2012 Implementation of Sex-Related Education Policy in Mississippi

Prepared for

The Center for Mississippi Health Policy

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Executive Summary

The 2012 Implementation of Sex-Related Education Policy (ISREP) study collected data on a representative sample of middle and high schools in Mississippi to assess the implementation of House Bill 999. The project was a collaborative effort between the Mississippi Department of Education (MDE), Mississippi Department of Health (MDH), and The University of Southern Mississippi.

According to House Bill 999 of the 2011 Regular Session of the Mississippi Legislature, which amends Section 37-13-171, Mississippi Code 1972, each local school board was to adopt a sex-related education policy to implement abstinence-only or abstinence-plus education into its local school district's curriculum by June 30, 2012, or to adopt the sex-related education program developed by the Mississippi Department of Human Services and the Department of Health (DHS program).

In this study, principals from 310 randomly selected middle and high schools were asked to complete a survey regarding their implementation of House Bill 999. These 310 schools had recently completed the comprehensive 2012 School Health Profiles (Profiles) study, which was a collaborative study between the Mississippi State Department of Education and the Centers for Disease Control and Prevention. The Profiles included surveys of principals, health educators, and physical education teachers regarding the implementation of nutrition, health, and physical education in their schools. Data collected on the implementation of sex-related education policy were to be viewed within the context of the data collected through the Profiles.

School principals were first contacted regarding the ISREP study in October 2012. They were contacted via written mail, and were provided a summary report of the Profiles. If unable to reach them by mail, they were then contacted via email, fax, or phone. ISREP Surveys could be completed online through an email attachment or hard-copy. Data were collected during December 2012.

This report provides estimates of implementation of sex-related education (abstinence-only, abstinence-plus, or DHS) policy among middle and high schools in Mississippi. This report also identifies barriers to implementation and needs of schools to successfully implement the policy. These findings provide a baseline for future efforts to assess the effectiveness of the implementation of the policy, providing much needed information for the state's legislators and policy-makers.

Introduction and Background

The Centers for Disease Control and Prevention (CDC), in collaboration with state and local education and health agencies, created the Profiles to assess school health policies and programs. The Profiles help state and local education and health agencies monitor and assess characteristics of and trends in several of the coordinated school health components. These include: health education, physical education, health services, healthy and safe school environment, and family and community involvement. The Profiles are conducted biannually, and the most recent was Spring 2012.

When approached to conduct the ISREP, the researchers recommended using the same sample of schools that had just completed the Profiles study. Subsequently, the ISREP surveys

were sent to the principals of the 310 previously selected middle and high schools across Mississippi. Five of the original 315 randomly selected schools had been either closed or were no longer middle or high schools and excluded from the Profiles study. In the remaining 310 schools, over 70% percent of the principals, health education and physical education teachers responded and completed the Profiles, resulting in weighted, representative data. The full set of all findings are available from Westat, Inc. and in summary form in the 2012 School Health Profiles report (Kolbo, 2012). Selected findings, which provide a context for the current ISREP study, are presented in this report.

Related Literature, Policy and Legislation

A rapidly growing body of research has been emerging regarding the issues surrounding teenage pregnancy and teen birth rates. In particular, in the past decade there has been an increased emphasis on abstinence education (Stanger-Hall & Hall, 2011). Debates continue regarding Abstinence-Only (AO) vs. Abstinence-Plus (AP) programs, such as whether they reduce or actually increase teenage sexual activity. For example, Kirby, Laris, and Rolleri (2006) looked at 83 pregnancy prevention programs in the US and other parts of the world. They concluded that while there was some positive impact, there were far too many variations of AO programs and simply too few empirical studies on AO programs to definitively determine their effectiveness. They also found AP programs did not increase sexual behavior (as often assumed), but rather students actually reduced sexual behaviors (i.e., delaying initiation, reducing frequency of sex, or reducing the number of partners). Further, Lindberg and Maddow-Zimet (2012) found that the "receipt of sex education, regardless of type, was associated with delays in first sex for both genders, as compared with receiving no sex education (p. 332)." The one key

to reducing sexual behavior, according to Aten, Sigel, Enaharo, and Auinger (2002), was for prevention intervention to occur before adolescence. While there is little debate that gaps remain in determining the effectiveness of sex-related education programs (Kirby et al, 2006), and that much more rigorous evaluation of these programs is needed, the purpose of the ISREP survey was to simply provide estimates of implementation of sex-related education (AO, AP and DHS) policy among middle and high schools in Mississippi.

During the 2011 Regular Session of the Mississippi Legislature, House Bill 999 was passed, which amended Section 37-13-171, Mississippi Code 1972. According to House Bill 999, each local school board was to adopt a sex-related education policy to implement abstinence-only or abstinence-plus education into its local school district's curriculum by June 30, 2012, or to adopt the program developed by the Mississippi Department of Human Services and the Department of Health. The ISREP survey was designed to identify barriers to implementation and needs of schools to successfully implement the state-mandated policy.

Method

Subjects and Sampling

ISREP surveys were sent to the principals of 310 middle and high schools across Mississippi. The sample used for the ISREP study was established by Westat, Inc. for the Health Profiles study. All regular secondary public schools having at least one of grades 6 through 12 were included in the sampling frame. Schools were sorted by estimated enrollment in the target grades within school level (high schools, middle schools, and junior/senior high schools combined) before sampling. Systematic equal probability sampling with a random start was used to select schools for the survey. Five out of the original 315 schools were ineligible due to closure or change in status. The principal or designee was surveyed in each participating school. The response rate for the Profiles study was 78% (241 out of 310 sampled eligible principals returned questionnaires).

Seven of the 310 schools included in the original sample were elementary schools and were excluded from the ISREP study. A total of 228 of the 303 (75.2%) schools participated in the ISREP survey. Additional characteristics of the schools are presented in the findings below.

Instruments

A 22-item ISREP survey was constructed, then reviewed, revised, and approved by representatives of the Mississippi Department of Education's Office of Healthy Schools. A copy of the instrument is attached. The ISREP survey was designed to address questions regarding implementation of the sex-related education policy and not duplicate questions already asked as part of the Profiles study.

Procedures

The ISREP study received Institutional Review Board approval through the Human Subjects Committee at The University of Southern Mississippi (USM). Principals from the 310 randomly selected schools were first contacted by mail in late October 2012. They were sent a letter by Scott Clements, director of the Office of Healthy Schools, and were provided a summary report of the 2012 School Health Profiles, the ISREP survey and a self-addressed, stamped envelope to return the survey. After two-to-three weeks, principals received follow-up correspondence via mail, email, phone and fax. Principals were given multiple opportunities to submit their surveys and data were collected through December 31, 2012.

Data Treatment and Analysis

Once ISREP surveys were received, the data were directly entered into SPSS (Statistical Program for the Social Sciences). The statistical software, SPSS, was used for all statistical analysis.

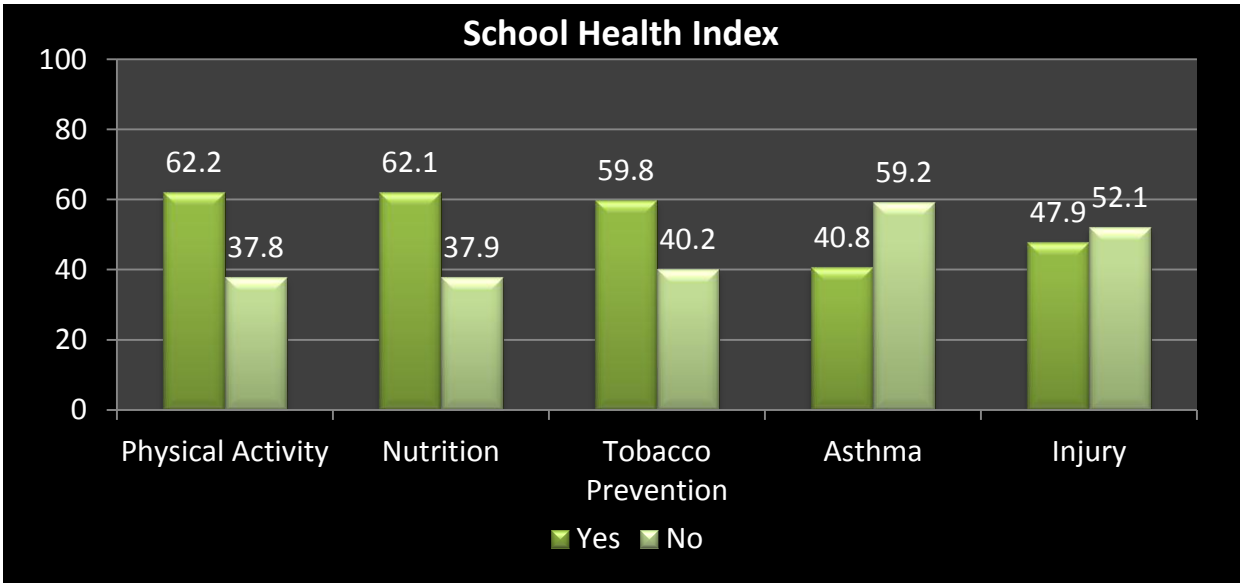
Findings (Profiles)

Seven selected findings from the Profiles study are presented first to provide a context for the ISREP study. The Profiles findings include: 1) School Health Index; 2) School Improvement Plans; 3) Coordination of health and safety programs; 4) Nurse to provide health services to students; 5) Provision of specific services to students; 6) Referrals to others for specific services; and 7) Involvement of families and community in developing policies and programs.

Profiles 1) School Health Index

For many years, the CDC has utilized the School Health Index (SHI) in schools and across the nation to assess school health needs and develop policy. In Mississippi, 62.2% of middle and high schools reported using the SHI to assess policies, activities and programs related to physical activity, nutrition, tobacco use prevention, asthma, and injury and violence prevention (See Figure 1). The SHI does not directly assess or report pregnancy prevention.

