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“It falls on all our shoulders”: Overcoming Barriers to Delivering Sex Education in West Texas Schools

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“It falls on all our shoulders”: Overcoming Barriers to Delivering Sex Education in West Texas Schools

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Nationwide, there exist racial, socioeconomic, and geographic disparities in rates of pregnancy, birth, and sexually transmitted infections (STIs) for teens, with particularly high rates among teens in Texas.¹⁻⁶ Abundant evidence has shown that comprehensive sex education can be an effective strategy for reducing sexual risk behaviors and adverse sexual health outcomes such as those listed above.⁷⁻¹⁰ However, access to and quality of sex education in public schools often falls far below recommended standards,¹¹⁻¹³ particularly in Texas.^{14,15} In light of this deficiency, it is critical to identify approaches to increase access to this essential type of education, and particularly in school settings. The current exploratory study qualitatively investigates barriers to effectively delivering sex education in West Texas public schools and identifies strategies for overcoming these barriers.

Sexual and Reproductive Health in Texas

Texas consistently ranks among the top five states with the highest teen birth rates in the country. In 2016, Texas had a teen birth rate of 31.0 births per 1,000 girls (aged 15-19 years) compared to a national average of 20.3 births per 1,000.¹⁶ Texas was also one of only three states that experienced an *increase* in teen birth rates between 2014-2015.¹⁷ Furthermore, this study comes at a time when access to family planning and reproductive health services in Texas are in serious jeopardy. Recent legislation resulted in closure of 25% of the state's family planning clinics (most of which serve low-income women), resulting in significant declines in the number of patients served, the number of claims for long-acting reversible contraception, and the number of claims for contraceptive injections, as well as a documented increase in childbirths covered by Medicaid.^{18,19} Other resources to prevent teen pregnancy and STIs – such as programs developed and evaluated through the federal Teen Pregnancy Prevention program under the Office of Population Affairs – have been defunded under the current federal administration, resulting in a loss of \$200 million in teen pregnancy prevention funding nationwide and a loss of \$8.6 million in funding for Texas programs.^{20,21} More recently, increased Title X regulations have further restricted access to family planning services.²² Together, this indicates there is a significant shortage of sexual and reproductive health resources in Texas.

Extensive research has documented the effectiveness of sex education – specifically comprehensive sex education – at reducing adolescent sexual health risks. Comprehensive sex education refers to a curriculum that addresses a wide range of topics related to human development, relationships, abstinence, and disease prevention using age-

appropriate and medically accurate information.²³ This is in contrast to other types of sex education, such as abstinence-only (that does not discuss contraception or other risk prevention methods or discusses contraception in a negative light) and abstinence-based or abstinence-plus programs (that emphasize abstinence as the first and best choice for teens, but do teach about contraceptives and other risk prevention methods).²³ Both the Centers for Disease Control and Prevention and the Future of Sex Education project have put forth recommendations to guide the development of comprehensive sex education curricula in K-12 education,^{11,24} yet many students do not receive adequate sex education, especially in Texas. For example, in 2009 the state of Texas removed the high school health education requirement to graduate from Texas public schools. This change has removed the primary platform for the delivery of sex education content. In fact, a recent study of Texas public schools found that 44% of districts that did not have a health education course also did not teach anything about sex education.¹⁴ Coupled with a five-fold increase in federal funding for abstinence-only sex education (now referred to as “sexual risk avoidance education”),²⁵ Texas teens are at increased risk of not receiving the information they need to support their sexual health.

History of Sex Education in Texas

With over 1200 independent school districts containing almost 8800 campuses and serving 5.4 million K-12 youth,²⁶ the Texas public school system is the second largest in the country.²⁷ This school system is managed by the concept of “local control,” which is the authority given to local elected school boards to govern their respective school districts with little to no involvement from the Texas Education Agency (TEA) or the Texas Education Code (TEC), which defines Texas public school regulations and policies.

When it comes to sex education, local control is partially provided, but with statutory guidance from the TEC. Technically, sex education is not required to be taught in Texas. Nonetheless, the TEC defines certain parameters on sex education for local school district officials, with specific guidance about the elements of instruction (see Appendix A). Within the TEC is the requirement of a School Health Advisory Council (SHAC), an appointed parent and community group that specifically is charged “...to assist the district in ensuring that local community values are reflected in the district’s health education instruction.”²⁸ Specific guidance as to the makeup, role, and function of these committees is also found within the statute (see Appendix B). It should be noted that there is no penalty provided in Texas law for those districts not in compliance with the TEC.

