community opposition, lack of involvement in community advocacy is a barrier in the adoption of sex education programs. The question, "Parents lack of community sex education support is a barrier to the adoption of integrated sex education programs in the Rio Grande Valley area", measures the extent to which youth development professionals find parents lack of community support for sex education programs to hinder the adoption of the programs. In order for parents to overcome their aversion to community advocacy for sex education programs and to dispel the perception of the strength of sex education opposition groups, parents who support sex education to become involved in the efforts and engage in visual community support.

Personal Attitudes

To determine whether youth development professionals find that parents' personal attitudes towards integrated sex education programs hinders the adoption of the programs in the Rio Grande Valley, survey participants were asked to rank their feelings on a scale of strongly agree, somewhat agree, neutral, somewhat disagree or strongly disagree in reference to the following question, "The personal attitudes of parents towards integrated sex education programs prevents the adoption of sex education programs in the Rio Grande Valley". This question measures the degree to which youth development professionals find parents' personal attitudes towards sex education programs affects the adoption of sex education programs because it allows the survey respondent to gauge how impactful this particular barrier has been in the Rio Grande Valley.

Literature suggests that parents‟ belief that sex education opposition to integrated sex education programs is a barrier to having sex education programs (Scales and Kirby, 1983). The question, “Parents‟ perception that sex education should not be covered during school hinders the adoption of integrated sex education programs in the Rio Grande Valley area”, measures the extent to which youth development professionals find parents‟ personal attitudes towards sex education programs to prevent sex education from being implemented during the school day. The personal attitude of parents towards sex education being taught in schools is critical because parents can become aware of the need for this education in the schools and the benefits of the programs by becoming more knowledgeable and involved in the development of the sex education programs.

Parents‟ fear of the content covered in sex education programs is a major barrier to the implementation of sex education programs (Marsman and Herold, 1986). The question, “Parents fear of the content covered during sex education programs, hinders the adoption of integrated sex education programs in the Rio Grande Valley”, measures the extent to which youth development professionals find that parents‟ fear of sex education program content prevents to adoption of sex education programs in the Rio Grande Valley. Parents‟ fear of sex education content is an important barrier because through awareness of what sex education programs entail and becoming involved in the development of the programs and their adoption, parents can alleviate this fear.

Parents concern with the values being covered during sex education programs is a barrier to the adoption of the programs (Brown, 2009). The question, “Parents concern over what values are covered during sex education programs, hinders the adoption of integrated sex education programs in the Rio Grande Valley”, measures the extent to

which youth development professionals find parental concerns over the values associated with sex education prevents the adoption of sex education programs. Parental concern over the values being associated with sex education is important because through involvement in the adoption of sex education programs, parents can gain the sex education knowledge needed to eradicate this concern.

Adolescent Health Providers

Program Knowledge

To determine whether youth development professionals find that adolescent health providers lack of knowledge of sex education programs is a barrier to the adoption of integrated sex education programs in the Rio Grande Valley, survey participants were asked to rank their feelings on a scale of strongly agree, somewhat agree, neutral, somewhat disagree or strongly disagree in reference to the following question, "Adolescent health providers knowledge of sex education programs, in the Rio Grande Valley area is a barrier to the adoption of integrated sex education programs. This is an effective measurement of the degree to which youth development professionals find adolescent health providers lack of sex education program knowledge to affect the adoption of sex education programs because it allows the survey respondent to gauge how impactful this particular barrier has been in the Rio Grande Valley

Research has found that when adolescent health providers fail to educate their peers on sex education programs, the level of support for the programs diminishes. The question, "Lack of adolescent health providers experience in community education, hinders the adoption of integrated sex education programs in the Rio Grande Valley area", measures the degree to which youth development professionals find that the

inability for adolescent health providers to educate the community on sex education programs, impacts the adoption of sex education programs. This is an important barrier to sex education program adoption because by providing adolescent health providers with the necessary training, resources and administrative support, they will be able to effectively educate the community on sex education programs and gain community advocacy for the cause.

Scales and Kirby (1983) report that a lack of knowledge of sex education policies is a barrier to providing sex education information. The question, "Adolescent health providers lack of knowledge of school district sex education policies, hinders the adoption of integrated sex education programs in the Rio Grande Valley", measures the extent to which youth development professionals find that a lack of knowledge of sex education policies among adolescent health providers, serves as a barrier to implementing sex education programs in the Rio Grande Valley. This barrier is important because without adequate communication between parents, adolescent health providers, administrators and school board members, all parties cannot be knowledgeable of what is or is not expected from sex education courses, which in result limits the sex health education youth are receiving.

Literature supports that when adolescent health providers use evidence-based sex education programs, they provide students with medically accurate information. Using evidence based sex education programs reduces the risk of providing misguided information to the youth and reduces parents fear of the content discussed in sex education courses (Tortolero, 2011). The question, "Adolescent health providers lack of awareness of evidence-based sex education curricula, hinders the adoption of integrated

sex education programs in the Rio Grande Valley area", measures the extent to which youth development professionals find that a lack of knowledge of sex education evidence based programs, among adolescent health providers, serves as a barrier to implementing sex education programs in the Rio Grande Valley. This barrier is important because by becoming knowledgeable of evidence based sex education programs, adolescent health providers can provide the school board, parents and administrators with scientific evidence that programs delay initiation of sex among youth and will reduce the opposition and fear surround sex education programs.

Community Support

To determine whether youth development professionals find that adolescent health providers fear of community opposition to sex education programs is a barrier to the adoption of integrated sex education programs in the Rio Grande Valley, survey participants were asked to rank their feelings on a scale of strongly agree, somewhat agree, neutral, somewhat disagree or strongly disagree in reference to the following question, "Adolescent health providers fear of community opposition to sex education programs is a barrier to the adoption of integrated sex education programs in the Rio Grande Valley area." This is an effective measurement of the degree to which youth development professionals find adolescent health providers fear of community opposition to affect the adoption of sex education programs because it allows the survey respondent to gauge how impactful this particular barrier has been in the Rio Grande Valley.

Scales and Kirby (1983) found the lack of sex education coalitions in the community to be one of the greatest barriers to sex education programs. The question, "adolescent health providers inability to develop functioning sex education coalitions,

serves as a barrier to the adoption of integrated sex education programs in the Rio Grande Valley area", measures the extent to which youth development professionals find that a failure of adolescent health providers to organize sex education coalitions serves as a barrier to implementing sex education programs in the Rio Grande Valley. This is a critical barrier because without the ability to organize sex education supporters, advocacy for change to sex education policies currently will be limited. With adequate support, resources and training on community advocacy, adolescent health providers will be knowledgeable to organize such efforts.

In addition to creating functioning sex education coalitions, adolescent health providers must organize sex education stakeholders for community advocacy (Schultz and Boyd, 1984). The question, "adolescent health providers inability to organize sex education stakeholders for community advocacy, serves as a barrier to the adoption of integrated sex education programs in the Rio Grande Valley, measures the extent to which youth development professionals find that an failure of adolescent health providers to organize sex education stakeholders for community advocacy for sex education programs, serves as a barrier to implementing sex education programs. This is an important barrier because without vivid community support of sex education programs, change to current sexual health policies will not occur.

Lack of community support for sex education programs is a major barrier to implementing sex education program (Alexander, 1984). The question, "Adolescent health providers lack of sex education community advocacy, is a barrier to the adoption of sex education programs in the Rio Grande Valley, measures the extent to which youth development professionals find that adolescent health providers lack of vivid support of

sex education programs in the community, serves as a barrier to implementing sex education programs in the Rio Grande Valley. This is an important barrier because without the support of administrators and peer sex education stakeholders, adolescent health providers will not have the resources or training to effectively advocate for sex education programs. Yet, without the community support of adolescent health providers, parents and other sex education supporters will not engage in civic advocacy.

Personal Attitudes

To determine whether youth development professionals find that adolescent health providers personal attitudes towards sex education programs is a barrier to the adoption of integrated sex education programs in the Rio Grande Valley, survey participants were asked to rank their feelings on a scale of strongly agree, somewhat agree, neutral, somewhat disagree or strongly disagree in reference to the following question, "the personal attitudes of adolescent health providers towards sex education programs, is a barrier to the adoption of integrated sex education programs in the Rio Grande Valley. This is an effective measurement of the degree to which youth development professionals find that adolescent health providers" personal attitudes towards sex education programs affect the adoption of sex education programs because it allows the survey respondent to gauge how impactful this particular barrier has been in the Rio Grande Valley.

Literature supports that focusing on one particular type of sex education program is ineffective (Wiley, 2011). Programs need to be evidence based, regardless of the content they cover. The question, "adolescent health professionals bias or favor towards particular sex education programs, hinders to adoption of integrated sex education

programs in the Rio Grande Valley", measures the extent to which youth development professionals find that adolescent health providers" favor or dismiss of particular sex education programs due to a personal preference, serves as a barrier to implementing sex education programs in the Rio Grande Valley. This is an important barrier because school districts and organizations could be missing the opportunity to implement effective programs for the target population, due to a personal attitude of adolescent health provider. Also, due to this preference of material, youth could be receiving misleading information on important health issues.

Literature supports that by focusing on schools as the only resource for sex education information, another barrier preventing sex education implementation is created (Scales and Kirby, 1981). The question, "adolescent health providers failure to consider external sex education providers for sex education programs, such as after school programs or community organizations, hinders the adoption of sex education programs in the Rio Grande Valley", measures the extent to which youth development professionals find that adolescent health providers failure to look at alternative sex education providers, serves as a barrier to implementing sex education programs in the Rio Grande Valley. This is an important barrier because school educators have limited time and resources to allocate towards sex education. Bringing in sex educators from external organizations to provide the education to youth, creates a partnership between the school and the community.

Research has found that adolescent health providers have a perceived notion that the community does not support sex education programs which in turn, directly affects the ability of adolescent health providers to provide adequate sex education coverage.

The question, “adolescent health providers perception that the local community opposes sex education programs, hinders the adoption of integrated sex education programs”, measures the extent to which youth development professionals find that adolescent health providers belief that community members do not support sex education programs, serves as a barrier to implementing sex education programs in the Rio Grande Valley. This is an important barrier because when adolescent health providers do not feel they have the support of the community, they neglect critical sex education material, which can be hazardous to the sexual health of youth. By engaging in public advocacy for sex education programs, school administrators and school board members can help to alleviate these perceptions. Also, by providing resources and training opportunities, adolescent health providers will have the ability to organize sex education stakeholders and increase public support.

School Administrators

Program Knowledge

To determine whether youth development professionals find that school administrators lack of sex education program knowledge is a barrier to the adoption of integrated sex education programs in the Rio Grande Valley, survey participants were asked to rank their feelings on a scale of strongly agree, somewhat agree, neutral, somewhat disagree or strongly disagree in reference to the following question, “school administrators‟ lack of sex education knowledge, in the Rio Grande Valley, is a barrier to the adoption of integrated sex education programs” This is an effective measurement of the degree to which youth development professionals find the lack of knowledge regarding sex education programs, among school administrators, to affect the adoption of

sex education programs because it allows the survey respondent to gauge how impactful this particular barrier has been in the Rio Grande Valley.

School administrators‟ failure to acknowledge a need for sex education programs is a barrier to the implementation of sex education courses (Blinn-Pike, 2000). The question, “school administrators‟ failure to acknowledge the need for sex education programs, hinders the adoption of integrated sex education programs in the Rio Grande Valley”, measures the extent to which youth development professionals find school administrators failure to acknowledge the need for sex education programs, serves as a barrier to implementing sex education programs in the Rio Grande Valley. This is an important barrier because school administrators must be involved in the planning process of the program to ensure effectiveness. If administrators refuse to recognize the needs and benefits of the program; it is unlikely they will provide leadership and resources for the programs.