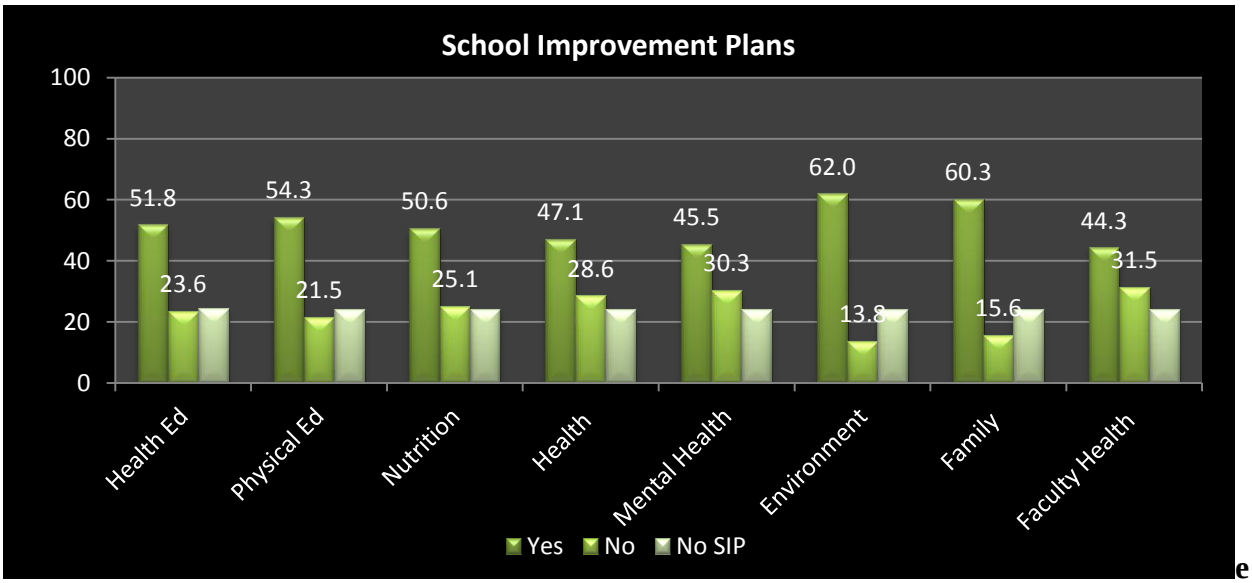
Figure 1. School Health Index



Profiles 2) School Improvement Plans

According to the federal Elementary and Secondary Education Act, schools are required to have a written School Improvement Plan (SIP). In 2012, 51.8% of middle and high schools in Mississippi reported having a written plan for focusing on the relationship between student health and education (See Figure 2). Currently, the highest percentages are for a healthy school environment (62.0%). To date, there is no direct reference to pregnancy prevention in the SIPs.

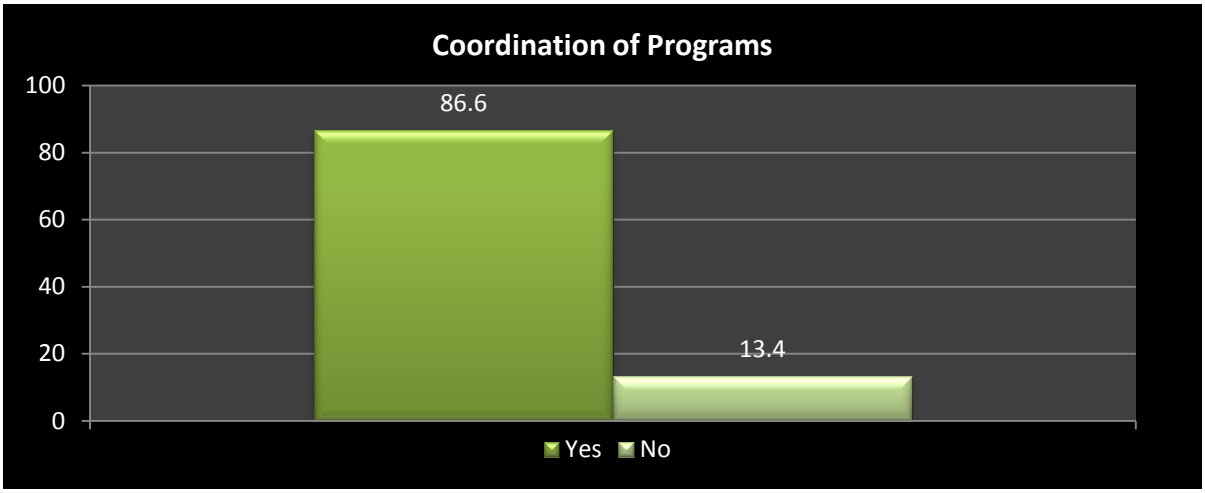
Figure 2. School Improvement Plans



Profiles 3) Coordination of Health and Safety Programs

Among most middle and high schools, 86.6% of principals reported having a person in their school who was responsible for overseeing school health and safety programs and activities (See Figure 3).

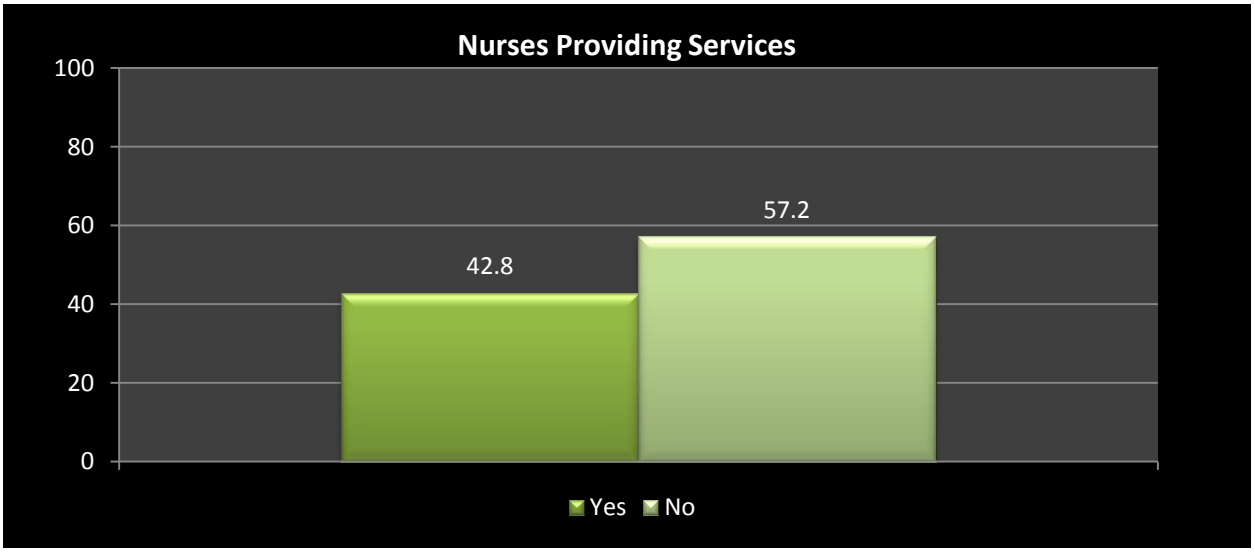
Figure 3. Coordination of Programs



Profiles 4) Nurses Providing Services

Each school was asked whether it had a full-time, registered nurse who provided health services to students. Less than half (42.8%) responded that they did (see Figure 4).

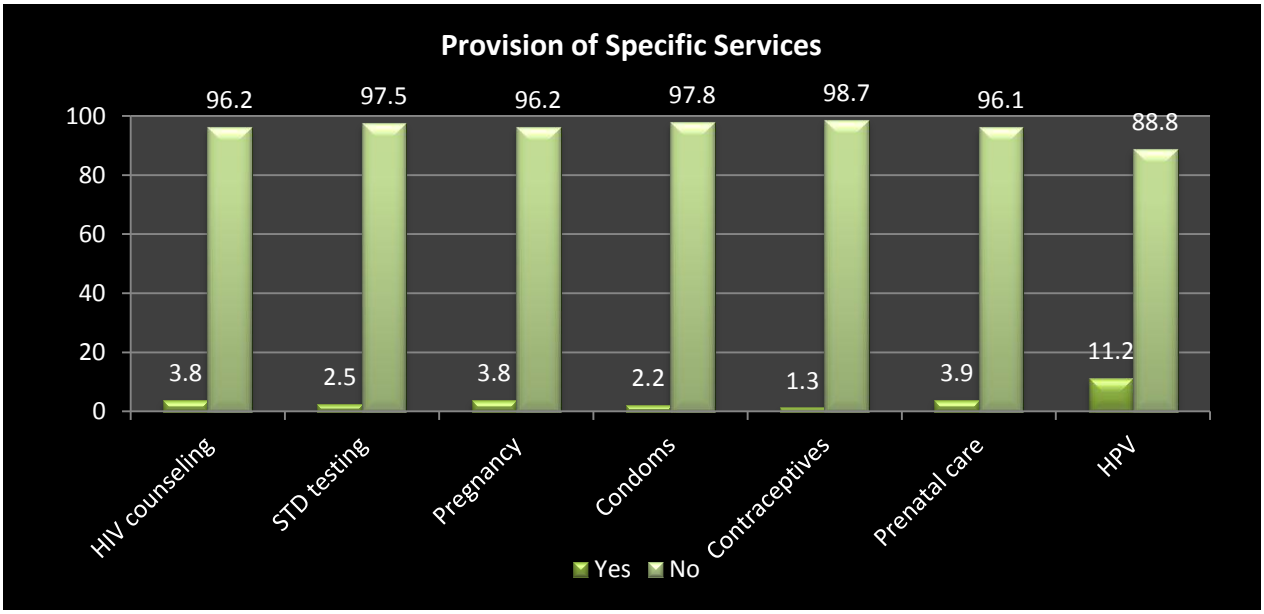
Figure 4. Nurses Providing Services



Profiles 5) Provision of Specific Services to Students

When it came to specific services to students, very few services related to sex-related education are provided by the schools (see Figure 5). Percentages ranged from 1.3% to 11.2%.