A 2016 report on the state of sex education in Texas public schools found that 83% of school districts provided abstinence-only sex education or no sex education at all.¹⁴ This means an overwhelming majority of students enrolled in public schools do not have access to essential sexual health information in schools. Furthermore, the percent of school districts providing no sex education at all was 11 times higher at the time of the study compared to nearly 10 years prior.¹⁴

Current Study

Increased access to comprehensive sex education is a critical need of Texas public schools, particularly considering the sociopolitical landscape restricting access to sexual and reproductive health services. There has been limited research regarding the delivery of sex education in school settings, and a significant gap exists in our understanding of factors influencing the implementation of such education in public schools (for an exception, see Eisenberg et al.²⁹). To address these, the current exploratory study qualitatively examines the following research questions:

1. What barriers exist that keep sex education from being effectively taught in West Texas schools?
2. What strategies can be used to overcome these barriers?

These findings provide a preliminary understanding of the sex education landscape in this geographic region to inform future efforts to deliver sex education to youth living in West Texas, particularly in school settings. This is essential in order to increase the reach and impact of existing programs, and ultimately reduce health disparities and the societal costs associated with childbearing.

METHODS

Study Setting

El Paso County is located in the westernmost tip of Texas. In 2015, El Paso County had over 800,000 residents and approximately 83% of the population identified as Hispanic/Latino.³⁰ Approximately 20% of the population lived in poverty and 23% did not have health insurance; these percentages were greater than the Texas population estimates overall but smaller than those of other Texas border counties.^{30,31}

Between 2002-2011, the teen birth rate in El Paso County was nearly twice the national birth rate for girls 15-19 years old.³² In 2013, the teen birth rate in El Paso County was 51 per 1000, compared to 40 per 1000 in Texas

and 27 per 1000 nationally.³² Furthermore, one of the priority health areas identified by the 2013 El Paso County Community Health Assessment included expanding the provision of sex education and reducing teen pregnancy.³³ Therefore, the goals of this study aligned with existing health needs.

El Paso County includes nine public school districts. Most recent student enrollment estimates indicate these school districts range significantly in size: from three schools (approximately 800 students) in the smallest district to 93 schools (approximately 57,000 students) in the largest district.³⁴

Participants

Eligible participants included individuals who work for an organization in El Paso County whose purpose directly impacts adolescent sexual health and/or the implementation of sex education programming; there were no exclusion criteria. Participants for this study (n = 4) included a district superintendent; a district director of health, wellness, and physical education; a health education manager for the department of public health; and the director of a countywide youth health education program. Each participant represented different sectors within El Paso County and had served in their current role for between 2-15 years.

Procedure

The study used in-depth interviews in order to better understand the community's sex education landscape. Participants were recruited via purposive sampling. A local community member identified potential stakeholders and provided contact information. Eligible participants were contacted by the lead author via email to assess interest and to schedule the interview. All interviews were conducted by the lead author, took place in a private meeting space in the participants' workplace, and lasted 45 to 70 minutes. The interview guide is available in Appendix C. Participants completed informed consent procedures prior to beginning the interview and were offered a \$25 gift card for their participation. The study also used youth focus groups. However, based on the research questions investigated in this study, only the data from the interviews were used in the analysis. All procedures were approved by the Institutional Review Board of the University of North Carolina at Chapel Hill (IRB # 16-0970).

Data Analysis

All interviews were audio recorded and transcribed using a professional transcription service. Transcripts served as the primary data source,

supplemented by field notes taken during and after each interview. All data were analyzed using Atlas.ti v.7. The lead author developed a codebook based on interview protocols and emerging themes identified throughout data collection. Coded transcripts were used to generate code reports, and excerpts from these reports were organized into quote matrices to analyze salient themes in the data, alongside memos written by the lead author. Findings from this analysis were discussed with content experts for validation.

RESULTS

Study participants identified several policy-, organizational-, and interpersonal-level barriers to effectively deliver sex education in schools. The results below are presented according to each of these levels, followed by strategies for overcoming these barriers.

Policy-Level Barriers

Participants expressed frustration at state-level policies regarding health education – including sex education – in public schools (Table 1). More specifically, participants reported that state health education policies hinder effective delivery of sex education in schools by making health education classes optional, withholding institutional support and limiting accountability for implementation, and providing vague guidance for content requirements.