Literature strongly supports that in order for sex education programs to be effective, administrators must provide leadership in the development of the program (Rose, 2005). The question, “school administrators failure to provide leadership in the development of sex education programs, hinders the adoption of sex education programs in the Rio Grande Valley”, measures the extent to which school administrators‟ lack of leadership in the development of sex education programs, serves as a barrier to implementing sex education programs in the Rio Grande Valley. This is an important barrier because without administrators‟ leadership in developing a strategy for the implementation of sex education programs, the success of the program is in jeopardy (Schultz and Boyd, 1984).

Failing to provide adequate resources for sex education personnel is a major barrier to implementing sex education programs (Fagen et al., 2010). Literature supports that for any program to be effective, it must have appropriate personnel, incentives, resources and operational control (Bandura, 2004). The question, "school administrators‟ failure to provide adequate resources for sex education programs, hinders the adoption of integrated sex education programs in the Rio Grande Valley", measures the extent to which youth development professionals find that school administrators refusal to provide the necessary resources to sex education programs, serves as a barrier to implementing sex education programs in the Rio Grande Valley. This is an important barrier because if teachers do not receive training and are not provided an evidence based curricula, they run the risk of only providing partial sex education information or providing inaccurate sex education.

Community Support

To determine whether youth development professionals find that school administrators perceptions of sex education program opposition is a barrier to the adoption of integrated sex education programs in the Rio Grande Valley, survey participants were asked to rank their feelings on a scale of strongly agree, somewhat agree, neutral, somewhat disagree or strongly disagree in reference to the following question, "school administrators‟ perceptions of sex education program opposition is a barrier to the adoption of integrated sex education programs in the Rio Grande Valley area." This is an effective measurement of the degree to which youth development professionals find school administrators‟ perceptions of sex education program opposition, to affect the adoption of sex education programs because it allows the survey

respondent to gauge how impactful this particular barrier has been in the Rio Grande Valley.

Literature supports that while school administrators may support sex education, they often fail to participate in sex education coalitions and committees (Peskin et al., 2011). The question, "school administrators lack of participation in community sex education coalitions, is a barrier to the adoption of integrated sex education programs in the Rio Grande Valley", measures the extent to which youth development professionals find that school administrators" lack of participation in sex education coalitions, serves as a barrier to implementing sex education programs in the Rio Grande Valley. This is an important barrier because in addition to illustrating a lack of support to campus staff, not participating in coalitions shows a lack of sex education support to the community. For a sex education program to be effective, it must be visually supported by those who have the capacity to make systematic changes in sex education program implementation.

By failing to participate in sex education coalitions, school administrators are also failing to provide community support for sex education programs (Alton, 2011). The question, "school administrators lack of community support for sex education programs, is a barrier to the adoption of integrated sex education programs in the Rio Grande Valley", measures the extent to which youth development professionals find that school administrators refusal to provide community support for sex education programs, serves as a barrier to implementing sex education programs in the Rio Grande Valley. This is an important barrier because in order for sex education programs to be effective, school administrators must be involved in the implementation of the programs and provide visual support of the programs (Peskin et al., 2011). By failing to provide support, they

are hindering the development of sex education programs locally and in some ways failing state-wide initiatives.

Research supports that administrators are more influenced by perceived opposition to sex education programs than by those who support it (Somerfield, 1970). The question, "school administrators‟ fear of community opposition to sex education programs, serves as a barrier to the adoption of integrated sex education programs in the Rio Grande Valley", measures the extent to which youth development professionals find that school administrators‟ fear of sex education opposition from the community, serves as a barrier to implementing sex education programs in the Rio Grande Valley. This is an important barrier because in sheer numbers, sex education supporters far outnumber those who oppose sex education. Yet, due to the lack of public support for sex education programs, the strength of opposition groups appears much greater than it really is. Unless administrators can overcome their adversity to community support for sex education, the perceived fear of community opposition will continue to hinder sex education efforts.

Personal Attitudes

To determine whether youth development professionals find that school administrators personal attitudes towards sex education programs is a barrier to the adoption of integrated sex education programs in the Rio Grande Valley, survey participants were asked to rank their feelings on a scale of strongly agree, somewhat agree, neutral, somewhat disagree or strongly disagree in reference to the following question, "the personal attitudes of school administrators towards sex education programs, is a barrier to the adoption of integrated sex education programs in the Rio Grande Valley area." This is an effective measurement of the degree to which youth

development professionals find the personal attitudes of school administrators to affect the adoption of sex education programs because it allows the survey respondent to gauge how impactful this particular barrier has been in the Rio Grande Valley.

Literature supports that school administrators perceive a high level of parental aversion to sex education programs (Peskin et al., 2011). The question, "school administrators‟ belief that parents do not support sex education programs, hinders the adoption of sex education programs in the Rio Grande Valley", measures the extent to which youth development professionals find that school administrators‟ personal beliefs towards parental support of sex education programs, serves as a barrier to implementing the programs in the Rio Grande Valley. This is an important barrier because literature reports parents being very receptive to their children receiving sex education and a lot of parents wish schools spent more time on sex education (Tortolero et al., 2011). Unless parents who support sex education become more vocal about their desires for their children‟s sexual health education, the personal beliefs of administrators that parents do not support sex education will continue to prevail.

Literature supports the personal belief of school administrators‟ that school should focus on academia and not on subjects such as sex education (Donovan, 1998). The question, "school administrators‟ belief that sex education programs are not academia, hinders the adoption of sex education programs in the Rio Grande Valley", measures the extent to which youth development professionals find that school administrators‟ failure to acknowledge sex education as an academic need, serves as a barrier to implementing sex education programs in the Rio Grande Valley. This is an important barrier because research shows a direct link between the consequences of teens engaging in sexual

activity and poor academic performance. Failing to provide youth with sex education leads them to making poor sexual health choices, which has an adverse effect on their academic performance. It is difficult for youth to concentrate on academia if they are concerned about STD symptoms or pregnancy.

Research has found that effective sex education programs must increase sexual health knowledge and have an effect on youth sexual behavior (Jemmont et al., 2010) Literature also supports the belief that one-day or one-session sex education programs provide a barrier to implementing more comprehensive sex education programs (Kalmuss et al., 2003). The question, "school administrators" belief that sex education can be fully covered in minimal class meetings, hinders the adoption of integrated sex education programs in the Rio Grande Valley", measures the extent to which youth development professionals find that school administrators" perception that one-day or one-session sex education programs are effective sexual health education, serves as a barrier to implementing sex education programs in the Rio Grande Valley. This is an important barrier because research has found that a majority of sex education courses in the US consist of one to three class meetings, which is insufficient time for an effective sex education program (Henry J. Kaiser Family Foundation, 2000). For sex education programs to be effective they must include components on esteem building, communication skills, conflict resolution and decision-making, as well as provide opportunity for youth to build upon these skills through exercises and sexual health information (Kirby, 1989). One or two class periods are inadequate times for this level of education.

School Board Members

Program Knowledge

To determine whether youth development professionals find that school board members‟ lack of sex education program knowledge is a barrier to the adoption of integrated sex education programs in the Rio Grande Valley, survey participants were asked to rank their feelings on a scale of strongly agree, somewhat agree, neutral, somewhat disagree or strongly disagree in reference to the following question, “school board members‟ lack of sex education program knowledge, in the Rio Grande Valley area, is a barrier to the adoption of integrated sex education programs in the Rio Grande Valley area.” This is an effective measurement of the degree to which youth development professionals find school board members‟ lack of sex education program knowledge, to affect the adoption of sex education programs because it allows the survey respondent to gauge how impactful this particular barrier has been in the Rio Grande Valley.

Literature supports that school board members‟ failure to provide clear consensus on sex education policies is a direct barrier to providing effective sex education programs (Henry J. Kaiser Family Foundation, 2000). The question, “school board members‟ failure to provide consensus on a sex education policy for the district, hinders the adoption of integrated sex education programs in the Rio Grande Valley”, measures the extent to which youth development professionals find that school board members‟ failure to provide clear direct policies surround sex education programs, serves as a barrier to implementing sex education programs in the Rio Grande Valley. This is an important barrier because without sex education guidelines and policies, teachers often have their hands tied due to administrators‟ fear of public opposition if sex education programs are implemented. Not providing consensus on sex education policies creates a variance

among campuses on the sex education information available, creating a discrepancy in the knowledge shared with youth.

Failure to disseminate sex education policy information to appropriate staff and the public is a barrier to implementing effective sex education programs (Fagen et al., 2010). The question, "school board members‟ failure to disseminate sex education policy information to appropriate leadership, hinders the adoption of integrated sex education programs in the Rio Grande Valley", measures the extent to which youth development professionals find that school board members‟ failure to disseminate sex education policy information to the appropriate staff, serves as a barrier to implementing sex education programs in the Rio Grande Valley. This is an important barrier because due to the lack of sex education policy information, school administrators are often hesitant to implement sex education programs for fear of causing controversy among the public. With current information on policy decisions, school administrators are more confident in implementing sex education programs because they have guidance on what acceptable.

Literature on sex education programs supports school board members‟ failure to require evidence based sex education programs to be implemented as a barrier to the implementation of sex education programs (Markham et al., 2011). The question, "school board members‟ failure to require evidence based sex education programs be used in schools providing sex education, hinders the adoption of sex education programs in the Rio Grande Valley", measures the extent to which youth development professionals find that school board members‟ failure to mandate evidence based sex education program be used, serves as a barrier to implementing sex education programs in the Rio Grande Valley. This is an important barrier because by using evidence based

sex education curricula, schools eliminate the risk of providing inaccurate information. Providing factual information, eases parent‟s apprehensions of the content their child is exposed it and increases adolescent health providers and school administrators‟ confidence in sex education programs.

Community Support

To determine whether youth development professionals find that school board members‟ perceptions of community opposition towards sex education programs is a barrier to the adoption of integrated sex education programs in the Rio Grande Valley, survey participants were asked to rank their feelings on a scale of strongly agree, somewhat agree, neutral, somewhat disagree or strongly disagree in reference to the following question, "school board members‟ perceptions of sex education program opposition in the community is a barrier to the adoption of integrated sex education programs in the Rio Grande Valley area." This is an effective measurement of the degree to which youth development professionals find school board members perceptions of community opposition to sex education programs to affect the adoption of sex education programs because it allows the survey respondent to gauge how impactful this particular barrier has been in the Rio Grande Valley.

Research finds that when school board members‟ fail to acknowledge the need for sex education programs and the benefits this education brings to youth, they are creating a barrier to providing sex education information to youth (Burdell, 1996). The question, "school board members‟ failure to acknowledge the need for sex education programs, is a barrier to the adoption of integrated sex education programs in the Rio Grande Valley", measures the extent to which youth development professionals find that school board

members‟ failure to recognize the need to provide sex education programs, serves as a barrier to implementing sex education programs in the Rio Grande Valley. This is an important barrier because research shows that when school board members fail to acknowledge the need for sex education programs, schools neglect to provide them, which , makes students vulnerable to unhealthy sexual behavior due to their lack of sexual health knowledge (Lindevaldsen, 2011).

Research finds community pressures hold more weight when it comes to elected representatives. School board members‟ fear of public opposition to sex education programs is a severe barrier to the implementation of sex education programs (Sharp, 2002). The question, “school board members‟ fear of sex education program community opposition is a barrier to the adoption of integrated sex education programs in the Rio Grande Valley”, measures the extent to which youth development professionals find that school board members‟ fear of community aversion to sex education programs, serves as a barrier to implementing sex education programs in the Rio Grande Valley. This is an important barrier because research has found that parents overwhelmingly support sex education programs, which means this fear of community aversion is in reality a perceived fear (Tortolero et al., 2011). Until school board members‟ see sex education support from parents and the community, they will continue to believe this perceived belief that the greater population does not support sex education.