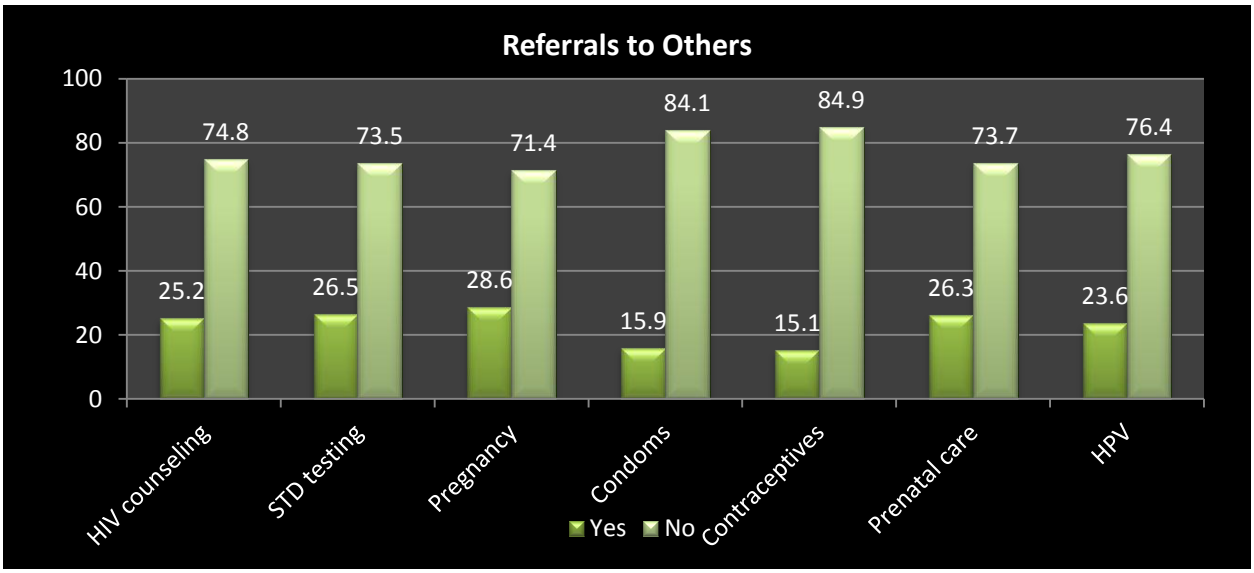
Figure 5. Provision of Specific Services to Students



Profiles 6) Referrals to Others for Specific Services

When compared to those services provided by the schools, percentages were somewhat higher for referring students to outside sources (See Figure 6). Percentages ranged from 15.1% to 28.6%.

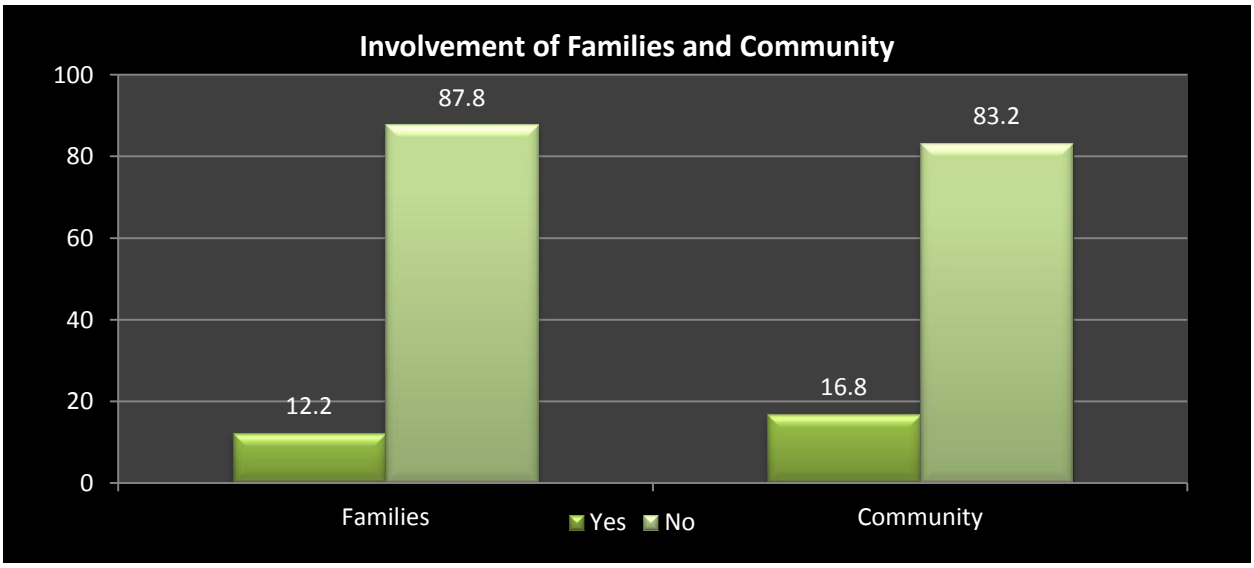
Figure 6. Referrals to Others for Specific Services



Profiles 7) Involvement of Families and Community

According to principals, 12.2% of students' families and 16.8% of community members helped develop or implement school health policies related to HIV, STD or teen pregnancy prevention (See Figure 7).

Figure 7. Involvement of Families and Community



Findings (ISREP)

The following is a list of the topics addressed in the 22-item ISREP survey.

1) Policies adopted by schools
2) Oversight of policy
3) Specific curriculum
4) Teaching of curriculum
5) Professional development for those teaching
6) When curriculum is being taught
7) Grades in which curriculum is taught
8) Is curriculum being taught identically in all grades and if not, why…
9) Are classes separated by gender
10) Is parental approval being sought and how
11) Number of hours per week and number of weeks per semester curriculum is taught
12) Barriers and challenges limiting implementation
13) Barriers and challenges limiting teaching
14) Who had most influence in process of adopting the policy
15) Who had the most influence in selecting the material being taught
16) Factors that weighed most heavily in decisions on implementation of the policy
17) Modifications to existing health, nutrition, or physical education policies
18) Costs associated with implementing policy and teaching the curriculum
19) Resources, materials, and services needed to fully implement the policy
20) If the law had not been passed, what would the school be doing
21) What changes in the law would help implement the policy
22) Anything else regarding the implementation of the policy

ISREP 1) Sex-Related Education Policies Adopted by the Schools

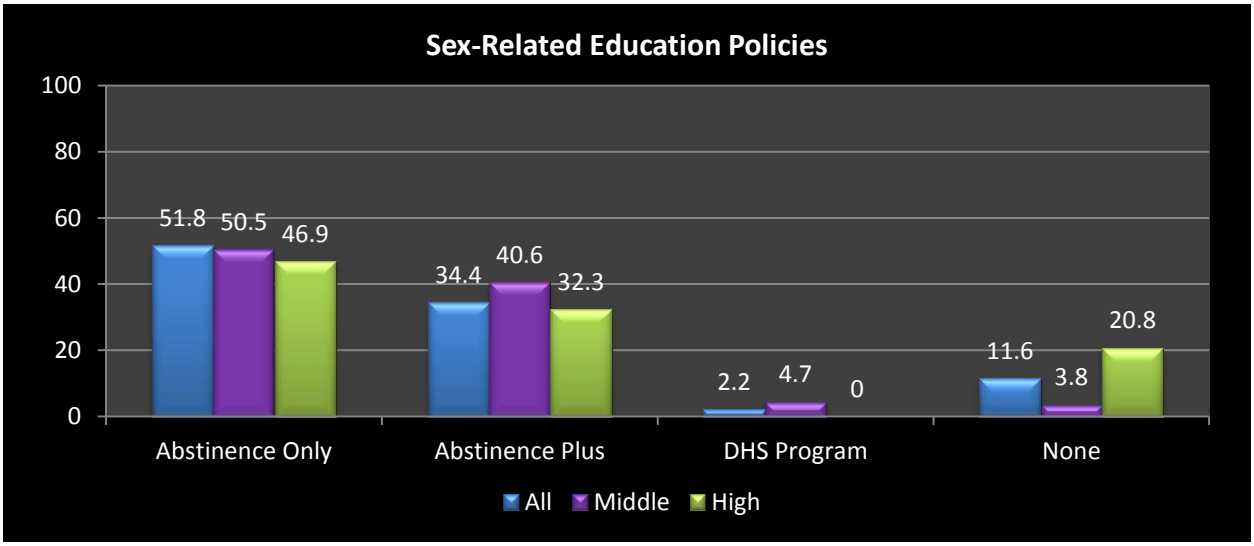
According to House Bill 999, passed by the 2011 Legislature, each local school board was to adopt a sex-related education policy to implement Abstinence-Only (AO) or Abstinence-Plus (AP) education into its local school district's curriculum by June 30, 2012, or to adopt the sex-related education program developed by the Mississippi Department of Human Services and the Department of Health.

Of the 228 respondents, 43.4% indicated that they were high schools, 46.9% indicated that they were middle schools and 9.6% included all grades (e.g., attendance centers). Among high schools, 46.9% selected AO, 32.3% selected AP, and 20.8% selected none. Among middle schools, 50.5% selected AO, 40.6% selected AP, 4.7% selected the DHS program, and 3.8% selected none (Refer to ISREP Figure 1).

It should be noted that while not reflected on Figure 1, among the 22 schools including all grades (e.g., attendance centers), 77.3% selected AO, 13.6% selected AP, and 9.1% selected none. Consequently, the percentages for both middle and high schools in ISREP Figure 1 are lower than that for all AO schools.

The majority of the 288 schools indicated that their school had adopted an AO policy (51.8%). Another 34.4% adopted an AP policy. Another 2.2% adopted the program developed by the Department of Human Services (DHS), and 11.6% reported not adopting a policy. In the cases where schools indicated that they were not implementing a policy this year, many reported that another school in their district was implementing a policy, but their school was not doing so this year.

ISREP Figure 1. Sex-Related Education Policies Adopted by the Schools

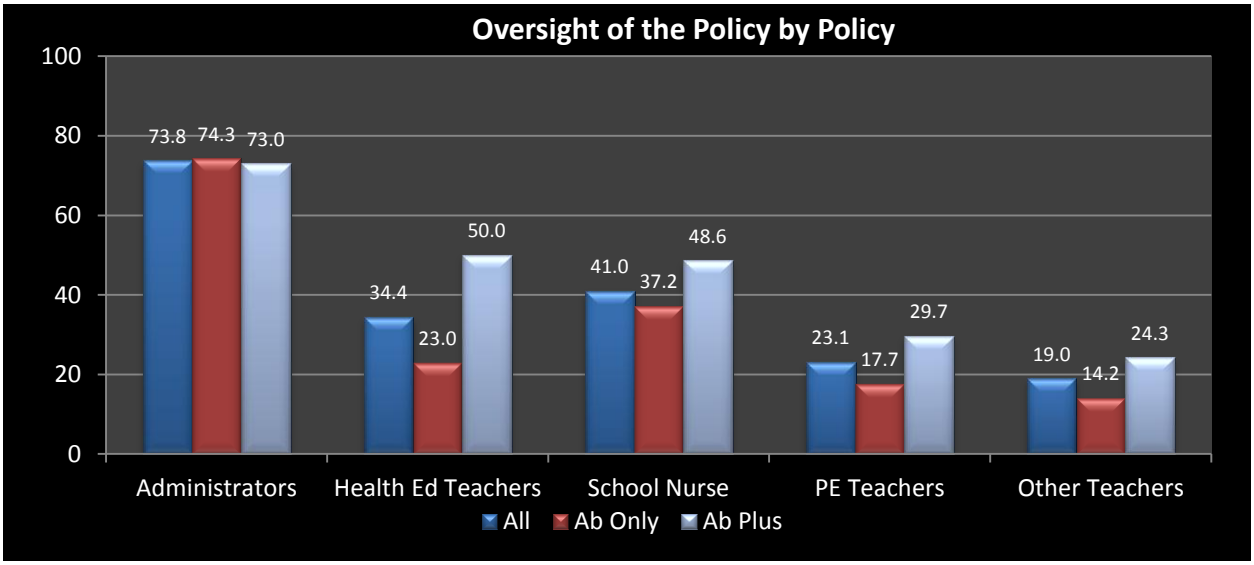


ISREP 2) Oversight of the Policy

Principals were asked to indicate all in their schools who were responsible for overseeing the implementation of the policy. The vast majority (73.8%) indicated that school administrators were responsible. A second group emerged, primarily registered nurses (41.0%) and health education teachers (34.4%).