Table 1. Policy-Level Barriers to Delivering Sex Education in School Settings, July 2016

Barrier	Quote(s)
Health education is not required for high school graduation	“Our lawmakers don't see that health has to be a required component of things... [and] in some places, if it's not required, it's not done.”
Limited in-school time to teach sexual health and other health topics	“I think we have to address that. I think we need that time back. I don't know where it's gonna come from 'cause everybody wants their time. But how are we supposed to teach sex education when we have a [total of one] semester to teach health, to teach nutrition, to teach wellness, to teach consumer health, all those things that are also just as important. Where's

	the time gonna come from? Where do we put it? That's a huge issue for us.”
Misinterpretation of state sex education policies	“The other barrier that we have is that programs like ours are not allowed in school... Because of the sexuality. And in the state of Texas, it's abstinence only. And this is not abstinence only. Because it covers birth control, it covers services, [etc]”

First, by eliminating the high school health requirement in 2009, health education classes have become optional. As a result, many school districts simply do not offer it. This has important implications for sex education considering sexual health topics are most often covered during health education classes, and participants identified this as an important barrier. Second, the absence of state-level requirements for health education means that schools which choose to offer this type of instruction do not receive institutional support for implementing the course. Schools have limited time to deliver sex education content – often one semester during which several health topics are taught – and therefore do not have enough protected time to teach this material. When faced with competing priorities and limited time, participants reported that many educators prefer not to teach sexual health content. Finally, the terms of the policies regarding sex education (stipulating that abstinence must be emphasized) causes confusion and concern over what is permissible by law. For many, this focus on abstinence is interpreted to mean they cannot teach about other sexual health topics (eg, contraception). These policies result in successful community-based programs or evidence-based curricula being heavily discouraged from being implemented in school settings. Participants said that without a clear understanding of the Texas Education Code, educators often default to taking an overly cautious approach to sex education content.

Study participants clearly noted how state policies – or the lack thereof – create disincentives for public schools to offer sex education. Additionally, participants described how schools are not accountable for providing accurate or evidence-based information, and misinterpretation of requirements deter many educators from using comprehensive curricula. These factors illustrate the complex manner in which state-level policy directly and indirectly influences how sex education is delivered in schools – and if it is offered at all.

Organizational-Level Barriers

Both the lack of teacher training and school culture pose important barriers to delivering sex education in schools (Table 2). First, in the instances when health education is offered, health education teachers are the primary agents responsible for teaching sex education, yet participants described how many of them are underprepared for teaching this material. On one hand, health education teachers are discouraged from bringing in outside health professionals to teach sex education topics and face increased pressure to teach this material themselves. On the other hand, many teachers – even those with health certification – currently lack adequate training for delivering this material. Health education teachers, therefore, face conflicting demands: to assume the sole responsibility of teaching sex education in schools, while lacking the appropriate training and resources to perform this task effectively, ultimately setting unreasonable expectations for instruction.

Table 2. Organizational-Level Barriers to Delivering Sex Education in School Settings, July 2016

Barrier	Quote(s)
Pressure on teachers to teach sexual health content themselves	“There’s a big push to not bring in outside speakers so much anymore... [because] ‘We have health teachers; why should we bring in somebody from outside when these folks are here to teach it?’”
Lack of teacher training	“I do know that there are teachers who maybe even have a health certification as a health teacher who just don't feel comfortable teaching that content. One, because lack of training. And that kind of falls on us [administrators]. But go out there and try to find an effective staff development piece for the instruction of human sexuality. There's lots of curriculums out there, but nobody teaches us, really.”
School culture	“There's nine school districts, and every school district's a little different, and their values are a little different. There's a couple of school districts that are very open to having you go in and talk about birth control. Others, they don't want you to touch it.”

School culture is another important contributing factor. Nearly all the participants in this study described a wide degree of heterogeneity – even within school districts – when it comes to acceptance of sexual health content. While local control over curricular decisions is not inherently a concern, this wide variation in tolerance for teaching sexual health content poses significant barriers to delivering sex education in the absence of broader education guidelines. In other words, without specific requirements regarding the type of sex education that must be offered, participants noted that students living in the same town or county may experience dramatically different types of instruction based on local decisions in each school district.

Interpersonal-Level Barriers

The sensitive nature of sexuality education topics creates discomfort while teaching and – coupled with lack of parental involvement – causes tension among teachers and parents over what is appropriate for students to learn (Table 3). In general, the study participants acknowledged that the awkward nature of the content interfered with students' access to this information, both at home and at school. For educators specifically, the sensitive nature of sexual health topics can be difficult to broach given the blurred boundaries between facts and values. This becomes especially difficult if an educator has not been properly trained on the subject matter, and increasingly so if their personal values do not align with the curriculum. Moreover, school personnel fear backlash from parents who do not want their children learning this content. Over time, the *potential* (emphasis added) negative reactions of a handful of parents are often enough to dissuade educators from teaching the content at all.