School board members‟ have been reluctant to allow external sex education providers to influence the development of sex education programs, which has created a barrier to their implementation (Land, 2002). The question, “school board members‟ failure to consider sex education expertise from external sex education providers, serves

as a barrier to the adoption of integrated sex education programs in the Rio Grande Valley", measures the extent to which youth development professionals find that school board members" refusal to consider external expertise on sex education programs for youth, serves as a barrier to implementing sex education programs in the Rio Grande Valley. This is an important barrier because school board members" focus primarily on what they consider academia based curricula, external organizations with expertise in sexual health programs have more time and resources allocated to researching evidence based curricula, applying for grants to provide sex education programs and monies to train appropriate staff. By alienating these organizations schools are missing an opportunity to receive valuable information and resources from the organizations.

Personal Attitudes

To determine whether youth development professionals find that school board members towards sex education programs is a barrier to the adoption of integrated sex education programs in the Rio Grande Valley, survey participants were asked to rank their feelings on a scale of strongly agree, somewhat agree, neutral, somewhat disagree or strongly disagree in reference to the following question, "school board members" personal attitudes towards sex education programs is a barrier to the adoption of integrated sex education programs in the Rio Grande Valley area." This is an effective measurement of the degree to which youth development professionals find school board members" personal attitudes towards sex education programs to affect the adoption of sex education programs because it allows the survey respondent to gauge how impactful this particular barrier has been in the Rio Grande Valley.

Literature supports that parents want sex education to be a part of the regular school day and believe more time and resources should be allocated towards the programs (Tortolero et al., 2011). School board members‟ personal beliefs that sex education programs do not belong in the public school system poses a barrier to the implementation of sex education programs. The question, "school board members‟ belief that sex education is not a responsibility of the public school system hinders the adoption of integrated sex education programs in the Rio Grande Valley", measures the extent to which youth development professionals find that school board members‟ personal opinions that sex education is not academic and therefore does not belong in school, serves as a barrier to implementing sex education programs in the Rio Grande Valley. This is an important barrier because parents want this education to be provided by the public school to their children. School board members are neglecting to fulfill the desire of their target population, youth and parents, when they refuse to acknowledge that sex education provides academic benefits to youth. Schools should provide education to youth to enable them to make educated decisions on their lifestyle choices; sex education programs provide this opportunity for youth.

Literature supports the personal attitude that sex education has long been considered as morality based rather than education based. However, with medically accurate evidence-based sex education programs, sex education shifts from morality oriented to scientific based (Luker, 2006). School board members‟ failure to acknowledge this shift is a barrier to sex education implementation. The question, "school board members‟ belief that sex education is morality education rather than health based education hinders the adoption of integrated sex education programs in the Rio

Grande Valley", measures the extent to which youth development professionals find that school board members‟ failure to recognize the shift in sex education program content to being scientific based and medically accurate, serves as a barrier to implementing sex education programs in the Rio Grande Valley. This is an important barrier because by becoming more knowledgeable of evidence based sex education programs, school board members can recognize the value of sex education programs in providing youth with scientific health information and youth development skills.

Research has found that a barrier to school boards‟ ability to impact student sexual health education is the „withholding of resources that are essential to successful implementation" (Golden and Zajac, 2001:1106). By ignoring the sex education expertise of outside adolescent health providers, school board members are jeopardizing the success of youth being able to make healthy sexual decisions. The question, "school board members‟ bias towards collaborations with external sex education providers, hinders the adoption of sex education programs in the Rio Grande Valley", measures the extent to which youth development professionals find that school board members‟ bias towards school and community organization collaborations in providing sex education programs to youth, serves as a barrier to implementing sex education programs in the Rio Grande Valley. This is an important barrier because until school board members‟ can acknowledge the need for sex education programs, become involved in community efforts to increase support for sex education programs and accept the sexual health expertise of external adolescent health providers and the wealth they can bring to schools and youth, little change will occur in the personal attitudes of school board members. For integrated sex education programs to be effective, parents, adolescent health providers,

school administrators and school board members need to become educated in the value of sex education programs and become advocates for providing youth with the education needed to make lifelong healthy sexual choices.

Survey Research

This study utilized survey research to obtain the perceived barriers to sex education implementation, from the perspective of youth development professionals. Survey research is commonly used in social research because it enables data collection for populations that are too large to directly observe (Babbie, 2004). In addition, because this study serves a descriptive research purpose, surveys are the most appropriate use of data collection (Babbie, 2004).

Babbie reports that researchers are able to minimize the risk of collecting unreliable data by utilizing a standardized survey tool (2004). And while this can be an advantage to using survey research, it can be a limitation as well. One of the weaknesses of using a standardized survey to collect data is the problem of artificiality (Babbie, 2004). Artificiality occurs when respondents determine their own opinion on the particular research subject at the time they begin taking the survey, which in turn may not reflect their true opinion on the matter. Also, surveys often require respondents give predetermined response to the questions, such as strongly agree, somewhat agree or disagree. This small realm of choices often does not capture respondents‟ complex feelings on the subject, which forces them to settle on an answer that may not reflect their true opinion.

King et al. (2004), discuss an occurring problem with survey research due to the individuality of the respondents. Each respondent understands the same question in

different ways, which cause data collected through survey methods to become unreliable. By constructing survey questions that measure one precise variable and use specific language, rather than vague technical terms can help alleviate this threat to survey research.

The survey tool for this research utilizes the Likert scale to measure the respondents‟ agreement to a series of questions. The Likert scale is one of the most common formats used in questionnaire research (Babbie, 2004). McCall (2001) notes that when properly developed, Likert scales can be great tools in addressing the need to consider opinions or attitudes. The questions in this study were developed through an analysis of the existing literature and operationalized to gain insight to the perceived barriers to implementing sex education programs in the Rio Grande Valley area.

Survey Distribution

Access to remote individuals, virtual communication with respondents and instant gratification have long steered survey distribution techniques away from traditional methods to online distribution of survey research. Once costly and confusing, online survey distribution has now become not only cheaper but much more time efficient.

Wright expresses the unique ability of the internet to provide access to large groups of people with likeminded interests, beliefs and values regarding issues, problems or activities, as one of the selling points of online survey distributions (2005:2). No longer do researchers have to spend labor intensive hours figuring out where to find a particular population; instead they can discover an answer if not the population itself with the touch of a few keys. In addition, web based survey distribution typically offers a

lower cost to researchers than paper methods, due to declining software and development expenses (Sax et al., 2003).

While researchers have found that distribution of electronic surveys do incur fewer costs than paper surveys, research on the response rate to electronic surveys is still questionable. Wright (2005) describes response rates as a disadvantage to online survey distribution, due to the inability to control the sample population due to snowballing sampling, it is difficult to determine how many individuals actually receive the survey, yet simply fail to respond.

The concern over privacy is another disadvantage to using electronic survey distribution (Shannon et al, 2002). If surveys are sent to respondents through email, the respondents return email is typically visible to the researcher when the survey is returned. By using web-based survey distribution, such as survey monkey, where the survey is posted online and respondents are sent a URL link to access the survey, researchers can control for some of the concern of privacy, however when transferring information online, nothing can be one hundred percent secure.

Self-administered, web-based and paper based surveys were used in this research. Babbie states that "self-administered surveys are cheaper and quicker than face to face interviews" (2004: 273). For this reason, the survey tool was constructed through the online survey software, www.surveymonkey.com, and administered by emailing the URL link associated with the survey to select youth development professionals participating in the study (see *Appendix B*). Using a purposive population sample, this study targets specific youth development professionals in the Rio Grande Valley. These professionals include elementary, middle and high school staff, as well as, youth development program

staff of local non-profit organizations, all of which play a direct role in sex education. For schools this is most often a nurse, counselor or health instructor.

This study utilized a purposive sample population due to the specific elements targeted in the research. Babbie notes that "sometimes it"s appropriate to select a sample on the basis of knowledge of a population, its elements and the purpose of the study" (2004:183). Due to the need for Rio Grande Valley respondents to have knowledge of youth development, sex education programs, and sex education policies for school districts, purposive sampling was the most appropriate choice for this study.

Though using a purposive sampling method could leave room for error due to researcher bias, however this bias only becomes a disadvantage when the researcher uses poorly considered populations (LAERD dissertation, 2012). After a review of the scholarly literature on sex education programs and potential barriers, youth development professionals with a direct role in sex education programs are an accepted population.

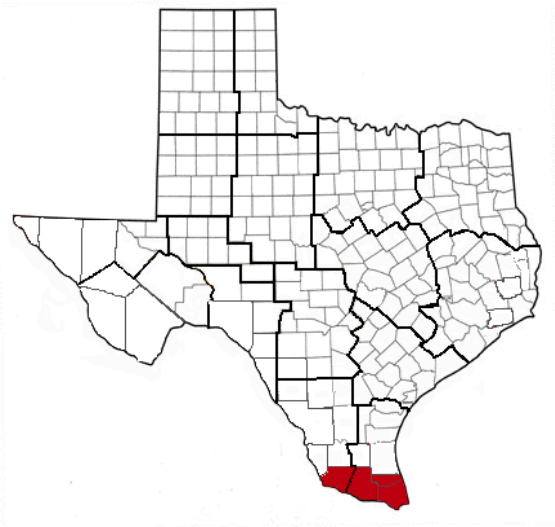
Population

The sample population for this study constitutes youth development professionals serving the Rio Grande Valley area. While the survey focuses on barriers to sex education programs among four primary stakeholders; parents, adolescent health providers, school administrators and school board members, the survey population consists of youth development professionals, not stakeholders. Youth development professionals are those who in a sector which provide youth development services directly or indirectly through subcontractors to the public. This includes but is not limited to afterschool employees, sex education school personnel, nurses, government agencies with a focus on youth development, health care professionals, higher education personnel

and non-profit organizations. Describing sex education barriers from the perspective of youth development professionals enables a more comprehensive observation of the barriers that inflict each sex education stakeholder and provides opportunity to develop an inclusive plan for overcoming the barriers, promoting cohesiveness among the stakeholders.

The Rio Grande Valley in Texas constitutes a large span of land and population, thus making a research across the entire area time consuming and costly. For this reason, this study focused on select areas representing the Lower Rio Grande Valley area in Texas to conduct a survey analysis in efforts of describing the barriers to sex education implementation in the Rio Grande Valley area, from the perspective of youth development professionals. *Table 3.2* illustrates the Lower Rio Grande Valley area in the State of Texas (Judd et al., 1996).

Table 3.2
Mapping of the Lower Rio Grande Area



The highlighted region of the state represents the Lower Rio Grande Valley area, which will be focused on for this study. *Table 3.3* displays the cities which constitute the Lower Rio Grande Valley in Texas (Perry Castaneda Library, 2011).

Table 3.3

Rio Grande Valley Map

For the purpose of this study, the following cities were selected to participate in the survey research; Edinburg, McAllen, Harlingen, Mission, Pharr, Mercedes, Donna and Weslaco.

To reach the target population, this study utilized purposive sample population to select specific participants to receive the survey tool. To obtain a contact list for survey distribution, school campus websites were access to determine the correct youth development professional to participate in the study. When the information was not

available online, campuses were contacted by phone to determine the correct individual and obtain their information.

There are roughly 693 Elementary, Middle and High schools in the lower Rio Grande Valley area, however not all campuses were included in this study. This study only focused on traditional instructional school campuses in the targeted Texas cities; McAllen, Edinburg, Mission, Mercedes, Harlingen, Pharr, San Juan, Weslaco and Donna. Of 693 campuses, a total of 205 fit the study"s demographics. Twenty additional campuses were removed from the study due to a failure to obtain correct contact information for the appropriate staff member, resulting in a total of 185 campuses eligible to participate in the study.