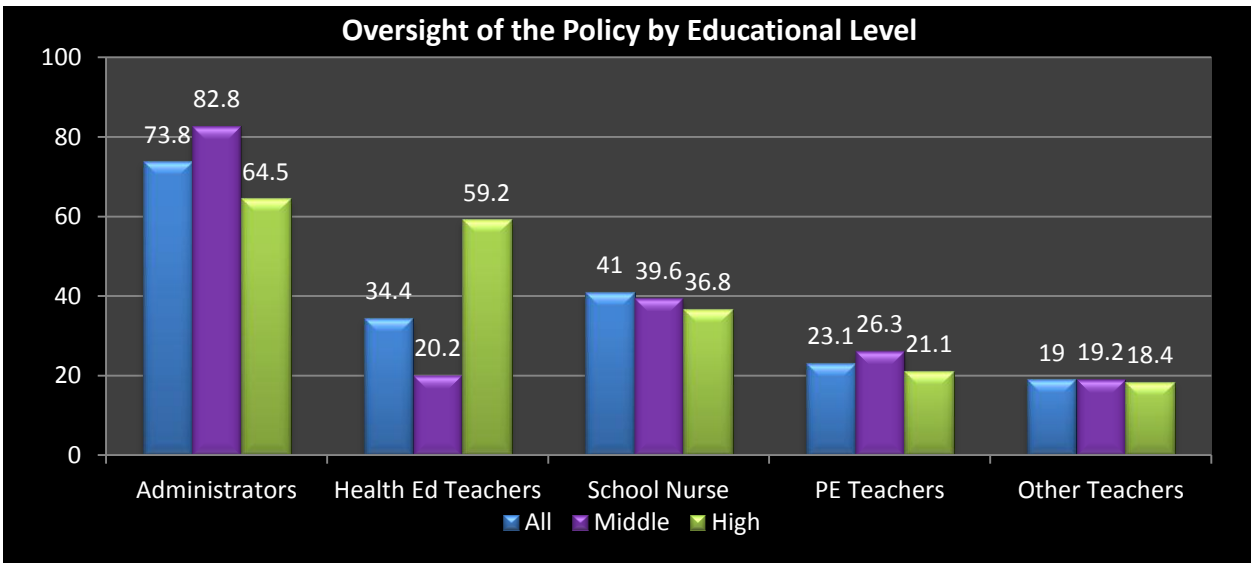
When compared to those implementing AO, the AP schools reported higher percentages of health education teachers (50.0% vs. 23.0%), nurses (48.6% vs. 37.2%), physical education teachers (29.7% vs. 17.7%) and other teachers (24.3% vs. 14.2%) responsible for the oversight of the policy (ISREP Figure 2a).

ISREP Figure 2a. Oversight of the Policy by Policy



Two differences were noted among the different educational levels. High schools were less likely than middle schools (82.8% vs. 64.5%) to report administrators as being responsible for oversight, and more likely than middle schools (20.2% vs. 59.2%) to report heath education teachers as responsible for the oversight of the policy (ISREP Figure 2b).

ISREP Figure 2b. Oversight of the Policy by Educational Level



ISREP 3) Specific Curriculum being Taught

Among those reporting to have implemented the AO curriculum and describing the specific curriculum being taught in their school, 74% reported using the "Choosing the Best" curriculum. Another 7.8% reported using the "WAIT Training" curriculum. Twenty-three percent did not answer this question.

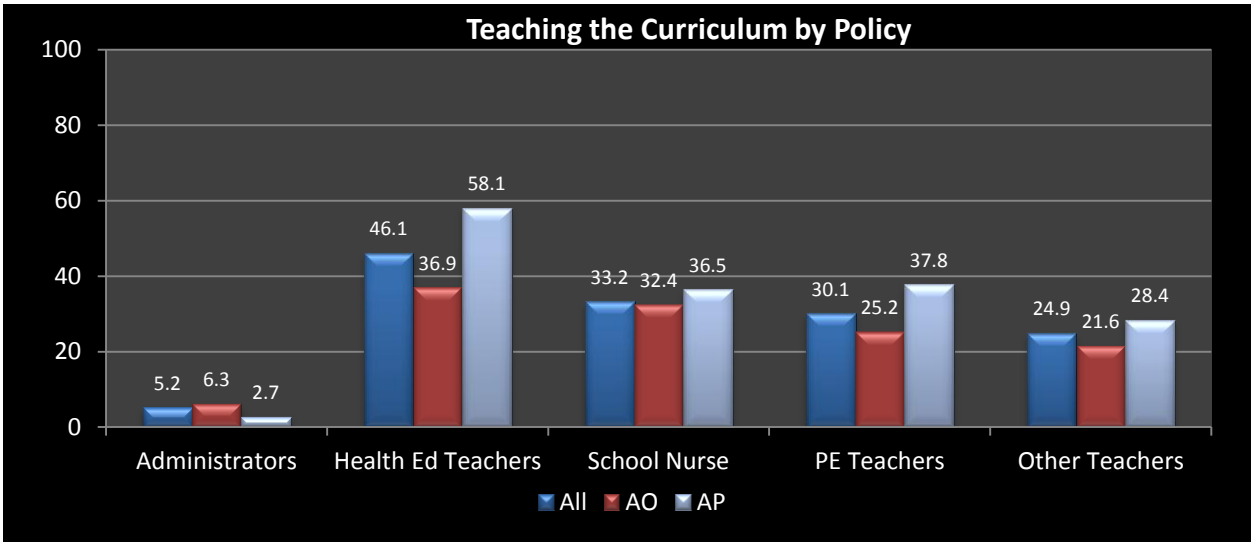
Among those implementing the AP program and describing the specific curriculum being taught in their school, 39.0% also reported using the "Choosing the Best" curriculum. Thirty-four percent were using the "Draw the Line" curriculum. Another 6.8% also reported using the "WAIT Training" curriculum. The CHART curriculum was used by 3.4%. Seventeen percent did not answer this question.

ISREP 4) Teaching of the Curriculum

Principals indicated all in their schools that were responsible for teaching the curriculum. The primary responsibility falls on the health education teachers (46.1%), followed by school nurses (33.2%), PE teachers (30.1%) and other teachers (24.9%). When compared to the oversight of the policy, lower percentages of administrators and nurses, and higher percentages of health education teachers, PE teachers and other teachers were teaching the curriculum.

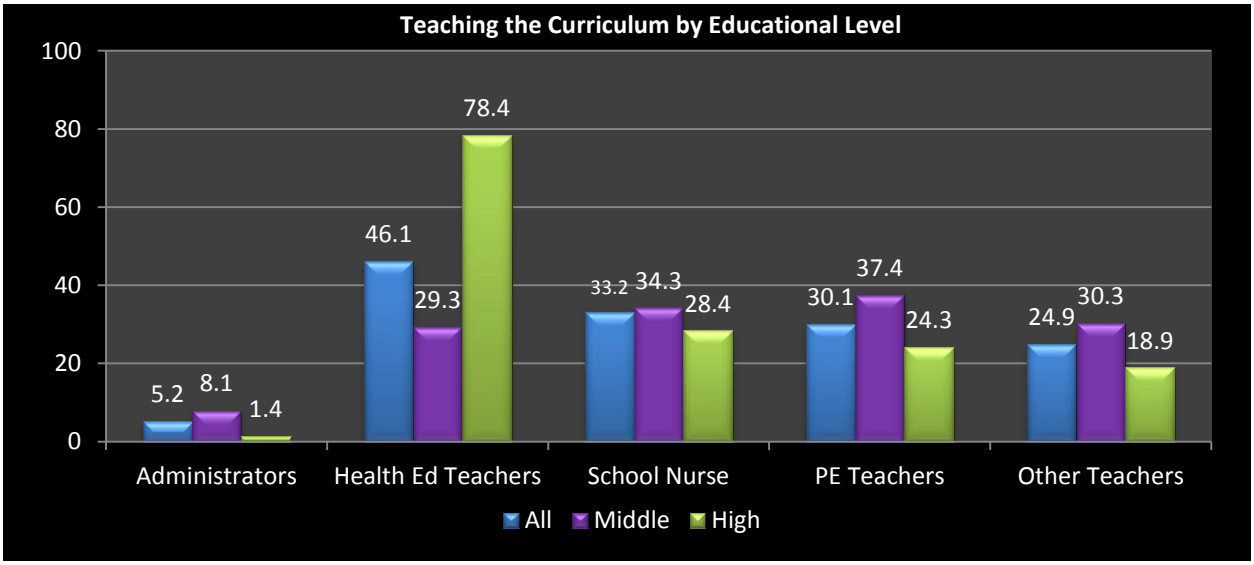
When compared to those implementing AO, the AP schools reported higher percentages of health education teachers (58.1% vs. 36.9%), physical education teachers (37.8% vs. 25.2%) and other teachers (28.4% vs. 21.6%) were responsible for teaching the curriculum (Figure 4a).

ISREP Figure 4a. Teaching of the Curriculum by Policy



When compared to middle schools, high schools reported higher percentages of health education teachers (78.4% vs. 29.3%), and lower percentages of nurses (28.4% vs. 34.3%), PE teachers (24.3% vs. 37.4%) and other teachers (18.9% vs. 30.3%). See ISREP Figure 4b.