Table 3. Interpersonal-Level Barriers to Delivering Sex Education in School Settings, July 2016

Barrier	Quote(s)
Uncomfortable nature of sexual health topics	"It's not being taught at home, either, to the degree that we'd like it to be taught. 'Cause people are uncomfortable with the subject. They don't want to talk about it with their kids. And teachers don't want to talk about it with their kids, either, even in an educational setting."
Blurry boundaries	"How do you teach without putting yourself out there? Even math teachers find a way to make a personal

<p>between facts and values</p>	<p>attachment to it. But yet in human sexuality we're being told you can't give your personal opinion. You have to teach the facts and only the facts."</p>
<p>Teachers fear backlash from parents when teaching sexual health topics</p>	<p>"I know other health teachers who just like, "Oh, I just don't wanna touch the subject." Maybe they had a bad experience where they said something; the child when home and told the parent; the parent complained to the principal. And so they're just like, 'Uh-uh. I don't want anything to do with this.'"</p>
<p>Teachers need parents' help to teach sexual health topics</p>	<p>"We remind parents that they are the people that are responsible for teaching values. Not the school, not the church. Those are just compliments that reinforce or support whatever values you are teaching."</p> <p>"Something that we've found helpful as we've taught these things is to remind the kids that we're not here to tell you what you should or shouldn't do. We're really just here to give you the information so you can make a better decision. And these are things that we would encourage you to talk to your parents about. How do they [your parents] feel about it?"</p>

However, this tension stems in part from a lack of parental involvement and the void this creates within sex education instruction in schools. Participants all expressed their enthusiasm for working alongside parents to teach sex education, either by inviting them to sit in on their child's health class, providing programming specifically for parents, or inviting them to join the local SHAC. However, the desire to include parents often fell short of execution. This is particularly troublesome for school personnel because many educators recognize that sex education extends beyond facts, knowledge, and skills to include morals and values. As such, teachers felt they should not be solely responsible for teaching students this content and wanted more parental involvement in this area.

Collectively, these policy-, organizational-, and interpersonal-level factors greatly impact the way sex education is delivered in school settings. Sex education in the classroom begins to resemble a battleground, with teachers pitted against state policy, administrators, and parents, all at the

same time, and challenges encountered at each of these levels magnify the effects of the factors preceding it.

Opportunities

Despite these extensive barriers, school leaders and health education professionals can leverage important opportunities for success, specifically through collaboration with SHACs. While participants discussed many experiences of tension between administrators, teachers, and parents, these same concerns are remediable by working collaboratively across groups. As one participant said:

“It is a public health issue, but the burden of it does not fall on their shoulders. It doesn't fall on the school's shoulders. It doesn't fall on the legislature's shoulders. It doesn't fall on the parents' shoulders. It falls on all of our shoulders... collectively. We have to find a way for us to come together and be okay with just teaching this stuff.”

Participants also pointed to the central role SHACs play in making sex education decisions. School personnel are accountable to SHACs for their health education recommendations, making SHACs a safeguard for educators, school administrators, and school board trustees in the event of backlash from parents:

“That's the decision that these parents [in the SHAC] collectively made [about sex education curricula]. I kind of like being able to have that. 'Cause then it's not about me... This is the decision that these parents made in the best interests of their kids and the kids in this particular district.”

In fact, some of the more successful initiatives are those that do leverage SHACs to direct change in their communities. One participant noted:

“The topic that we're discussing now actually really, really came to light this last school year with our parents; and because we started pushing our parents to get involved I felt very pleased in the spring when we had about seven of them show up and we were having this conversation about sex, and how much we want to talk to our kids about it.”

This evidence demonstrates how SHACs can be leveraged to address some of the barriers identified above.

DISCUSSION

The current exploratory study investigated the barriers that keep sex education from being effectively delivered in West Texas schools, and identified strategies for overcoming these barriers. Participants identified complex barriers at the policy, organizational, and interpersonal levels. Each of these barriers magnifies the effects of barriers at other levels, which means that school personnel must endure several challenges along different points of the spectrum to succeed. Given the current sociopolitical landscape affecting sexual and reproductive health services in Texas, it is critical to identify ways in which schools can meet important sexual health needs for adolescents.