Youth development program staff with a direct role in sex education from the following organizations were selected to participate; Boys & Girls Club McAllen, Department of Human Services, Edinburg Kids, Planned Parenthood, Kids Clinic, Hidalgo County Health Department, Region One Educational Services Center, Palmer Drug Abuse, Rio Grande Valley Council, Children"s Advocacy Center, Nuestra Clinic, Big Brothers Big Sisters, Prevention Research Center, Boys and Girls Club of Edinburg, Harlingen Department of Health Services, University of Texas Pan-America, University of Texas Pan-America, Social Work Department and Texas A&M University. Each organization selected to participate currently provides services to the targeted Rio Grande Valley cities. Organizations were selected to participate due to their involvement in the Rio Grande Valley Teen Pregnancy Prevention Coalition, which is an active coalition that focuses on addressing sex education needs in the area.

Descriptive Statistics

This study employees the use of descriptive statistics to effectively illustrate the results of the survey questionnaire. Descriptive statistics provide "important summary information about variables….such as knowing the percentage of citizens favoring improved parks" (Berman, 2007:96).

Using the mean provides an opportunity to determine the favorability of each barrier within the descriptive categories. In addition, descriptive statistics, such as frequency distributions, allow insight into the range in perceptions of youth development professionals towards the barriers to the implementation of sex education programs in the Rio Grande Valley area.

Frequency distributions also provide an opportunity for future research into developing a multi-dimensional strategy to overcoming the barriers to sex education program implementation across all descriptive categories as a whole.

Human Subjects Protection

All research which involves the use of human subjects is govern by law and required to obtain approval from an Institutional Review Board prior to conducting the study (Babbie, 2004). This study requires the use of survey questionnaires to be completed by human subjects. Due to the participation of human subjects in completing the survey questionnaires, a request for review was sent to the Texas State University Institutional Review Board and approval was granted.

Social research concerns with ethical research falls into three main areas which are, that participation is voluntary, the study does not pose harm to the participant and confidentiality of the participants must be protected (Babbie, 2004). This study utilized

precautions to avoid any ethical issues. To protect the participant‟s identity, the survey questionnaire used for this study does not include any identifying information such as name or date of birth. Prior to participating in the survey study, participants were informed verbally and written that participation in the study was voluntary and they could refrain from continuing participation at any time.

Chapter 4
Results

Chapter Purpose

The purpose of this chapter is to present the results and analysis of the survey research, describing the perceived barriers to implementing sex education programs in the Rio Grande Valley, from the perspective of youth development professionals. This analysis uses simple descriptive statistics to describe the respondents‟ results to closed ended questions regarding sex education in the Rio Grande Valley. The findings from the data collected support this research purpose by describing the perceived barriers to the implementation of sex education programs in the Rio Grande Valley, from the perspective of youth development professionals.

Population Demographics

The survey tool utilized for this research was distributed to a purposive sample of youth development professionals with a direct role in sex education programming were drawn from the following school districts and organizations; McAllen Independent School District, Edinburg Independent School District, Mission Independent School District, Mercedes Independent School District, Harlingen Independent School District, Pharr/San Juan Independent School District, Weslaco Independent School District, Donna Independent School District, Boys & Girls Club McAllen, Department of Human Services, Edinburg Kids, Planned Parenthood, Kids Clinic, Hidalgo County Health Department, Region One Educational Services Center, Palmer Drug Abuse, Rio Grande Valley Council, Children‟s Advocacy Center, Nuestra Clinic, Big Brothers Big Sisters, Prevention Research Center, Boys and Girls Club of Edinburg, Harlingen Department of

Health Services, University of Texas Pan-America, University of Texas Pan-America, Social Work Department and Texas A&M University.

To identify target recipients of the survey tool, a current list of traditional schools (excludes charter, alternative and specialized campuses) within each district was obtained through internet research. Once identified, campuses were contacted to identify and obtain contact information for sex education providers on each campus. Communication with the President and Vice President of the Rio Grande Valley Teen Pregnancy Prevention Coalition resulted in a list of community organizations with a direct role or interest in teen pregnancy and sex education. The community organizations were contacted to obtain contact information for all staff with direct roles in sex education programming.

A total of 215 surveys were distributed, 185 were distributed to select school personnel and 30 surveys were distributed to personnel from the organizations listed above. Sixty five surveys were received, resulting in a response rate of thirty-three percent.

Of the youth development professionals participants, demographic questions revealed that the majority of respondents were female representing roughly eighty-five percent compared to male which represented approximately fifteen percent. Demographics results also reveal that approximately fifty-nine percent of respondents hold youth development positions in the public education system, twenty-three percent hold positions in the healthcare industry and nine percent represent the non-profit sector. In addition, thirty-nine percent have over fifteen years of experience in the youth development sector, twelve percent have between 10-15 years of experience, nineteen

percent have between 5-10 years of experience and twenty six percent have between 0-5 years of experience. All Rio Grande Valley cities selected to participate in the study had representation, with Edinburg having the largest representation (23.1%). *Table 4.1* provides the demographics of the survey respondents. A comprehensive list of results for all survey information collected can be found in *Appendix B*.

Table 4.1 Survey Respondent Demographics

Gender	Female	Male
N= 65	84.6%	15.4%

Employment Sector	State Government Agency	Local Government Agency	Non-Profit	Public Education	Higher Education	Health Care	Private Sector
N=64	3.1%	0%	9.2%	58.5%	4.6%	23.1%	0%

Years of Experience	0-5 years	5-10 years	10-15 years	More than 15 years
N=62	26.2%	18.5%	12.3%	38.5%

Sex Education Stakeholders

One of the most critical factors in determining the barriers to sex education program implementation is to identify the key stakeholders in the programs themselves. A review of the literature identified four primary stakeholders in the implementation of sex education programs, parents, adolescent health providers, school administrators and school board members (Kirby, 1983). While all four stakeholders play a major role in the implementation of sex education programs, some hold more influence than others. *Table 4.2* describes the perceptions of stakeholder influence on sex education programs and their content, from the perspective of youth development professionals.

Table 4.2 Stakeholder Influence on Sex Education Program Implementation

Survey Question	N	% Strongly and Somewhat Agree
1a. Parents have the greatest influence on whether or not a school provides a sex education program to its students.	62	84.6%
1b. Adolescent Health Providers have the greatest influence on whether or not a school provides a sex education program to its students.	56	44.6%
1c. School Administrators have the greatest influence on whether or not a school provides a sex education program to its students.	58	76.9%
1d. School Board Members have the greatest influence on whether or not a school provides a sex education program to its students.	58	81.5%

Parental Barriers to Sex Education Implementation

Parents are often cited as the number one barrier to the implementation of sex education programs. A majority of survey participants (84.6%) cited parents as having the greatest influence on whether or not a school will provide sex education (*Table 4.2*). While research has shown that parents often do support sex education programs, parents remain to be a perceived barrier due to their lack of knowledge, failure to advocate for programs and personal beliefs on sex education programs (Tortolero et al., 2011).

An overwhelming ninety-two percent of survey respondents indicated that parents‟ lack of knowledge about sex education programs prevents their adoption in the Rio Grande Valley (*Table 4.3*). In addition, *Table 4.3* illustrates that respondents found parents personal attitudes towards sex education programs to be a factor in the adoption of sex education programs in the Rio Grande Valley. Parental opposition to sex education programs was found to have less impact on the implementation of sex education programs.

Table 4.3 Parental Barriers to Sex Education Programs

Survey Question	N	% Strongly and Somewhat Agree
3. Parents lack of knowledge about integrated sex education programs prevents their adoption in the Rio Grande Valley.	65	92.3%
5. Parental opposition to sex education programs is a barrier to providing sex education programs in the Rio Grande Valley.	63	80%
7. The personal attitudes of parents towards integrated sex education programs prevents the adoption of school based sex education courses in the Rio Grande Valley.	64	87.7%

Program Knowledge

The majority of respondents (86.2%) felt parents are a barrier because of their lack of sex education program knowledge (*Table 4.4*). A majority of respondents (78.4%) also strongly or somewhat agreed that parents" lack of involvement in the development of sex education programs hinders the adoption of sex education programs (*Table 4.4*). *Table 4.4* illustrates participant"s responses to all parental program knowledge barriers.

This aligns with research that suggests parents need to be involved in the first steps to developing sex education programs to alleviate perceive prejudice against sexual health programs and to educate parents on the comprehensive information these programs cover (Russell et al. 2004).

Table 4.4 Parental Program Knowledge Barriers to Sex Education Implementation

Barrier	N	% Strongly and Somewhat Agree
4a. Parents lack of awareness for the need of sex education programs hinders the adoption of integrated sex education programs in the Rio Grande Valley.	61	86.2%
4b. Parents belief it is their right to provide sex education to their children hinders the adoption of integrated sex education programs in the Rio Grande Valley.	58	69.2%
4c. Parents lack of involvement in the development of sex education programs hinders the adoption of integrated sex education programs in the Rio Grande Valley.	59	78.4%

Community Support

While parental opposition to sex education programs was not ranked as highly as lack of program knowledge or the influence of personal attitudes, a majority of the respondents felt that parents opposition to community advocacy for sex education programs (75.4%) and their lack of community support of sex education programs (73.8%) hinder the adoption of the programs in the Rio Grande Valley (*Table 4.5*). *Table 4.5* illustrates participant"s responses to all parental community support barriers to sex education adoption.

These findings reflect the major barriers to sex education programs cited in literature. Though parents may support sex education programs, they rarely reflect this opinion through community advocacy and vocal support of the programs due to a lack of participation in advocacy efforts (Donovan, 1998).

Table 4.5 Parental Community Support Barriers to Sex Education Implementation

Barrier	N	% Strongly and Somewhat Agree
6a. Parents opposition to community advocacy for sex education is a barrier to the adoption of integrated sex education programs in the Rio Grande Valley.	60	75.4%
6b. Parents perceptions of the strength of sex education opposition groups are a barrier to the adoption of integrated sex education programs in the Rio Grande Valley.	59	72.3%
6c. Parents lack of community support for sex education programs is a barrier to the adoption of integrated sex education programs in the Rio Grande Valley.	59	73.8%

Personal Attitudes

Survey respondents found the personal attitudes of parents to have a considerable influence on the adoption of sex education programs among schools. The majority of respondents (83.1%) felt parents‟ concerns over the values associated with sex education programs to be a greater barrier to the adoption of sex education programs than the actual fear of what content is included in the program (80%) (*Table 4.6*). *Table 4.6* illustrates participant‟s responses to all parental personal attitude barriers to sex education program adoption.

The findings reflected in this research on parental personal attitudes towards sex education reflect the findings author Kristin Luker (2006) discusses in her book, *When Sex Goes to School*, which illustrate that when parents connect sexual health education to their own personal values and those of their children, parents can exert great influence on the implementation of sex education programs among schools.

Table 4.6 Parental Personal Attitude Barriers to Sex Education Implementation

Barrier	N	% Strongly and Somewhat Agree
8a. Parents perception that sex education should not be covered at school hinders the adoption of integrated sex education programs in the Rio Grande Valley.	62	78.1%
8b. Parents fear over the content covered during sex education programs hinders the adoption of integrated sex education programs in the Rio Grande Valley.	58	80%
8c. Parents concern over the values associated with sex education programs hinders the adoption of integrated sex education programs in the Rio Grande Valley.	58	83.1%

Adolescent Health Providers Barriers to Sex Education Implementation

While only forty-five percent of respondents found adolescent health providers to have the greatest influence in whether or not a school will offer sex education programs (*Table 4.2*), they often play the greatest role in the actual delivery of sex education materials to youth Schultz and Boyd, 1984). In addition, it is typically the adolescent health providers who bear the responsibility of generating support for sex education programs.

The majority of respondents (70.8%) found that adolescent health providers fear of community opposition to be the greatest adolescent health provider barrier to implementing sex education programs (*Table 4.7*). Because adolescent health providers bear a large responsibility for generating community support of sex education programs, they face a tremendous task of balancing what they believe should be taught in sex education programs and what they feel they can promote without causing opposition from the community (Dailard, 2001). *Table 4.7* illustrates participant"s responses to adolescent health providers" barriers to sex education implementation.