ISREP Figure 4b. Teaching of the Curriculum by Educational Level



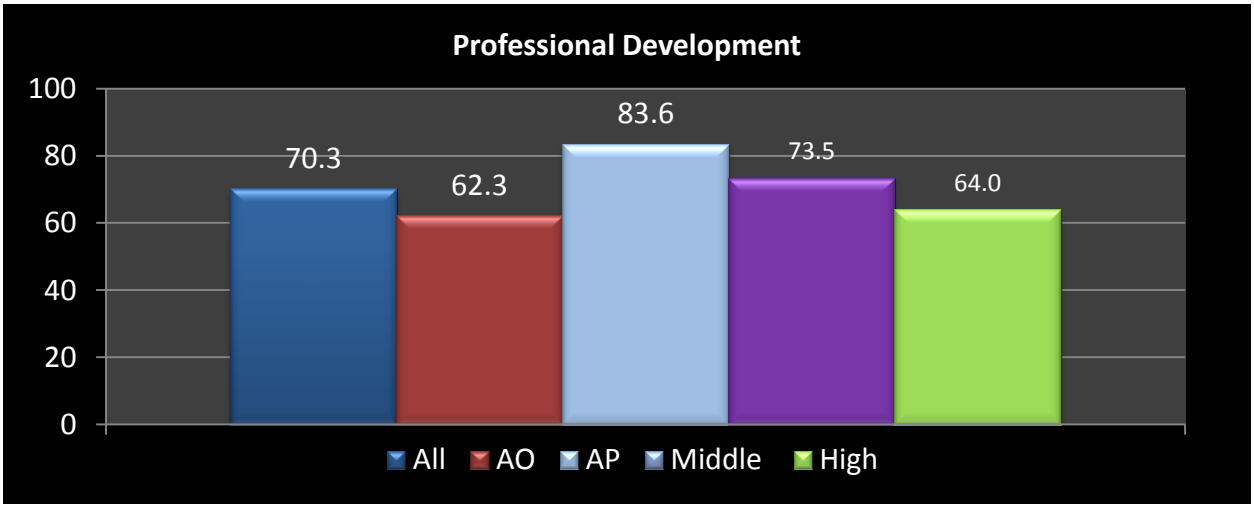
ISREP 5) Professional Development for Those Teaching

Seventy percent of those teaching the curriculum are reported to have received professional development. Principals from AP schools were more likely to report professional development for those teaching the curriculum than AO schools (83.6% vs. 62.3%). Among those responding from the AO schools, 34.6% received "Choosing the Best" training, 23% received district/MDE training, and 7.7% received training hosted by Health Works.

Among those responding from the AP schools, 21.3% received "Choosing the Best" training, 17% received district/MDE training, 14.9% received training through a workshop provided by the Mississippi State Department of Health, and 10.6% received "Draw the Line" training.

Among educational levels, 64.0% of high schools and 73.5% of middle schools reported providing professional development for those teaching the curriculum.

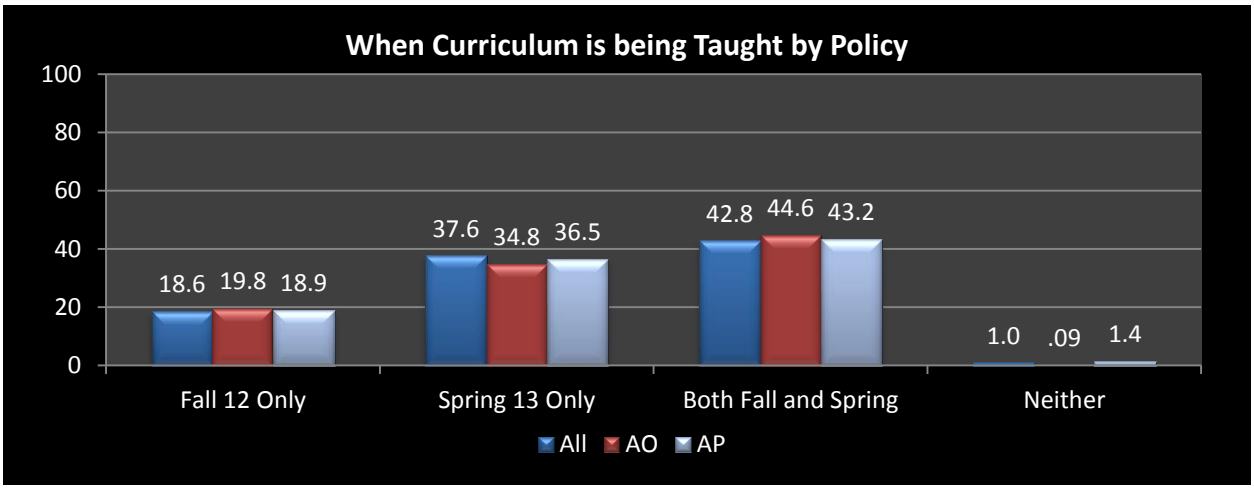
ISREP Figure 5. Professional Development



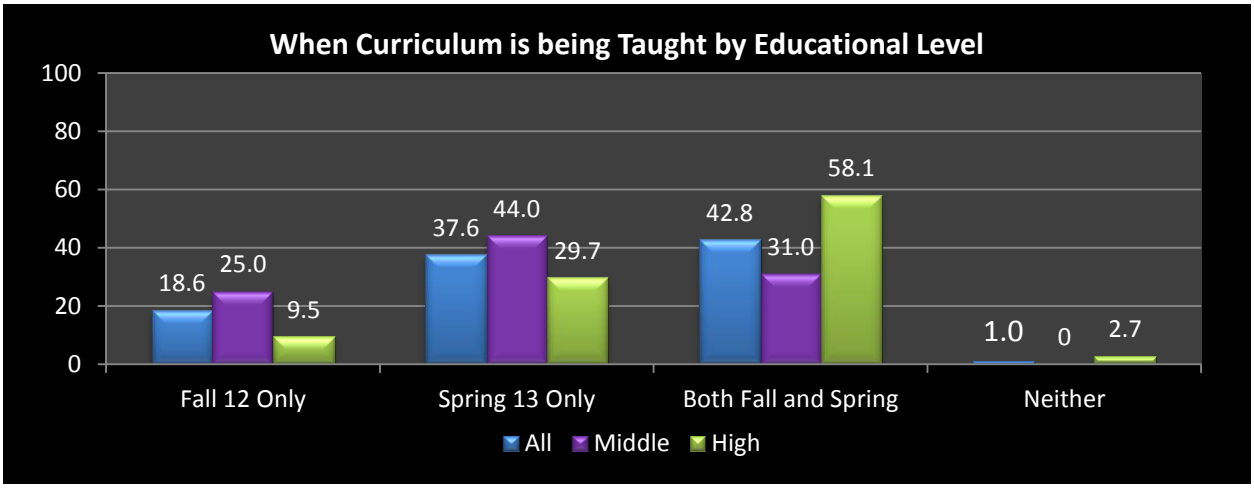
ISREP 6) When Curriculum is being Taught

During the 2012-2013 academic year, 18.6% were teaching the curriculum during Fall 2012 only, 37.6 % planned on teaching it during Spring 2013 only, and 42.8% planned to teach it both fall and spring. No differences were noted between the AO and AP schools (ISREP Figure 6a). When compared to middle schools, high schools reported higher percentages of teaching the curriculum both fall and spring (58.1% vs. 31.%). See ISREP Figure 6b.