Findings from this study support and extend other research on this topic.^{29,35-37} For example, a 2009 study found 82% of Texas school districts could not identify a sex education recommendation from their respective SHAC to the local school board.³⁸ Such a finding suggests that SHAC may appear in statutory language, but the actual functioning of these groups may not follow the law, as was described in the current study. Furthermore, state policies pose important (real and perceived) barriers to delivering sex education.¹⁴ Teachers and other school personnel lack essential training for delivering this content.³⁹⁻⁴¹ While there has been important progress in this area - for example, with the creation of Professional Learning Standards for Sex Education⁴²- increased support from school districts and school leaders is needed in order to incorporate these standards into professional development efforts. These findings highlight the importance of looking at contextual factors, in addition to individual-level factors, for understanding why so few schools actually implement comprehensive sex education programs. This study also reveals persistent concerns from school personnel about potentially negative reactions from parents over teaching sexual health content. This is despite ample evidence that shows parents overwhelming support sex education in schools.^{43,44} There is a clear need to enhance communication and collaboration between parents and teachers to facilitate delivery of sex education in the classroom.

Despite the importance of delivering high-quality sex education in schools, existing sex education programs are far from perfect. Other researchers have critiqued existing curricula for perpetuating narrow views of human sexuality.^{45,46} Many programs only discuss sexual health risks as framed through heterosexual behaviors, and as a result, many LGBTQIA+ teens believe they are not at risk for negative health outcomes. In some

states, sex education materials are also expressly prohibited from discussing same-sex sexual encounters.¹³ Similarly, many programs do not adequately discuss harmful stereotypes and gender roles that contribute to interpersonal violence and other negative outcomes.⁴⁶ Consequently, parallel efforts should strive to both improve existing sex education curricula and address barriers to delivering sex education in schools.

Limitations

Limitations for this study include the small, qualitative sample, which means findings may not generalize to other populations. Some research suggests that the Texas border region may face unique challenges when it comes to sexual and reproductive health. For example, Texas border counties have higher rates of teen pregnancy and adverse pregnancy outcomes compared to Texas nonborder counties and border counties in other states.^{47,48} This indicates there may be additional influences that impact the provision of sexual and reproductive health resources in Texas border counties that may not be applicable to other geographic regions. Results from this study should be considered preliminary evidence for additional efforts to improve sexual and reproductive health in this geographic area. Future studies should investigate these themes among a larger and more geographically diverse sample. Additionally, no parents were included in this study, which represents an important group whose perspective should be more purposefully investigated in future studies. This is particularly important given parents' critical role in teaching sexual health topics to their children. However, this exploratory study is one of the few that examines contextual factors contributing to the implementation of sex education in schools, and participants represented a cross-section of stakeholders that work in different capacities related to sex education in public schools. Therefore, these findings capture a range of valuable perspectives and challenges not previously investigated.

IMPLICATIONS

These findings highlight the key role SHACs play in addressing barriers to effectively delivering comprehensive sex education in school settings, in addition to three tasks for school personnel and school health professionals. The first is the importance of learning the actual terms of local sex education policies, as well as TEC regulations. As evidenced in this study, misinterpretation of what is required and allowed by law can have widespread effects on whether and what kind of sex education is offered in schools. To this end, school districts can implement technology-based practices to facilitate proper training for SHAC members. There are many

challenges associated with coordination and assigning responsibilities within volunteer groups, such as SHACs, but online training is an appealing option that can help overcome some of these challenges.⁴⁹

Second, it is essential that SHAC members be trained on how to properly evaluate sex education curricula. Given the SHAC's central role in making decisions about sex education delivery in the classroom, these individuals must be able to critically assess different options. Few SHACs currently follow established best practices. As an example, in a 2009 comprehensive study of sex education programs in Texas public schools, not a single school district reported using the Characteristics of Effective Programs or any other national standard when making sex education recommendations to the local school board.³⁸ With accurate knowledge of sex education policies and best practices, school personnel, health professionals, and parents can more effectively advocate for curricular changes in their school district. SHACs will then be equipped to make better decisions regarding effective curricula to improve students' health and educational outcomes. One tool for doing this is the CHAMPSS Model designed to help school districts select and implement evidenced-based sex education programs.⁵⁰ This model includes strategies for addressing barriers and leveraging assets to ensure that the right programs are selected to address the district's needs while aligning with evidence and best practices.