Table 4.7 Adolescent Health Providers Barriers to Sex Education Program Implementation

Survey Question	N	% Strongly and Somewhat Agree
9. Adolescent health providers‟ lack of knowledge about integrated sex education programs prevents their adoption in the Rio Grande Valley.	64	46.1%
11. Adolescent health providers‟ fear of community opposition is a barrier to providing sex education programs in the Rio Grande Valley.	64	70.8%
13. The personal attitudes of adolescent health providers towards integrated sex education programs prevent the adoption of school based sex education courses in the Rio Grande Valley.	62	49.2%

Program Knowledge

The majority of survey participants found the greatest adolescent health provider program knowledge barrier to sex education program is the lack of knowledge of school district sex education policies (50.8), rather than an actual lack of sex education curriculum knowledge (46.2%) (*Table 4.8*). *Table 4.8* illustrates participant‟s responses to all adolescent health providers‟ program knowledge barriers.

This aligns with research conducted by Peskin et al. (2011), which found that only about seventy three percent of 604 school professionals interviewed were aware of the school districts policy on sexual health education.

Table 4.8 Adolescent Health Providers Program Knowledge Barriers to Sex Education Implementation

Barrier	N	% Strongly and Somewhat Agree
10a. Adolescent health providers‟ lack of experience in community education hinders the adoption of integrated sex education programs in the Rio Grande Valley.	61	41.6%
10b. Adolescent health providers‟ lack of knowledge on the school district sex education policies hinders the adoption of integrated sex education programs in the Rio Grande Valley.	59	50.8%
10c. Adolescent health providers‟ lack of awareness of evidence-based sex education curricula hinders the adoption of integrated sex education programs in the Rio Grande Valley.	60	46.2%

Community Support

Adolescent health providers‟ fear of community opposition to sex education program was found to be the greatest barrier among adolescent health providers to the implementation of sex education programs. Among community support, sixty-three percent of respondents found adolescent health providers lack of community advocacy for sex education programs to be the greatest hindrance to sex education program adoption in the Rio Grande Valley (*Table 4.8*). *Table 4.8* illustrates participant‟s responses to all adolescent health providers‟ community support barriers to sex education adoption.

These findings reflect the major barriers to community advocacy in sex education programs cited in literature. Adolescent health providers share the greatest burden in garnering community support for sex education programs. If an environment is hostile to sex education program implementation, it is reasonable to expect a fear among adolescent

health providers in engaging in community advocacy for sex education programs (Butterfoss et al., 1995).

Table 4.8 Adolescent Health Providers Community Support Barriers to Sex Education Implementation

Barrier	N	% Strongly and Somewhat Agree
12a. Adolescent health providers‟ inability to develop functioning sex education coalitions is a barrier to the adoption of integrated sex education programs in the Rio Grande Valley.	61	53.8%
12b. Adolescent health providers‟ inability to organize sex education stakeholders for advocacy is a barrier to the adoption of integrated sex education programs in the Rio Grande Valley.	57	49.2%
12c. Adolescent health providers‟ lack of community advocacy for sex education programs is a barrier to the adoption of integrated sex education programs in the Rio Grande Valley.	60	63.1%

Personal Attitudes

While less than half of respondents (49%) felt adolescent health providers personal attitudes greatly influence the adoption of sex education programs (*Table 4.7*), a majority (62.9%) did find that adolescent health providers perception that the community is unsupportive of sex education programs (*Table 4.9*), hinders the adoption of the programs in the Rio Grande Valley. *Table 4.9* illustrates participant‟s responses to all adolescent health providers‟ personal attitude barriers to sex education program adoption.

These findings are consistent with other research on adolescent health providers‟ perceptions on sex education programs. Adolescent health providers have a perceived notion that parents and the community do not support the instruction of sex education programs (Peskin et al. 2011).

Table 4.9 Adolescent Health Providers Personal Attitude Barriers to Sex Education Implementation

Barrier	N	% Strongly and Somewhat Agree
14a. Adolescent health providers‟ bias or favor towards particular sex education programs hinders the adoption of integrated sex education programs in the Rio Grande Valley.	61	35.4%
14b. Adolescent health providers‟ failure to consider external youth development providers for sex education programs, such as after school programs or community organizations hinders the adoption of integrated sex education programs in the Rio Grande Valley.	56	37%
14c. Adolescent health providers‟ perception that the community is unsupportive of sex education programs hinders the adoption of integrated sex education programs in the Rio Grande Valley.	56	62.9%

School Administrator Barriers to Sex Education Implementation

While respondents only ranked school administrators third as the greatest influence on the adoption of sex education programs (*Table 4.2*), a majority (73.9%) felt that school administrators lack of sex education program knowledge and their perceptions of sex education opposition in the community were great barriers in the adoption of programs in the Rio Grande Valley (*Table 4.10*).

The majority of respondents (70.8%) found that adolescent health providers fear of community opposition to be the greatest adolescent health provider barrier to implementing sex education programs (*Table 4.7*). School administrators often provide the leadership for sex education programs, so it is critical that if sex education programs are going to be successful, that school administrators are knowledgeable and supportive

of the programs (Sabia, 2006). *Table 4.10* illustrates participant‟s responses to school administrator barriers to sex education implementation.

Table 4.10 School Administrator Barriers to Sex Education Program Implementation

Survey Question	N	% Strongly and Somewhat Agree
15. School administrators‟ lack of sex education program knowledge is a barrier to the adoption of sex education programs in the Rio Grande Valley.	63	73.9%
17. School administrators‟ perceptions of sex education opposition in the community is a barrier to providing sex education programs in the Rio Grande Valley.	62	73.9%
19. The personal attitudes of school administrators towards integrated sex education programs prevent the adoption of school based sex education courses in the Rio Grande Valley.	64	61.6%

Program Knowledge

Roughly seventy-one percent of survey participants found the most impactful school administrator program knowledge barrier to sex education program to be school administrators‟ failure to provide leadership in the development of sex education programs (*Table 4.11*). *Table 4.11* illustrates participant‟s responses to all school administrators‟ program knowledge barriers.

Research finds that in order for sex education programs to be accurately implemented, school administrators must play a direct role in providing leadership on how that program should play out (Rose, 2005). By failing to provide that leadership, school administrators are essentially lacking the program knowledge to ensure its‟ effectiveness.

Table 4.11 School Administrators Program Knowledge Barriers to Sex Education Implementation

Barrier	N	% Strongly and Somewhat Agree
16a.School administrators‟ failure to acknowledge a need for sex education programs hinders the adoption of integrated sex education programs in the Rio Grande Valley.	60	61.5%
16b.School administrators‟ failure to provide leadership in the development of sex education programs hinders the adoption of integrated sex education programs in the Rio Grande Valley.	60	70.8%
16c. School administrators‟ failure to provide adequate resources for sex education programs hinders the adoption of integrated sex education programs in the Rio Grande Valley.	60	67.7%

Community Support

School administrator‟s perception of sex education opposition in the community is one of the top barriers to implementing sex education programs in the Rio Grande Valley. Among community support, seventy-four percent of respondents found school administrators fear of community opposition be the greatest hindrance to sex education program adoption in the Rio Grande Valley (*Table 4.12*). *Table 4.12* illustrates participant‟s responses to all school administrator community support barriers to sex education adoption.

These findings reflect the major barriers to community advocacy in sex education programs cited in literature. Research has found that school administrators‟ fear of community opposition to sex education programs has a greater influence on their adaption of curricula than those who support it (Sommerfield, 1970). In addition, due to the perceived fear of community opposition, not only will school administrators fail to

implement programs, but many refuse to exhibit any type of support for sex education programs (Blinn-Pike, 2002).

Table 4.12 School Administrators Community Support Barriers to Sex Education Implementation

Barrier	N	% Strongly and Somewhat Agree
12a. Adolescent health providers" inability to develop functioning sex education coalitions is a barrier to the adoption of integrated sex education programs in the Rio Grande Valley.	61	53.8%
12b. Adolescent health providers" inability to organize sex education stakeholders for advocacy is a barrier to the adoption of integrated sex education programs in the Rio Grande Valley.	57	49.2%
12c. Adolescent health providers" lack of community advocacy for sex education programs is a barrier to the adoption of integrated sex education programs in the Rio Grande Valley.	60	63.1%

Personal Attitudes

As mentioned in *Table 4.10*, more than half (61.6%) of survey participants reported school administrator"s personal attitudes towards sex education programs to be a barrier to sex education program implementation. In addition, an overwhelming seventy-seven percent felt that school administrators" belief that parents do not support sex education programs is a barrier to the adoption of these programs (*Table 4.13*). *Table 4.13* illustrates participant"s responses to all school administrator personal attitude barriers to sex education program adoption.

These findings are consistent with other research on school administrators" personal attitudes towards parents" acceptance of sex education programs. School administrators often limit or eliminate sex education programs to avoid controversy and

report a strong parental opposition to sex education programs (Alexander, 1984; Peskin et al., 2011).

Table 4.13 School Administrator Personal Attitude Barriers to Sex Education Implementation

Barrier	N	% Strongly and Somewhat Agree
20a. School administrators" belief that parents do not support sex education programs hinders the adoption of integrated sex education programs in the Rio Grande Valley.	62	76.9%
20b. School administrators" belief that sex education should not be a part of academia hinders the adoption of integrated sex education programs in the Rio Grande Valley.	57	53.8%
20c. School administrators" belief that sex education can be adequately covered in one to three class meetings hinders the adoption of integrated sex education programs in the Rio Grande Valley.	58	50.8%

School Board Member Barriers to Sex Education Implementation

School board members along with parents have been found to have the greatest influence on the adoption of sex education programs in the Rio Grande Valley. While roughly seventy-five percent of survey participants found all three categories of school board member barriers to sex education implementation to have a great influence on the adoption of programs, the majority of participants (78.5%) ranked school board members perception of community opposition to sex education programs as the greatest barrier (*Table 4.14*).

School board members hold the greatest power granted in Texas to make the ultimate decision on whether sex education programs will be adopted, therefore it is critical that their perceptions of how the community feels about sex education is a true

reflection of the population. *Table 4.14* illustrates participant‟s responses to school board members‟ barriers to sex education implementation.

Table 4.14 School Board Member Barriers to Sex Education Program Implementation

Survey Question	N	% Strongly and Somewhat Agree
21. School board members‟ lack of sex education program knowledge is a barrier to the adoption of sex education programs in the Rio Grande Valley.	63	75.4%
23. School board members‟ perceptions of sex education opposition in the community is a barrier to providing sex education programs in the Rio Grande Valley.	62	78.5%
25. The personal attitudes of school board members towards integrated sex education programs prevent the adoption of school based sex education courses in the Rio Grande Valley.	62	73.9%

Program Knowledge

Roughly seventy-four percent of survey participants agree and somewhat agree that school board members failure to provide a consensus on district sex education policies is the greatest barrier among school board members program knowledge barriers (*Table 4.15*). *Table 4.15* illustrates participant‟s responses to all school board members‟ program knowledge barriers.

These findings are consistent with other research on school board members‟ influence on sex education programs. Often due to school board members lack of sex education program knowledge, they leave the decision of program implementation to individual campuses, which creates huge discrepancies among the information youth are receiving and what is or is not supported (Alton, 2011). By failing to provide a

consensus on what is supported by the district, school board members feed into the fallacy that the community opposes sex education programs.

Table 4.15 School Board Members Program Knowledge Barriers to Sex Education Implementation

Barrier	N	% Strongly and Somewhat Agree
22a.School board members failure to provide a consensus on district sex education policies hinders the adoption of integrated sex education programs in the Rio Grande Valley.	62	73.8%
22b.School board members failure to disseminate sex education policy information to appropriate leadership hinders the adoption of integrated sex education programs in the Rio Grande Valley.	57	64.6%
22c. School board members‟ failure to require the use of evidence based sex education programs hinders the adoption of integrated sex education programs in the Rio Grande Valley.	60	64.6%

Community Support

Respondents found school board members perceptions of community opposition to sex education programs to be the greatest barrier on program adoption in the Rio Grande Valley. Among community support, seventy-nine percent of respondents found school board members fear of community opposition be the greatest hindrance to sex education program adoption in the Rio Grande Valley (*Table 4.14*). In addition, seventy-seven percent of respondents found school board members failure to make an acknowledgement for the need for sex education programs the be a severe barrier to program adoption as well (*Table 4.16*). *Table 4.16* illustrates participant‟s responses to all school board member community support barriers to sex education adoption.