ISREP Figure 6a. When Curriculum is being Taught by Policy



ISREP Figure 6b. When Curriculum is being Taught by Educational Level

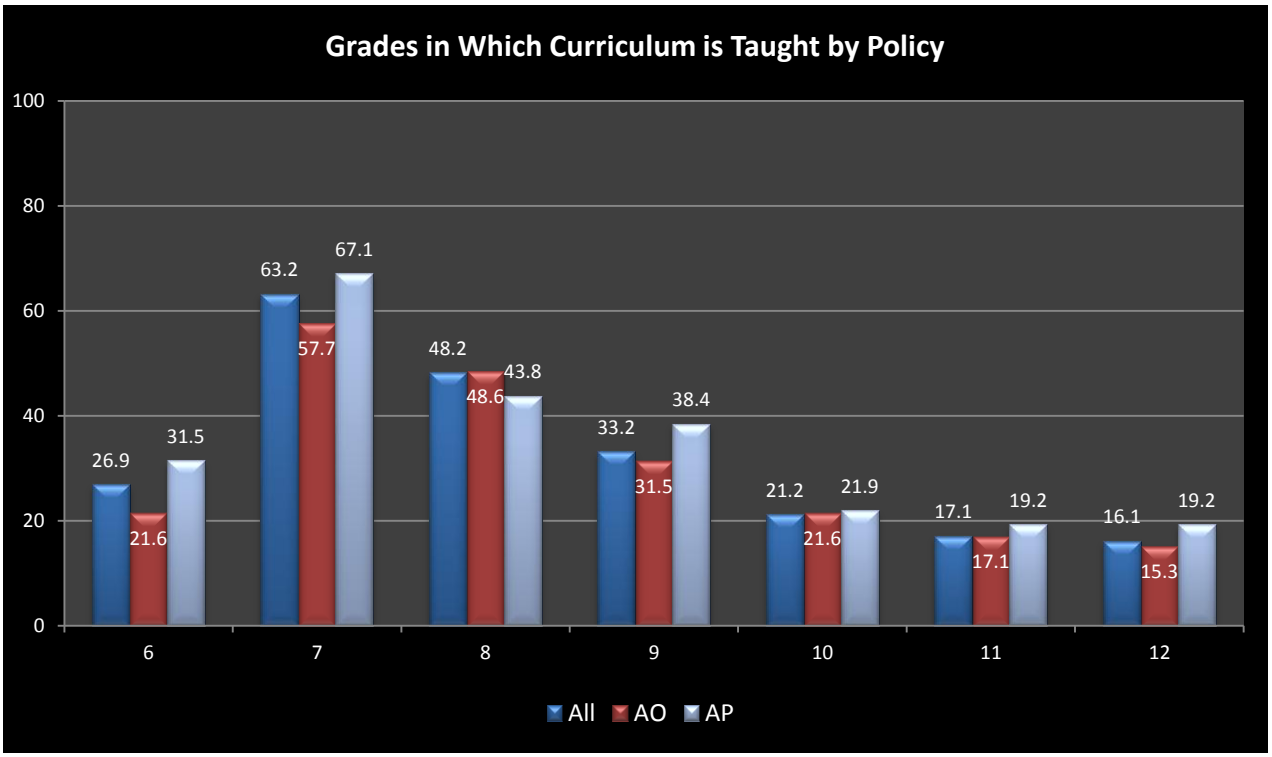


ISREP 7) Grades in Which Curriculum is Taught

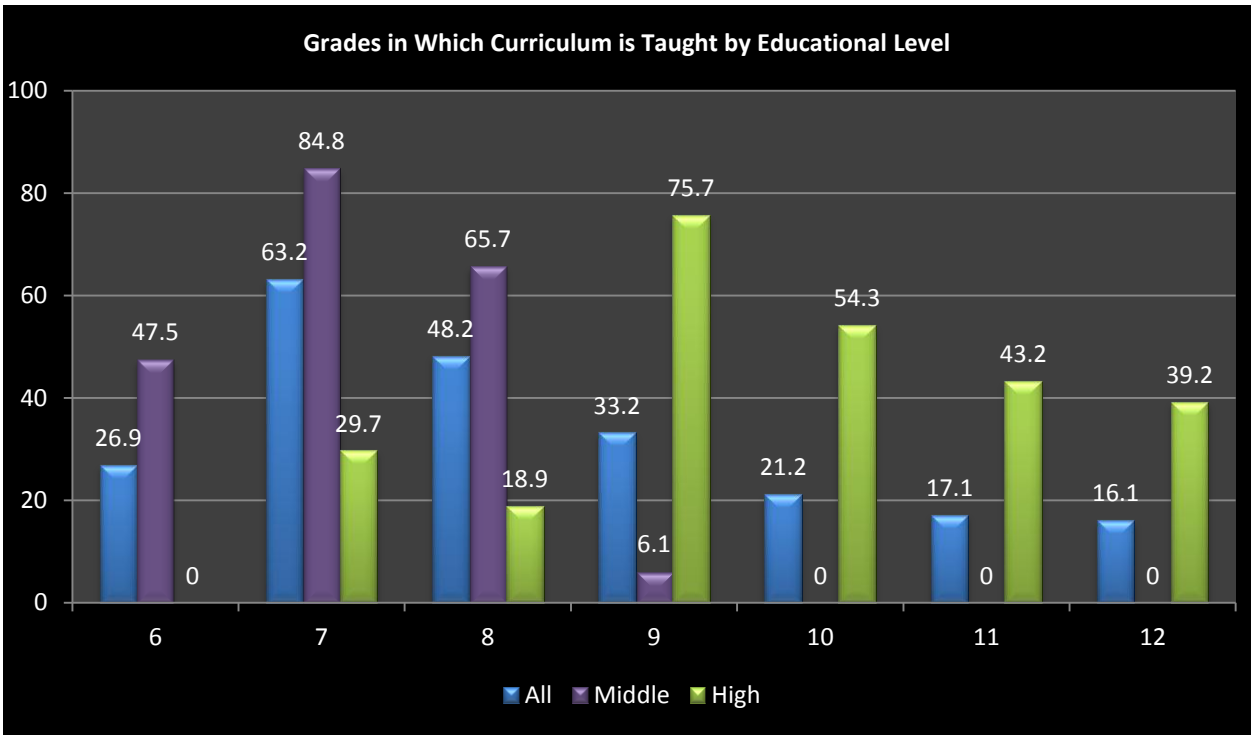
Among the respondents, middle school grades (i.e., 7-8) were most likely to be where the curriculum is and will be taught. Slightly higher percentages of AP schools reported teaching in grades 6, 7, and 9 (Refer to ISREP Figure 7a.).

When compared by educational level, it should be noted that some middle schools included elementary grade levels and some high schools included junior high grade levels. Among high schools, three-quarters (75.7%) taught the curriculum in the 9th grade, followed by 54.1% in the 10th grade, 43.2% in the 11th grade and 39.2% in the 12th grade. Among middle schools, 84.8% taught the curriculum in the 7th grade, followed by 65.7% in the 8th grade and 47.5% in the 6th grade (Refer to ISREP Figure 7b).

ISREP Figure 7a. Grades in Which Curriculum is Taught by Policy



ISREP Figure 7b. Grades in Which Curriculum is Taught by Educational Level

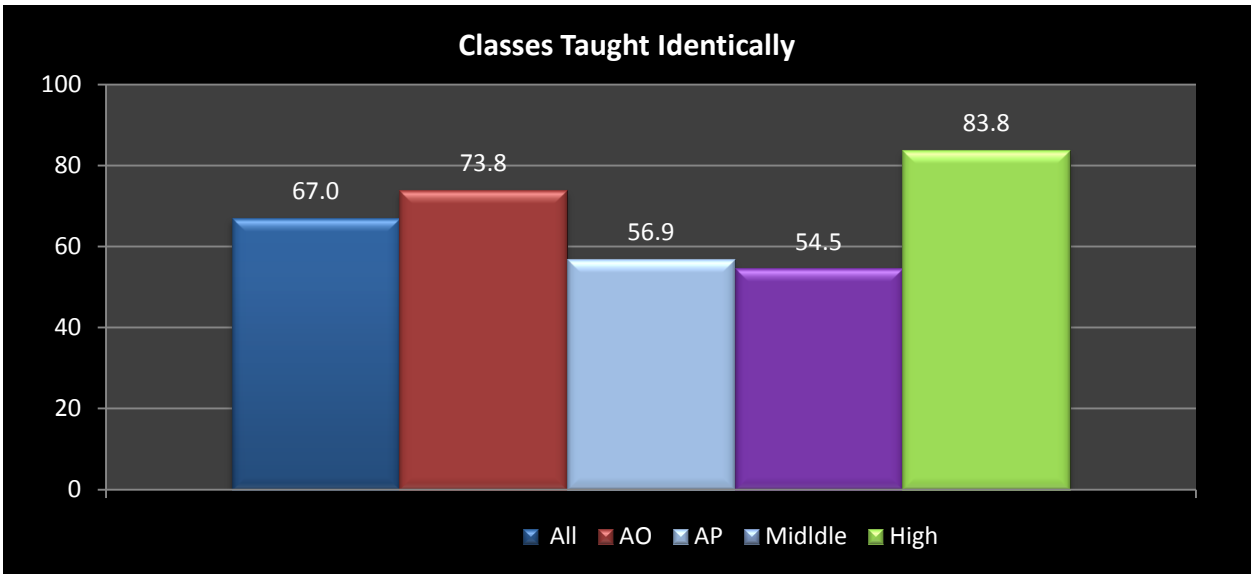


ISREP 8) Are all Classes Taught Identically

Two-thirds of principals (67.0%) responded that the curriculum was being taught identically in all grades. When compared to AP schools, higher percentages of AO reported teaching the curriculum identically in all grades (73.8% vs. 56.9%). When asked why the curriculum was not taught identically, the vast majority indicated that it was due to the age and grade appropriateness of the content.

Among high schools, 83.8% reported teaching classes identically in all grades. Among middle schools, 54.5% taught classes identically.

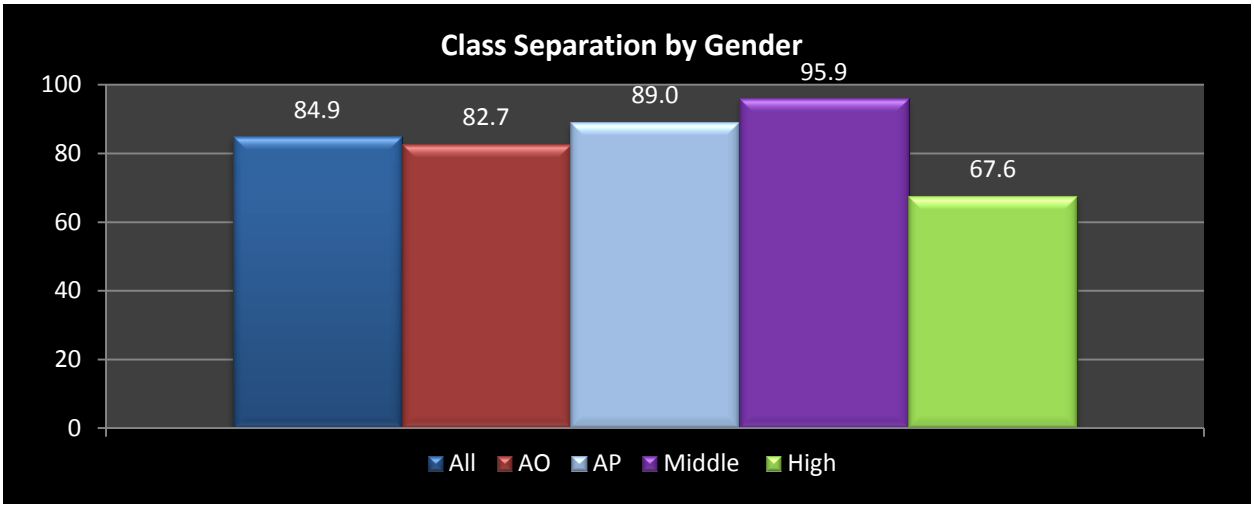
ISREP Figure 8. Are all Classes Taught Identically



ISREP 9) Class Separation by Gender

Most principals responded that they separated classes by gender. AP schools were more likely (89.0%) than were AO schools (82.7%). Among high schools, 67.6% separated classes by gender. Among middle schools, 95.9% separated classes by gender.