Finally, school districts should strive to make health education a local requirement for graduation and actively engage community members to participate in SHACs. Though the state of Texas removed health education as a statewide graduation requirement, local school boards still have the power to reverse this decision at the local level and reestablish the health education requirement. Additionally, SHACs can only achieve their fullest potential by having an active community base that fosters ongoing communication and collaboration to improve the delivery of sex education. Having a stable platform for delivery of all health content, including sex education, is an important step in helping students learn health content, as well as key decision-making skills that will prepare them for life as a young adult.

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APPENDIX A

TEC 28.004 Texas Education Code - EDUC § 28.004. Health Education Instruction

(e) Any course materials and instruction relating to human sexuality, sexually transmitted diseases, or human immunodeficiency virus or acquired immune deficiency syndrome shall be selected by the board of trustees with the advice of the local school health advisory council and must:

(1) present abstinence from sexual activity as the preferred choice of behavior in relationship to all sexual activity for unmarried persons of school age;

(2) devote more attention to abstinence from sexual activity than to any other behavior;

(3) 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;

(4) 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; and

(5) 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.

(f) A school district may not distribute condoms in connection with instruction relating to human sexuality.

(g) A school district that provides human sexuality instruction may separate students according to sex for instructional purposes.

(h) The board of trustees shall determine the specific content of the district's instruction in human sexuality, in accordance with Subsections (e), (f), and (g).

(i) Before each school year, a school district shall provide written notice to a parent of each student enrolled in the district of the board of trustees' decision regarding whether the district will provide human sexuality instruction to district students. If instruction will be provided, the notice must include:

(1) a summary of the basic content of the district's human sexuality instruction to be provided to the student, including a statement informing the parent of the instructional requirements under state law;

(2) a statement of the parent's right to:

(A) review curriculum materials as provided by Subsection (j); and

(B) remove the student from any part of the district's human sexuality instruction without subjecting the student to any disciplinary action, academic penalty, or other sanction imposed by the district or the student's school; and

(3) information describing the opportunities for parental involvement in the development of the curriculum to be used in human sexuality instruction, including information regarding the local school health advisory council established under Subsection (a).

APPENDIX B

Texas Education Code - EDUC § 28.004. Local School Health Advisory Council

(a) The board of trustees of each school district shall establish a local school health advisory council to assist the district in ensuring that local community values are reflected in the district's health education instruction.

(b) A school district must consider the recommendations of the local school health advisory council before changing the district's health education curriculum or instruction.

(c) The local school health advisory council's duties include recommending:

(1) the number of hours of instruction to be provided in health education;

(2) policies, procedures, strategies, and curriculum appropriate for specific grade levels designed to prevent obesity, cardiovascular disease, Type 2 diabetes, and mental health concerns through coordination of:

(A) health education;

(B) physical education and physical activity;

(C) nutrition services;

(D) parental involvement;

(E) instruction to prevent the use of tobacco;

(F) school health services;

(G) counseling and guidance services;

(H) a safe and healthy school environment; and

(I) school employee wellness;

(3) appropriate grade levels and methods of instruction for human sexuality instruction;

(4) strategies for integrating the curriculum components specified by Subdivision (2) with the following elements in a coordinated school health program for the district:

(A) school health services;

(B) counseling and guidance services;

(C) a safe and healthy school environment; and

(D) school employee wellness; and

(5) if feasible, joint use agreements or strategies for collaboration between the school district and community organizations or agencies.

(d) The board of trustees shall appoint at least five members to the local school health advisory council. A majority of the members must be persons who are parents of students enrolled in the district and who are not employed by the district. One of those members shall serve as chair or co-chair of the council. The board of trustees also may appoint one or more persons from each of the following groups or a representative from a group other than a group specified under this subsection:

(1) public school teachers;

(2) public school administrators;

(3) district students;

(4) health care professionals;

(5) the business community;

(6) law enforcement;

(7) senior citizens;

(8) the clergy;

(9) nonprofit health organizations; and

(10) local domestic violence programs.

(d-1) The local school health advisory council shall meet at least four times each year.

APPENDIX C

Adult Stakeholder Interview Guide

1. What type of teen sexual health issues does your organization focus on?
2. How long have you been working on teen sexual health issues?
3. What would you say are the biggest teen sexual health concerns in El Paso?
 - a. Which are being addressed?
 - b. Which are not being addressed?
4. What obstacles interfere with the ability to address these teen sexual health concerns?
5. Who needs to play a role in addressing these teen sexual health concerns?
6. How are these teen sexual health concerns associated with other challenges teens face?
7. What circumstances have influenced the current state of teen sexual health in El Paso?