These findings are synonymous to what has been found in past research on sex education programs. Research has found that due to a fear of public opposition, school board members often refuse to acknowledge sex education as a role of the school system or delay in making any concrete decisions on sex education program implementation (Land, 2002; Sharp, 2002).

Table 4.16 School Board Members Community Support Barriers to Sex Education Implementation

Barrier	N	% Strongly and Somewhat Agree
24a.School board members failure to acknowledge the need for sex education programs is a barrier to the adoption of integrated sex education programs in the Rio Grande Valley.	63	76.9%
24b. School board members fear of sex education community opposition is a barrier to the adoption of integrated sex education programs in the Rio Grande Valley.	59	78.5%
24c. School board members failure to consider sex education expertise from external youth development providers, such as after school programs or community organizations is a barrier to the adoption of integrated sex education programs in the Rio Grande Valley.	58	67.7%

Personal Attitudes

Roughly seventy-four percent of participants strongly and somewhat agree that school board members‟ personal attitudes towards sex education programs are an important barrier to sex education program implementation in the Rio Grande Valley (*Table 4.14*). In addition, a majority of respondents (67.7%) found school board members‟ belief that sex education is morality education rather than health education

hinders the adoption of sex education programs in the Rio Grande Valley (*Table 4.17*). *Table 4.17* illustrates participant‟s responses to all school board members‟ personal attitude barriers to sex education program adoption.

These findings are consistent with other research on school board members‟ personal attitudes towards sex education in the public school system. Sex education has long been synonymous with morality and values based education, compared to other countries where sex education comes from a more scientific approach (Luker, 2006). Because of the historically close relationship sex education has with religion, school board members are often apprehensive about introducing sex education content into the classroom for fear of prosecution (Merriam, 2011).

Table 4.17 School Board Members Personal Attitude Barriers to Sex Education Implementation

Barrier	N	% Strongly and Somewhat Agree
26a. School board members belief that sex education is not a responsibility of the public school system hinders the adoption of integrated sex education programs in the Rio Grande Valley.	62	66.2%
26b. School board members belief that sex education is morality education rather than health education hinders the adoption of integrated sex education programs in the Rio Grande Valley.	60	67.7%
26c. School board members‟ bias towards collaborations with outside sources to provide sex education hinders the adoption of integrated sex education programs in the Rio Grande Valley.	58	57%

While many barriers lie in the face of sex education program adoption, they are barriers that can no longer be ignored. With approximately 4,500 births to females age 15-19, in the Rio Grande Valley area each year, it is critical that children receive the

sexual health information needed to make educated decisions on their sexual health (Texas Department of State Health Services, center for Health Statistics, 2011). Though historically parents have been the primary sexual health educator, it is necessary that all four identified stakeholders in sex education; parents, adolescent health providers, school administrators and school board members engage in an unified effort to bring forth change in the availability of sex education information to youth. By identifying the barriers that hinder sex education program adoption in the Rio Grande Valley, strategies can be developed to overcome these barriers and recommendations to address the changes.

Chapter 5
Conclusion

Chapter Purpose

The purpose of this final chapter is to provide a summary of the key research findings on the perceived barriers to the implementation of sex education programs in the Rio Grande Valley, from the perspective of youth development professionals. The research findings are based on a review of the literature and analysis of the survey questionnaires administered to a select group of youth development professionals with a direct role in sex education programming. This chapter also discusses recommendations for overcoming the described barriers and recommendations for future studies.

Summary of Research

While the survey results largely reflect the findings in the existing literature, the results also identify a large discrepancy in communication and an unidentified source of fear among all four stakeholders. For each of the categories assessed, the barriers with the greatest impact on the adoption to sex education programs can be largely attributed to a perceived fear of community opposition and a lack of involvement among stakeholders (see *table 5.1*). Youth development professionals found parents to have the largest influence on whether or not a school provided sex education programs to its" students, with school board members having the second greatest influence, followed by school administrators and adolescent health providers.

Among parental barriers, youth development professionals identified parents" lack of sex education program knowledge to have the greatest influence on parental objections to sex education implementation in the Rio Grande Valley. Parents" lack of involvement in the development of sex education programs leaves them susceptible to misperceptions

of the content and values associated with the programs. Without direct participation in the program development, parents depend on past experiences with sex education or on the opinions of others to develop their support for the programs. In addition, because parents do not participate in program development they also lack the awareness for the need of sex education. Parents need to be involved in program development to understand the benefits associated with participation in sex education programs.

According to youth development professionals, adolescent health providers‟ lack of community advocacy hinders the adoption of sex education programs in the Rio Grande Valley. Adolescent health providers have a responsibility to educate the public on adolescent health issues including sex education. Since they have more direct contact with the public, the community looks to adolescent health providers as a gateway to staying up to date on adolescent issues. Yet, when they fail to raise community awareness towards sex education, the public fails to allocate attention to the issue. In providing community advocacy for sex education, adolescent health providers open doors for collaborations among community members to advance the development of programs.

School administrators‟ failure to provide leadership in the development of sex education programs and their fear of community opposition prevents the adoption of sex education programs in the Rio Grande Valley. Youth development professionals identified the need for school administrators to provide leadership in the development of sex education programs as key to their success. When school administrators provide leadership on the issue, adolescent health providers feel more comfortable addressing the public on the need for sex education and request their participation in the program. Youth development professionals also identified school administrators‟ fear of public

opposition as a barrier to the implementation of sex education. As school administrators take on a more active role in the development of the programs, they gain knowledge in the number of sex education supporters in the community. In becoming aware of these supporters the perceived fear of public opposition diminishes and is replaced with the knowledge that a majority of the community is in support of the programs.

According to youth development professionals, school board members‟ fear of community opposition to sex education programs prevents the adoption of sex education programs in the Rio Grande Valley. Due to the nature of school board members‟ election to the board, they are especially sensitive to public opposition of adolescent health issues. While sex education opposition groups tend to be the most vocal in school board meetings, they majority of the community actually support sex education. School board members need to be made aware of the amount of community support for sex education programs, to gain the confidence that the public wants and expects these programs to exist for youth. This will require sex education advocates becoming vocal to the school board and for members to keep an open mind to the issues adolescents face in today‟s times.

Though improving the communication among these stakeholders will greatly diminish the barriers to sex education implementation in the Rio Grande Valley, the systematic process to acquire this open dialogue can be difficult. Some general recommendations to improve this dialogue are presented in the next section.

Table 5.1 Summary of Survey Results

Parental Barriers
Results Summary
According to youth development professionals, parents lack of involvement in the development of sex education programs and their lack of awareness for the need of sex education programs prevents the adoption of the programs in the Rio Grande Valley.
Adolescent Health Providers Barriers
Results Summary
According to youth development professionals, adolescent health provider‟s lack of community advocacy inhibits the adoption of sex education programs in the Rio Grande Valley.
School Administrator Barriers
Results Summary
According to youth development professionals, school administrators‟ failure to provide leadership in the development of sex education programs and their fear of community opposition prevents the adoption of sex education programs in the Rio Grande Valley.
School Board Member Barriers
Results Summary
According to youth development professionals, school board members‟ fear of community opposition to sex education programs prevents the adoption of sex education programs in the Rio Grande Valley.

Recommendations

Sex education is a highly political issue surrounding science, religion, morality, personal development, healthcare and economics. Because of the politics surrounding sex education, the first step to overcoming barriers associated with program development and implementation is to reframe the focus of the issue. There are two ways of doing this. One method is using a youth development approach to sex education. Literature supports that sex education programs include esteem building, communication skill development, instruction on conflict resolution and decision making (Kirby, 1989). In addition to information regarding sexually transmitted infections, puberty and sexual engagement these programs provide youth development. In a conservative community,

approaching the public and schools with a need for additional youth development programming can open the doors to discussion and collaboration that would not happen if sex education was the basis of the conversation. Another method of reframing sex education includes a scientific approach. Because the dynamics of sex, diagnosis of sexually transmitted infections and pregnancy are science and health issues, approaching sex education from this standpoint allows it to be considered academia. If sex education is placed within an academic course, schools and the public are less likely to ignore the need for the programs, as that would be depriving youth of scientific information. This approach also involves school administrators and school board members because it removes the confusion of what sex education is and how it applies to the school day. As school administrators and school board members become more familiar with sex education and its relation to science, their perceived fear around the issue will diminish.

Approaching sex education in a more public-friendly way, enables adolescent health providers to address sex education publicly without the fear of opposition. The need for youth development and science programs are universally accepted. When sex education is a component of a larger program, the public is more likely to support the effort, which provides a greater opportunity for community involvement.

In gaining community involvement, adolescent health providers have the opportunity to educate those who are unfamiliar with sex education programs or the need for them. A second recommendation for overcoming sex education barriers is the need to involve non-traditional stakeholders in the development of sex education coalitions. It is critical that sex education community supporters and those in opposition develop a working relationship to ensure youth are not cheated of a well-rounded education.

Literature supports that while there are a few community activists who outright oppose any sex education at all; most opposition arises over the issue of what kind of sex education youth will receive (Peskin et al, 2011). Some are in favor of an abstinence message, while others want nothing less than condom distribution in schools. Rather than working to destroy the others efforts, these groups should work together to strengthen sex education awareness. In the Rio Grande Valley, adolescent health providers from Planned Parenthood, Tobacco Prevention, Boys and Girls Club and the Abstinence Education department of the Department of State Health Services have begun working together to address the need for medically accurate sex education in the area. Traditionally these organizations do not work together on joined efforts have not worked harmoniously, yet they all feel strongly that sex education is important to youth in making healthy choices and by working together they are able to enhance the strength of sex education. Building these non-traditional relationships allow sex education coalitions to have a greater audience and capacity for gaining attention and support.

Lastly, since parents are often unaware of the need for sex education and lack the knowledge of what sex education programs offer, it is critical that adolescent health providers make a strong effort to target parents for participation in sex education coalitions. While parental participation is often difficult to accomplish, adolescent health providers need to identify active, outspoken parents and encourage their participation. For parents that are not able to serve on coalitions, sex education discussion panels can be used to attract parents to a one-time event in efforts to acquaint them with sex education material, provide information about the programs and to raise awareness of the need for sex education. Research has shown that in providing parents the opportunity to become

acquainted with sexual health information decreases the likelihood of opposition (Tortolero et al., 2011). Enabling parents the opportunity to educate themselves on sexual health allows them to become part of the development of the program.

The Federal Administration on Children, Youth and Families currently endorses evidence-based sex education programs, most of which have a parent component built in (The National Campaign to Prevent Teen Pregnancy, 2012). The Texas Department of State Health Services requires all abstinence program contractors to provide at least one parent information session to all clients to engage parents in the development of the program and its content (Jamison, 2010). The involvement of parents in sex education is critical to ensure continued community support for the programs.

Future Research

The purpose of this study is to provide a description of the perceived barriers to the implementation of sex education programs in the Rio Grande Valley, from the perspective of youth development professionals, which focused on a select list of Rio Grande Valley schools and organizations. While the schools and organizations that participated provided valuable information regarding the perceived barriers, there is still further research to be conducted to provide a more comprehensive assessment of the barriers to implementing sex education programs. The study could be improved by expanding the research statewide. Determining the sex education barriers that inflict other areas of Texas can provide opportunity for collaborative efforts to address barriers, devise plans for overcoming challenges and provide insight to how different areas combat sex education opposition.