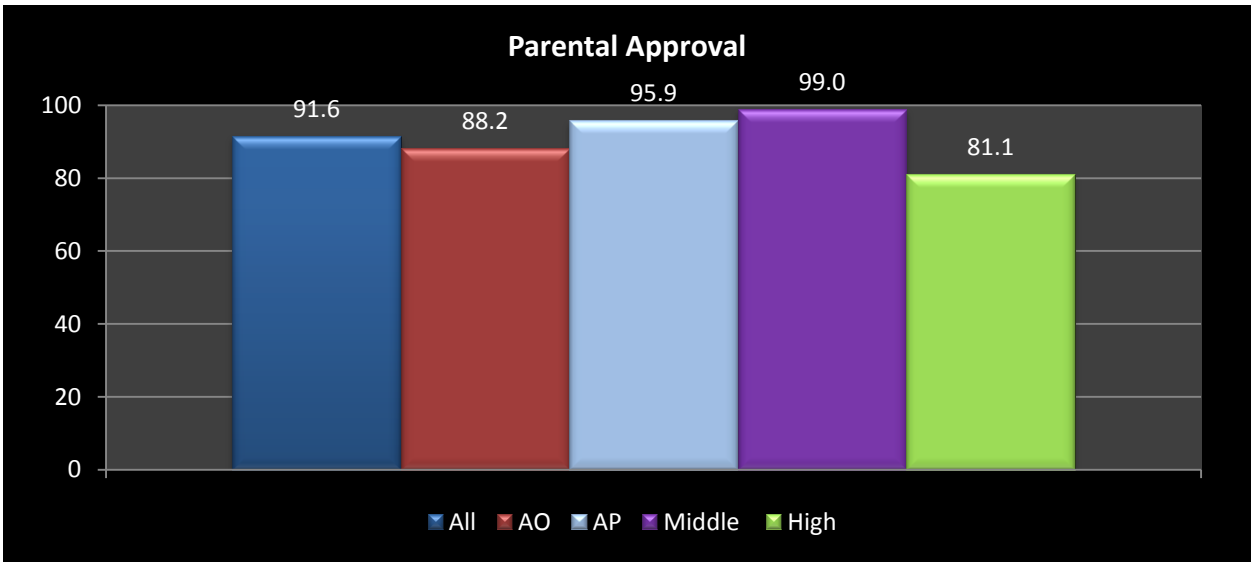
ISREP Figure 9. Class Separation by Gender



ISREP 10) Parental Approval

Most principals (91.6%) reported seeking parental approval for the students' participation in the curriculum. A much higher percentage of AP schools (95.9%) than AO schools (88.2%) middle schools (99.0%) than high schools (81.1%) reported seeking parental approval. The most common methods used were consent forms and permission slips sent home with the students.

ISREP Figure 10. Parental Approval



ISREP 11) Number of Hours per Week and Number of Weeks per Semester Curriculum is Taught

Principals were asked to indicate the number of hours per week and number of weeks per semester in which the curriculum was and would be taught. Due to inconsistencies in the reporting, the data are not reported here.

ISREP 12) Barriers and Challenges Limiting Implementation of the Policy

Among the AO schools, 27.0% did not respond and another 50.0% reported no barriers or challenges. The most frequent response was time and scheduling (23.8%), followed by gender separation (13.1%), consent forms not being returned (7.1%) and cost of materials (6.0%). Among the AP schools, 29.0% did not respond and another 40.0% reported no barriers or challenges. The most frequent response was time and scheduling (30.9%), followed by gender separation (18.2%), cost of materials (7.3%), forms not being returned (< 1%), and the challenge of finding space to teach and keep students who opted out of the curriculum (< 1%).

ISREP 13) Barriers and Challenges Limiting Teaching

Among the AO schools, 29.7% did not respond and another 60.2% reported no barriers or challenges. The most frequent response was time and scheduling (21.8%), followed by lack of materials and space (8.9%). Among the AP schools, 22.5% did not respond and another 36.4% reported no barriers or challenges. The most frequent response was scheduling (21.8%), followed by finding instructors (16.4%), resistance from parents, community, and teachers (9.0%) and gender separation (7.3%).

ISREP 14) Most Influential in Process of Adopting the Policy

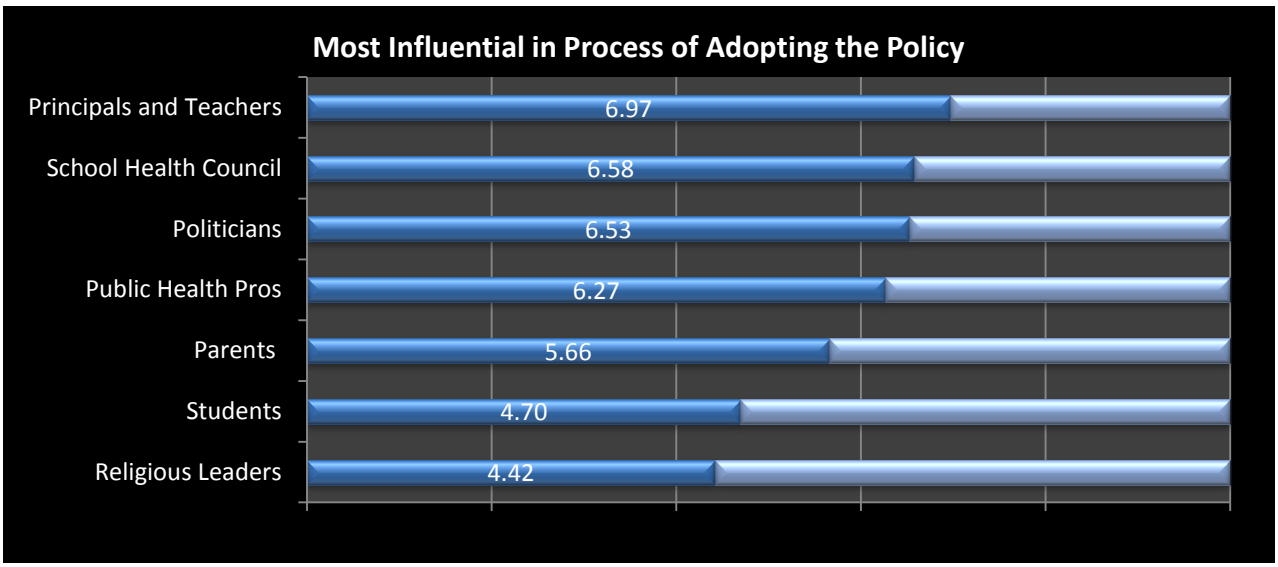
Principals were asked to rank those most influential in the process of adopting the policy. They ranked themselves and teachers as most influential (higher numbers equate with higher

level of influence), followed by the School Health Council, then politicians. These ranked higher than public health professionals, parents, students or religious leaders (See Figure 14).

Among the AO schools, principals ranked themselves and teachers as most influential, followed by politicians, and then the School Health Council. Among the AP schools, principals also ranked themselves and teachers as most influential, followed by the School Health Council, public health professionals, and then politicians.

Among high schools (similar to AO schools), principals and teachers were followed by politicians, then School Health Councils. Among middle schools, the ranking remained the same as below.

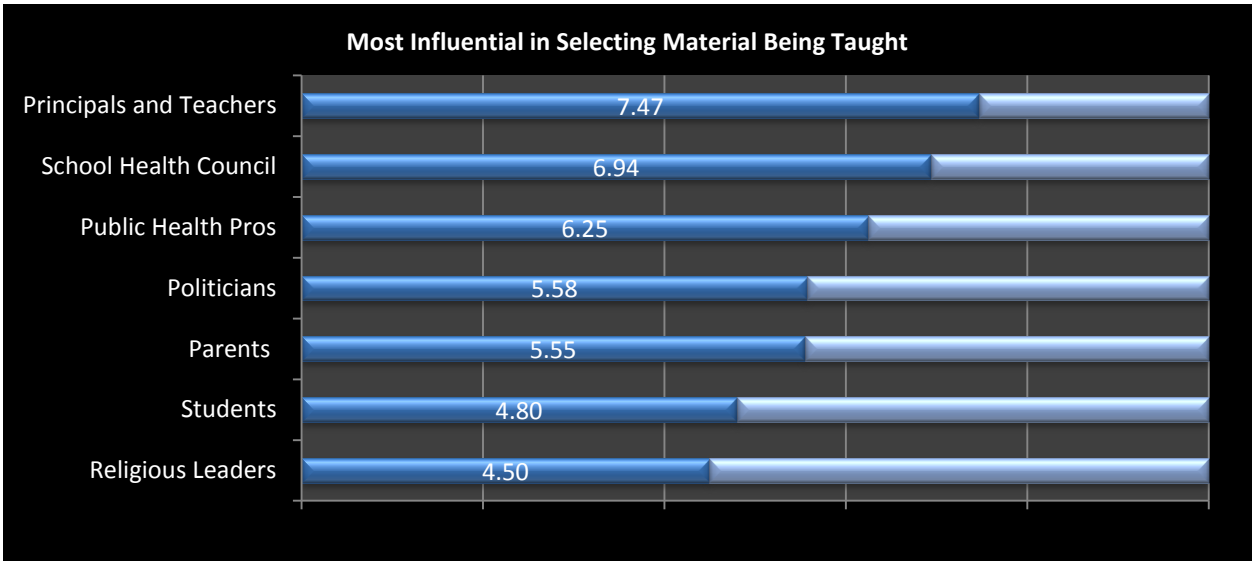
Figure 14. Most Influential in the Process of Adopting the Policy



ISREP 15) Most Influential in Selecting Material Being Taught

Principals were also asked to rank those most influential in the selection of the material being taught. They ranked themselves and teachers as most influential (higher numbers equate with higher level of influence), followed by the School Health Council, then public health professionals. These ranked higher than parents, politicians, students or religious leaders (See Figure 15 below). The only differences were among the AP schools, which placed parents before politicians, and among middle schools which placed parents above politicians.

