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A Coordinated and Systematic Model for Adopting, Implementing and Maintaining Effective Sexual Health Education Programs in Schools

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Adolescence is a time of transition when our young people establish patterns of behavior and make lifestyle choices that affect both their current and future health. Serious health and safety issues such as motor vehicle crashes, violence, substance use, and risky sexual behaviors highlight the need for prevention activities at the individual, peer, family, school, community, and societal levels. *Healthy People 2020*¹ has added adolescent health as a new topic area to reflect the need to effectively address several important public health and social problems that begin during this age range (ages 10-19), including teen and unplanned pregnancies.

School health programs and policies may be one of the most efficient means to prevent or reduce risk behaviors and prevent serious health problems among students,² but getting evidence-based sexual health education activities into schools can be a complicated process. A coordinated approach to school health is recommended by federal Centers for Disease Control and Prevention (CDC) to better enable schools to build partnerships and teamwork among school health and education professionals; build collaboration and communication among public health, school health, and education professionals; and focus efforts on helping students engage in protective, health-enhancing behaviors and avoid risk behaviors.^{3,4} Schools serve a very important role in promoting the health and safety of young people and helping them establish lifelong healthy behavior patterns. The model presented in this report uses a systematic and coordinated approach to increase evidence-based health education in schools.

The need to increase and sustain the use of effective school health programs related to sexual risk is evident when looking at the data. Sexual risk behaviors place adolescents at risk for HIV infection, other sexually transmitted diseases (STIs), and unintended pregnancy. An estimated 8,300 young people aged 13–24 years in the 40 states reporting to CDC had HIV infection in 2009,⁵ nearly half of the 19 million new sexually transmitted infections each year are among young people aged 15–24 years,⁶ and more than 400,000 teen girls aged 15–19 years gave birth in 2009.⁷ Data from the CDC Youth Risk Behavior Surveillance System (YRBSS), reports that among U.S. high school students surveyed in 2009⁸: 46% [52% in TX] had ever had sexual intercourse; 34% [38% in TX] had sexual intercourse during the previous 3 months. Of those currently sexually active, 39% [42% in TX] did not use a condom the last time they had sex; and 77% [84% in TX] did not use birth control pills or Depo-Provera to prevent pregnancy the last time they had sex.

While valuable resources exist that review the evidence on effective policies and programs related to teen pregnancy and sexually transmitted infections,⁹⁻¹¹ working models that assist our educational system in the selection, implementation, and maintenance of effective school-based adolescent health programs are needed. Models, such as the one presented in this paper, provide strategic tools to help increase the adoption and use of evidence-based sexual health programs in schools.

Replicating sexual health programs in school-based settings: A model for schools outlines four phases with seven action steps to assist school districts in the adoption, implementation, and maintenance of evidence-based programs designed to reduce unplanned teen pregnancies among school-aged youth. The methods used in the development of the model (i.e., knowledge acquisition; knowledge engineering; knowledge representation; knowledge validation) are excellent and the developed model corresponds nicely to the framework presented by *Healthy People 2020* in addressing our national health objectives: Mobilize, Assess, Plan, Implement, and Track (MAPIT).¹ The report provides a comprehensive plan that engages all of the important stakeholders associated with a school system (e.g., district level staff; school level staff; involvement of parents, students, community agencies) and develops an implementation plan based on input, review, and validation from these stakeholders. At the school level, the flexibility of the model is also advantageous to implementing evidence-based prevention, as schools may be at different levels of readiness to adopt such programs.

The model's four phases (Assessment; Preparation; Implementation; Maintenance) are logical and clearly described. The results from this study hold much potential to inform Texas and the nation about how a coordinated and practical model can assist school districts to increase the adoption, implementation, and maintenance of evidence-based programs addressing sexual health. It may also be advantageous for schools to have assessment procedures that offer clear, complete, and consistent analysis of health education curricula based on the National Health Education Standards.^{12,13} Such standards provide a framework for curriculum development and selection, instruction, and student assessment in health education and help integrate health education activities into a school system's educational structure. Following a standards-based structure may better assist school districts in the assessment and preparation phase of this exemplary model.

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