This research considered barriers to sex education implementation from the perspective of youth development professionals. Future research should focus on the perceptions of sex education and its barriers from the viewpoint of parents, adolescent health providers, school administrators and school board members. This will allow for more in-depth view of the influences behind the barriers and what is needed to overcome them.

Lastly, future research should focus on collecting an inventory of sex education programs that are being implemented with success from Texas schools and organizations. This will provide those who do not have sex education with a model for developing programs. An inventory will also allow for areas to observe locations with similar demographics to determine if their current sex education program may be an appropriate fit for them as well. At the very least, it will provide some insight as to where Texas falls in educating our youth on adolescent health in comparison to other states and may serve to highlight the need for sex education reform.

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Appendix A

Appendix A

Sex Education in the Rio Grande Valley

You are being invited to participate in a research survey describing the barriers to implementing sex education programs in the Texas Rio Grande Valley. This survey is being conducted by Crystal Starkey with supervision from Dr. Thomas
Longoria, Associate Professor with the Political Science Department at Texas State University. This study is being conducted as part of a graduate research project to fulfill requirements for a Masters in Public Administration degree. You were selected as a possible participant for this survey because you are currently a youth development professional with involvement in the sexual health education of youth living in the Rio Grande Valley area. This survey is completely anonymous. Your identity and answers are confidential. A summary of the findings can be provided to you upon completion of the study, if requested. Your participation in this study is voluntary and you may choose to withdraw from the study at any time. If you have questions or concerns about this study, please contact me at cs1694@txstate.edu or my supervisor, tl28@txstate.edu.

If you have any questions about your rights as a research participant, you may contact:
IRB chair, Dr. Jon Lasser (512-245-3413 – lasser@txstate.edu), or
Ms. Becky Northcut, Compliance Specialist (512-245-2102).

By continuing to the online survey, you indicate your consent to be in the study.
For the purpose of this study, a few terms are defined to help clarify what the questions are referring to.

* integrated sex education programs are defined as any type of education provided to youth on the topic of sexual health, provided during the regular school day. This can be only one class session, ongoing topic coverage in combination with another course or a seperate sex education course students are enrolled in.

* Adolescent health providers are defined as sex education instructors, non-profit sex education program staff, after school care providers, school nurses, healthcare providers, educational services providers, state agencies and local government departments with a role in adolescent health.

*School administrators include principals, health curriculum specialists, administration department and superintendents.

1. _____ have the greatest influence on whether or not a school provides an integrated sex education program* to its students

	Strongly Agree	Somewhat Agree	Neutral	Somewhat Disagree	Strongly Disagree
Parents					
Adolescent Health Providers*					
School Administrators*					
School Board Members					

2. If a school does provide sex education courses to its students, _____ have the greatest influence on the sexual health content covered during the course.

	Strongly Agree	Somewhat Agree	Neutral	Somewhat Disagree	Strongly Disagree
Parents					
Adolescent Health Providers					
School Administrators					
School Board Members					

3. Parents lack of knowledge about integrated sex education programs, prevents their adoption in the Rio Grande Valley area.

Parents lack of knowledge about integrated sex education programs, prevents their adoption in the Rio Grande Valley area. Strongly Agree

Somewhat Agree

Neutral

Somewhat Disagree

Strongly Disagree

4. _____, hinders the adoption of integrated sex education programs in the Rio Grande Valley.

	Strongly Agree	Somewhat Agree	Neutral	Somewhat Disagree	Strongly Disagree
Parents lack of awareness for the need of sex education programs					
Parents belief it's their right to provide sex education to their children					
Parents lack of involvement in the development of sex education programs					

5. Parental opposition to sex education is a barrier to providing integrated sex education programs in the Rio Grande Valley.

Strongly Agree

Somewhat Agree

- Neutral
- Somewhat Disagree
- Strongly Disagree

6. _____, is a barrier to the adoption of integrated sex education programs in the Rio Grande Valley.

	Strongly Agree	Somewhat Agree	Neutral	Somewhat Disagree	Strongly Disagree
Parents opposition to community advocacy for sex education					
Parents perceptions of the strength of sex education opposition groups					
Parents lack of community support for sex education programs					

7. The personal attitudes of parents towards integrated sex education programs, prevents the adoption of school based sex education courses in the Rio Grande Valley.

- Strongly Agree
- Somewhat Agree
- Neutral
- Somewhat Disagree
- Strongly Disagree

8. _____, hinders the adoption of integrated sex education programs in the Rio Grande Valley area.

	Strongly Agree	Somewhat Agree	Neutral	Somewhat Disagree	Strongly Disagree
Parents perception that sex education should not be covered at school					
Parents fear of					

	Strongly Agree	Somewhat Agree	Neutral	Somewhat Disagree	Strongly Disagree
the content covered during sex education programs					
Parents concern over the values associated with sex education programs					

9. Adolescent health providers knowledge level of sex education programs is a barrier to the adoption of integrated sex education programs in the Rio Grande Valley.

- Strongly Agree
- Somewhat Agree
- Neutral
- Somewhat Disagree
- Strongly Disagree

10. _____, hinders the adoption of integrated sex education programs in the Rio Grande Valley.

	Strongly Agree	Somewhat Agree	Neutral	Somewhat Disagree	Strongly Disagree
Adolescent health providers lack of experience in community education					
Adolescent health providers lack of knowledge on the school district sex education policies					
Adolescent health providers lack of awareness of evidence-based sex education					

	Strongly Agree	Somewhat Agree	Neutral	Somewhat Disagree	Strongly Disagree
curricula					

11. Adolescent health providers fear of community opposition is a barrier to the adoption of integrated sex education programs in the Rio Grande Valley.

- Strongly Agree
- Somewhat Agree
- Neutral
- Somewhat Disagree
- Strongly Disagree

12. _____, serves as a barrier to the adoption of integrated sex education programs in the Rio Grande Valley.

	Strongly Agree	Somewhat Agree	Neutral	Somewhat Disagree	Strongly Disagree
Adolescent health providers' inability to develop functioning sex education coalitions					
Adolescent health providers' inability to organize sex education stakeholders for advocacy					
Adolescent health providers' lack of community advocacy for sex education programs					

13. The personal attitudes of adolescent health providers towards sex education has become a barrier to the adoption of integrated sex education programs in the Rio Grande Valley.

- Strongly Agree
- Somewhat Agree
- Neutral
- Somewhat Disagree

Strongly Disagree

14. _____, hinders the adoption of integrated sex education programs in the Rio Grande Valley.

	Strongly Agree	Somewhat Agree	Neutral	Somewhat Disagree	Strongly Disagree
Adolescent health providers' bias or favor towards particular sex education programs					
Adolescent health providers' failure to consider external youth development providers for sex education programs, such as after school programs or community organizations					
Adolescent health providers' perception that the community is unsupportive of sex education programs					

15. School administrators' lack of sex education program knowledge is a barrier to the adoption of integrated sex education programs in the Rio Grande Valley.

Strongly Agree

Somewhat Agree

Neutral

Somewhat Disagree

Strongly Disagree

16. _____, hinders the adoption of integrated sex education programs in the Rio Grande Valley.

	Strongly Agree	Somewhat Agree	Neutral	Somewhat Disagree	Strongly Disagree
School administrators'					

	Strongly Agree	Somewhat Agree	Neutral	Somewhat Disagree	Strongly Disagree
failure to acknowledge a need for sex education programs					
School administrators' failure to provide leadership in the development of sex education programs					
School administrators' failure to provide adequate resources for sex education programs					

17. School administrators' perceptions of sex education opposition in the community is a barrier to the adoption of integrated sex education programs in the Rio Grande Valley.

- Strongly Agree
- Somewhat Agree
- Neutral
- Somewhat Disagree
- Strongly Disagree

18. _____, serves as a barrier to the adoption of integrated sex education programs in the Rio Grande Valley.

	Strongly Agree	Somewhat Agree	Neutral	Somewhat Disagree	Strongly Disagree
School administrators' lack of participation in community sex education coalitions					
School administrators' lack of community support for sex education					

	Strongly Agree	Somewhat Agree	Neutral	Somewhat Disagree	Strongly Disagree
programs					
School administrators' fear of community opposition to sex education programs					

19. The personal attitudes of school administrators towards sex education, is a barrier to adopting integrated sex education programs in the Rio Grande Valley.

- Strongly Agree
- Somewhat Agree
- Neutral
- Somewhat Disagree
- Strongly Disagree

20. _____, hinders the adoption of integrated sex education programs in the Rio Grande Valley.

	Strongly Agree	Somewhat Agree	Neutral	Somewhat Disagree	Strongly Disagree
School administrators' belief that parents do not support sex education programs					
School administrators' belief that sex education programs should not be part of academia					
School administrators' belief that sex education can be adequately covered in one to three class meetings					

21. School board members' lack of sex education program knowledge, is a barrier to the adoption of integrated sex education programs in the Rio Grande Valley.

- Strongly Agree
- Somewhat Agree
- Neutral
- Somewhat Disagree
- Strongly Disagree

22. _____, hinders the adoption of integrated sex education programs in the Rio Grande Valley.

	Strongly Agree	Somewhat Agree	Neutral	Somewhat Disagree	Strongly Disagree
School board members' failure to provide consensus on district sex education policies					
School board members' failure to disseminate sex education policy information to appropriate leadership					
School board members' failure to require the use of evidence based sex education programs in schools providing sexual health courses					

23. School board members perceptions of community opposition to sex education programs is a barrier to the adoption of sex education programs in the Rio Grande Valley.

- Strongly Agree
- Somewhat Agree
- Neutral
- Somewhat Disagree
- Strongly Disagree

24. _____, serves as a barrier to the adoption of integrated sex education programs in the Rio Grande Valley.

	Strongly Agree	Somewhat Agree	Neutral	Somewhat Disagree	Strongly Disagree
School board members' failure to acknowledge the need for integrated sex education programs					
School board members' fear of sex education program community opposition					
School board members' failure to consider sex education expertise from external youth development providers, such as after school programs or health organizations					

25. The personal attitudes of school board members towards sex education is a barrier to the adoption of integrated sex education programs in the Rio Grande Valley.

- Strongly Agree
- Somewhat Agree
- Neutral
- Somewhat Disagree
- Strongly Disagree

26. _____, hinders the adoption of integrated sex education programs in the Rio Grande Valley.

	Strongly Agree	Somewhat Agree	Neutral	Somewhat Disagree	Strongly Disagree
School board members' belief that sex education is not a responsibility of the public school system					

	Strongly Agree	Somewhat Agree	Neutral	Somewhat Disagree	Strongly Disagree
School board members' belief that sex education is morality education rather than health education					
School board members' bias towards collaborations with outside sources to provide sex education					

27. Please select your gender.

- Male
- Female

28. What is the highest level of education you have received?

- High School diploma
- Some college
- Associates degree
- Bachelor degree
- Masters degree
- PHD
- Other

29. How many years have you been employed in the youth development sector?

30. The majority of my experience in the youth development sector comes from_____.

- State government agencies
- Local government departments
- Non-profit organizations
- Local school districts
- Health care facilities
- Private sector

31. What is your current job title?

32. Please check the Rio Grande Valley areas that you currently serve.

- ☐ Edinburg
- ☐ McAllen
- ☐ Harlingen
- ☐ Mission
- ☐ Pharr
- ☐ Mercedes
- ☐ Donna
- ☐ Weslaco
- ☐ San Juan
- ☐ Other

Appendix B

Appendix B
Survey Response Results

Survey Question	N	Strongly Agree	Somewhat Agree	Neutral	Somewhat Disagree	Strongly Disagree
1a. Parents have the greatest influence on whether or not a school provides a sex education program to its students.	62	66.2%	18.5%	4.6%	3.1%	3.1%
1b. Adolescent Health Providers have the greatest influence on whether or not a school provides a sex education program to its students.	56	24.65%	20%	21.5%	10.8%	9.2%
1c. School Administrators have the greatest influence on whether or not a school provides a sex education program to its students.	58	52.3%	24.6%	4.6%	1.5%	6.2%
1d. School Board Members have the greatest influence on whether or not a school provides a sex education program to its students.	58	56.9%	24.6%	3.1%	0%	4.6%
2a. If a school does provide sex education courses to its students, parents have the greatest influence on the sexual health content covered.	58	50.8%	16.9%	6.2%	6.2%	9.2%
2b. If a school does provide sex education courses to its students, adolescent health providers have the greatest influence on the sexual health content covered.	57	30.8%	23.1%	16.9%	7.7%	9.2%
2c. If a school does provide sex	59	52.3%	24.6%	4.6%	4.6%	4.6%

education courses to its students, school administrators have the greatest influence on the sexual health content covered.						
2d. If a school does provide sex education courses to its students, school board members have the greatest influence on the sexual health content covered.	59	53.8%	16.9%	12.3%	3.1%	4.6%
3. Parents lack of knowledge about integrated sex education programs prevents their adoption in the Rio Grande Valley.	65	72.3%	20%	3.1%	1.5%	3.1%
4a. Parents lack of awareness for the need of sex education programs hinders the adoption of integrated sex education programs in the Rio Grande Valley.	61	63.1%	23.1%	0%	4.6%	3.1%
4b. Parents belief it is their right to provide sex education to their children hinders the adoption of integrated sex education programs in the Rio Grande Valley.	58	41.5%	27.7%	12.3%	6.2%	1.5%
4c. Parents lack of involvement in the development of sex education programs hinders the adoption of integrated sex education programs in the Rio Grande Valley.	59	64.6%	13.8%	9.2%	0%	3.1%
5. Parental opposition to sex education programs is a barrier to providing sex education programs in the Rio Grande	63	53.8%	26.2%	9.2%	3.1%	4.6%

Valley.						
6a. Parents opposition to community advocacy for sex education is a barrier to the adoption of integrated sex education programs in the Rio Grande Valley.	60	43.1%	32.3%	12.3%	0%	4.6%
6b. Parents perceptions of the strength of sex education opposition groups is a barrier to the adoption of integrated sex education programs in the Rio Grande Valley.	59	41.5%	30.8%	9.2%	3.1%	6.2%
6c. Parents lack of community support for sex education programs is a barrier to the adoption of integrated sex education programs in the Rio Grande Valley.	59	44.6%	29.2%	4.6%	6.2%	6.2%
7. The personal attitudes of parents towards integrated sex education programs prevent the adoption of school based sex education courses in the Rio Grande Valley.	64	64.6%	23.1%	4.6%	1.5%	4.6%
8a. Parents perception that sex education should not be covered at school hinders the adoption of integrated sex education programs in the Rio Grande Valley.	62	53.8%	24.6%	4.6%	7.7%	4.6%
8b. Parents fear over the content covered during sex education programs hinders the adoption of integrated sex education programs in the Rio Grande	58	58.5%	21.5%	3.1%	4.6%	1.5%

Valley.						
8c. Parents concern over the values associated with sex education programs hinders the adoption of integrated sex education programs in the Rio Grande Valley.	58	64.6%	18.5%	1.5%	3.1%	1.5%
9. Adolescent health providers‟ lack of knowledge about integrated sex education programs prevents their adoption in the Rio Grande Valley.	64	16.9%	29.2%	16.9%	15.4%	20%
10a. Adolescent health providers lack of experience in community education hinders the adoption of integrated sex education programs in the Rio Grande Valley.	61	15.4%	26.2%	20%	13.8%	18.5%
10b. Adolescent health providers‟ lack of knowledge on the school district sex education policies hinders the adoption of integrated sex education programs in the Rio Grande Valley.	59	30.8%	20%	13.8%	15.4%	10.8%
10c. Adolescent health providers‟ lack of awareness of evidence-based sex education curricula hinders the adoption of integrated sex education programs in the Rio Grande Valley.	60	23.1%	23.1%	20%	15.4%	10.8%
11. Adolescent health providers‟ fear of community opposition is a barrier to providing sex education programs in the Rio	64	40%	30.8%	13.8%	9.2%	4.6%

Grande Valley.						
12a. Adolescent health providers‟ inability to develop functioning sex education coalitions is a barrier to the adoption of integrated sex education programs in the Rio Grande Valley.	61	21.5%	32.3%	21.5%	7.7%	10.8%
12b. Adolescent health providers‟ inability to organize sex education stakeholders for advocacy is a barrier to the adoption of integrated sex education programs in the Rio Grande Valley.	57	21.5%	27.7%	18.5%	10.8%	9.2%
12c. Adolescent health providers lack of community advocacy for sex education programs is a barrier to the adoption of integrated sex education programs in the Rio Grande Valley.	60	27.7%	35.4%	12.3%	7.7%	9.2%
13. The personal attitudes of adolescent health providers towards integrated sex education programs prevents the adoption of school based sex education courses in the Rio Grande Valley.	62	12.3%	36.9%	21.5%	12.3%	12.3%
14a. Adolescent health providers bias or favor towards particular sex education programs hinders the adoption of integrated sex education programs in the Rio Grande Valley.	61	10.8%	24.6%	33.8%	9.2%	15.4%
14b. Adolescent	56	10.8%	26.2%	29.2%	9.2%	10.8%

health providers failure to consider external youth development providers for sex education programs, such as after school programs or community organizations hinders the adoption of integrated sex education programs in the Rio Grande Valley.						
14c. Adolescent health providers perception that the community is unsupportive of sex education programs hinders the adoption of integrated sex education programs in the Rio Grande Valley.	56	27.7%	35.4%	10.85	4.6%	7.7%
15. School administrators‟ lack of sex education program knowledge is a barrier to the adoption of sex education programs in the Rio Grande Valley.	63	47.7%	26.2%	10.8%	3.1%	9.2%
16a.School administrators‟ failure to acknowledge a need for sex education programs hinders the adoption of integrated sex education programs in the Rio Grande Valley.	60	49.2%	12.3%	7.75	7.7%	15.4%
16b.School administrators‟ failure to provide leadership in the development of sex education programs hinders the adoption of integrated sex education programs in the Rio Grande	60	55.4%	15.4%	7.7%	3.1%	10.8%

Valley.						
16c. School administrators‟ failure to provide adequate resources for sex education programs hinders the adoption of integrated sex education programs in the Rio Grande Valley.	60	55.4%	12.3%	10.8%	3.1%	10.8%
17. School administrators‟ perceptions of sex education opposition in the community is a barrier to providing sex education programs in the Rio Grande Valley.	62	50.8%	23.1%	10.8%	4.6%	6.2%
18a.School administrators‟ lack of participation in community sex education coalitions is a barrier to the adoption of integrated sex education programs in the Rio Grande Valley.	61	36.9%	30.8%	7.7%	7.7%	10.8%
18b. School administrators‟ lack of community support for sex education programs is a barrier to the adoption of integrated sex education programs in the Rio Grande Valley.	56	36.9%	24.6%	9.2%	6.2%	6.2%
18c. School administrators‟ fear of community opposition to sex education programs is a barrier to the adoption of integrated sex education programs in the Rio Grande Valley.	58	52.3%	21.5%	4.6%	3.1%	7.7%
19. The personal attitudes of school	64	35.4%	26.2%	15.4%	9.2%	12.3%

administrators towards integrated sex education programs prevent the adoption of school based sex education courses in the Rio Grande Valley.						
20a. School administrators‟ belief that parents do not support sex education programs hinders the adoption of integrated sex education programs in the Rio Grande Valley.	62	43.1%	33.8%	4.6%	3.1%	10.8%
20b. School administrators‟ belief that sex education should not be a part of academia hinders the adoption of integrated sex education programs in the Rio Grande Valley.	57	33.8%	20%	9.2%	9.2%	15.4%
20c. School administrators‟ belief that sex education can be adequately covered in one to three class meetings hinders the adoption of integrated sex education programs in the Rio Grande Valley.	58	30.8%	20%	16.9%	9.2%	12.3%
21. School board members lack of sex education program knowledge is a barrier to the adoption of sex education programs in the Rio Grande Valley.	63	56.9%	18.5%	6.2%	6.2%	9.2%
22a.School board members failure to provide a consensus on district sex education policies hinders the adoption of integrated sex	62	43.1%	27.7%	13.8%	4.6%	6.2%

education programs in the Rio Grande Valley.						
22b.School board members failure to disseminate sex education policy information to appropriate leadership hinders the adoption of integrated sex education programs in the Rio Grande Valley.	57	35.4%	29.2%	10.85	6.25	6.2%
22c. School board members failure to require the use of evidence based sex education programs hinders the adoption of integrated sex education programs in the Rio Grande Valley.	60	40%	24.6%	15.45	6.2%	6.2%
23. School board members perception of community opposition to sex education programs is a barrier to providing sex education programs in the Rio Grande Valley.	62	55.4%	23.1%	7.7%	4.6%	4.6%
24a.School board members failure to acknowledge the need for sex education programs is a barrier to the adoption of integrated sex education programs in the Rio Grande Valley.	63	56.9%	20%	6.2%	6.2%	7.7%
24b. School board members fear of sex education community opposition is a barrier to the adoption of integrated sex education programs in the Rio Grande	59	60%	18.5%	4.6%	4.6%	3.1%

Valley.						
24c. School board members failure to consider sex education expertise from external youth development providers, such as after school programs or community organizations is a barrier to the adoption of integrated sex education programs in the Rio Grande Valley.	58	46.2%	21.5%	9.2%	7.7%	4.6%
25. The personal attitudes of school board members towards integrated sex education programs prevents the adoption of school based sex education courses in the Rio Grande Valley.	62	46.2%	27.7%	9.2%	6.2%	6.2%
26a. School board members belief that sex education is not a responsibility of the public school system hinders the adoption of integrated sex education programs in the Rio Grande Valley.	62	40%	26.2%	16.9%	7.7%	4.6%
26b. School board members belief that sex education is morality education rather than health education hinders the adoption of integrated sex education programs in the Rio Grande Valley.	60	43.1%	24.6%	12.3%	6.2%	6.2%
26c. School board members bias towards collaborations with outside sources to	58	30.8%	26.2%	20%	6.2%	6.2%

provide sex education hinders the adoption of integrated sex education programs in the Rio Grande Valley.						

27.

Gender	Female	Male
N= 65	84.6%	15.4%

28. What is the highest level of education you have received?

Education Level	Responses N=64
High School Diploma	0%
Some College	10.8%
Associates Degree	23.1%
Bachelor Degree	26.2%
Masters Degree	30.8%
PHD	1.5%
Other	6.2%

29. How many years have you been employed in the youth development sector?

Years of Experience	0-5 years	5-10 years	10-15 years	More than 15 years
N=62	26.2%	18.5%	12.3%	38.5%

30. The majority of my experience in the youth development sector comes from_____?

Employment Sector	Responses N=63
State Government Agency	6.2%
Local Government Agency	1.5%
Non-profit Organization	6.2%
Local School District	49.2%
Healthcare Facilities	9.2%
Private Sector	1.5%
Multiple Sectors	23.1%

31. What is your current job title?

Job Title	Responses N=64
State Government Program Staff	3.1%
Local Government Program Staff	0%
Non-profit Program Staff	9.2%

Teacher	12.3%
Education Administration Staff	10.8%
School Nurse	20%
School Counselor	10.8%
Special Program Staff for School District	4.6%
Higher Education Staff	4.6%
Healthcare Staff	23.1%
Private Sector Staff	0%
Other	0%

32. Please check the Rio Grande Valley areas you currently serve.

Service Area	Responses N=65
Edinburg	23.1%
McAllen	12.3%
Harlingen	9.2%
Mission	1.5%
Mercedes	6.2%
Donna	3.1%
Weslaco	7.7%
San Juan/Pharr	3.1%
Other	20%
Multiple Service Areas	13.8%