ISREP Figure 15. Most Influential in Selecting Material Being Taught



ISREP 16) Factors that Weighed Most Heavily in Decisions on Implementation of the Policy

Among the AO schools, 37.6% of principals reported the factor that weighed most heavily in their decisions on implementing the policy was that it was state mandated. This was followed by community input (19.4%), scheduling and time demands (14.0%), teen pregnancy

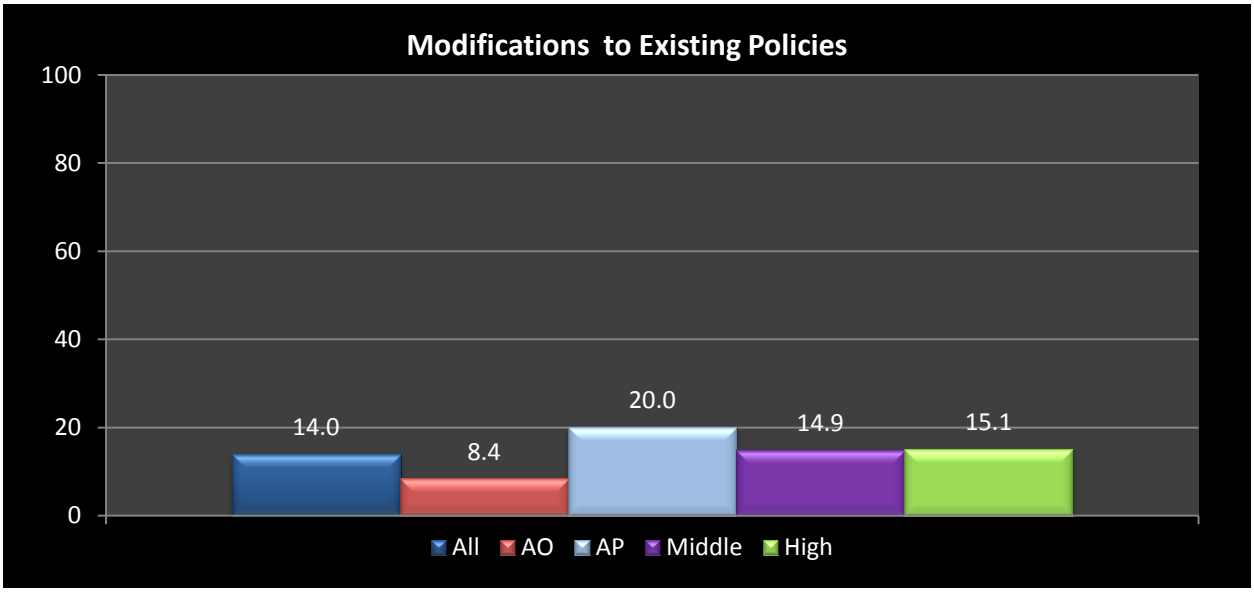
rates (8.6%), who would teach it (6.5%) and age-appropriateness of the curriculum (6.5%). Sixteen percent did not respond to this question.

Among the AP schools, 32.8% percent of principals reported the factor that weighed most heavily in their decisions on implementing the policy was that it was state mandated. The AP schools differed somewhat in that second most common response was teen pregnancy rates (24.1%), followed by community input (17.2%). The AP also differed in that 15.5% included effectiveness/what was best for the students. These were followed by age-appropriateness of the curriculum (8.6%). Eighteen percent did not respond to this question.

ISREP 17) Modifications to Existing Health, Nutrition, or Physical Education Policies

The vast majority of principals reported not having to make modifications to existing policies. Among the AO, 8.4% reported making modifications. A much higher percentage of AP schools than AO schools made modifications (20.0% vs. 8.4%). Changes were primarily in the areas of including/scheduling content in health and PE classes and separating classes by gender. No difference appeared between middle and high schools.

ISREP Figure 17. Modifications to Existing Health, Nutrition, or Physical Education Policies



ISREP 18) Costs Associated with Implementing Policy and Teaching the Curriculum

Similar responses were provided by AO and AP schools on costs associated with implementing the policy and teaching the curriculum. Among AO schools, 32.7% reported no additional costs, 34.7% reported materials, 12.7% were not sure/don't know yet, and 5.9% reported travel/training. Nine percent of the principals did not respond to this question.

Among the AP schools, 30.2% reported no additional costs, followed by materials (30.2%), not sure/don't know yet (12.7%), and travel/training (11.1%). Eleven percent did not respond to this question. The one difference between AO and AP schools was that AP schools reported the cost of salary for substitute teachers (12.7%).

ISREP 19) Resources, Materials, and Services Needed to Fully Implement the Policy

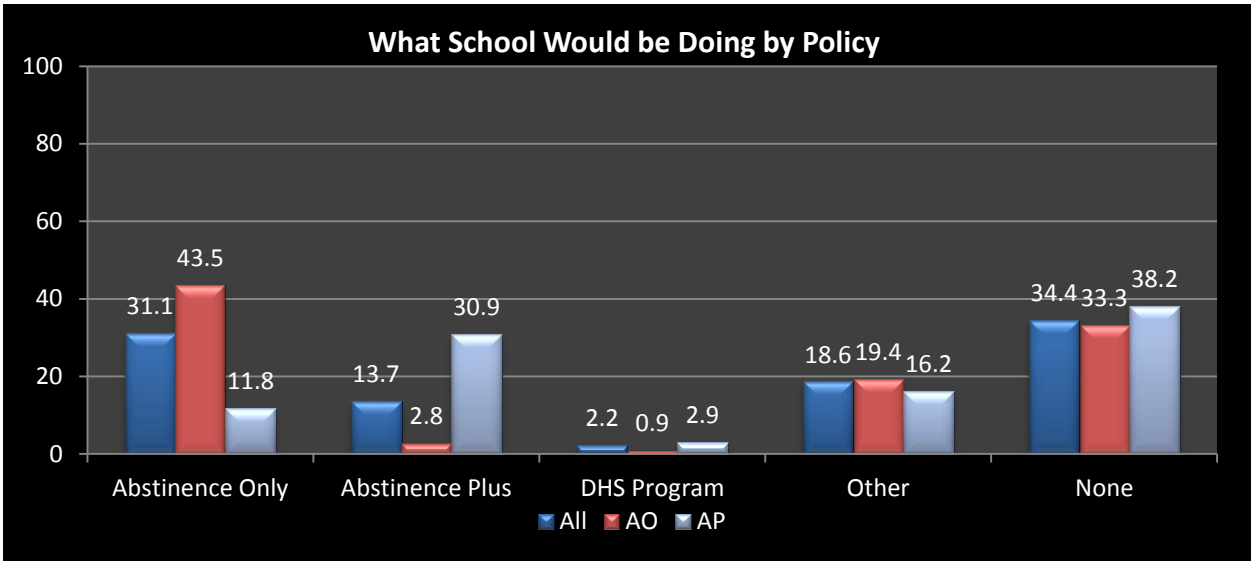
Similar responses (though very different percentages) were provided by AO and AP schools on resources, materials, and services needed to fully implement the policy. Among AO schools, 31.4% needed funds for books, videos, handouts and teachers, followed by none/have what is needed (30.2%), training for teachers (11.6%), outside agencies/professionals/nurses to teach (10.5%), and purchasing of the curriculum (10.5%). Twenty-three percent did not respond to this question.

Among AP schools, 55.8% needed funds for books, videos, handouts and teachers, followed by none/have what is needed (19.2%), training for teachers (13.5%), and outside agencies/professionals/nurses to teach (13.5%). AP schools did not mention the cost of the curriculum. Twenty-seven percent did not respond to this question.

ISREP 20) If the Law Had Not Been Passed, What Would the School be Doing Regarding Sex-Related Education

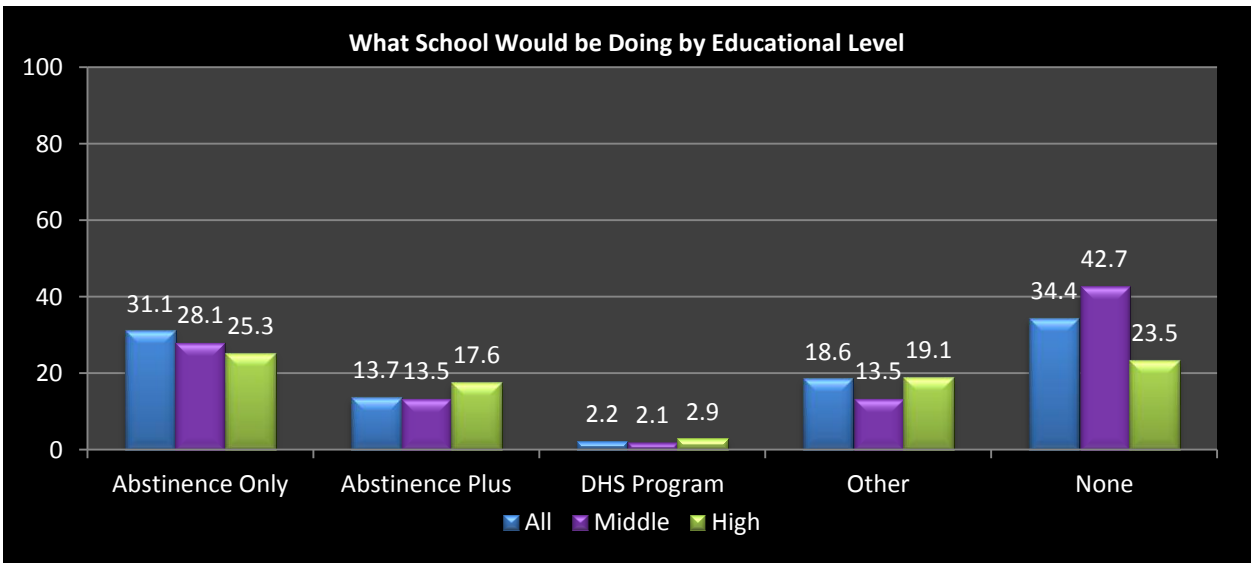
If the law had not been passed, the most frequent response was that the schools would not being doing anything (34.4%). That response was higher among the AP (38.2%) than the AO (33.3%) schools. Among AO Schools, 43.5% reported that they would be doing AO. Among the AP schools, 30.9% reported that they would be doing AP (See Figure 20a).

Figure 20a. If the Law Had Not Been Passed, What Would the School be Doing



Between middle and high schools, the most notable difference was among the selection of "none". Among high schools, 23.5% reported that if the law had not been passed, they would not be doing anything. Among middle schools, 42.7% reported that they would not be doing anything (See Figure 20b).

Figure 20b. If the Law Had Not Been Passed, What Would the School be Doing Regarding



ISREP 21) What Changes in the Law Would Help Implement the Policy

Several differences were noted in suggestions between AO and AP schools. Among AO schools that responded, 70.5% reported no changes were needed in the law. Approximately eight percent (7.7%) would like funds included for implementation, followed by requiring a credited course (6.4%), giving schools and teachers more autonomy/flexibility in implementation (3.8%), allowing genders to be taught together (2.6%) and not making this mandatory (2.6%). Thirty percent of the principals did not respond to this question.

Among AP schools, approximately half as many as the AO schools, 36.2% reported no changes were needed in the law. A much higher percent than the AO schools, 25.5%, requested that genders be taught together. Among the AP schools, 17% asked that parental consent be removed, 8.5% wanted funds for implementation, and 4.3% wanted to be able to provide condom demonstrations. Thirty-four percent of the AP principals did not respond to this question.

ISREP 22) Anything Else Regarding the Implementation of the Policy

Among the AO schools, 6.8% reported that the program was going well and 5.2% reported that the program was needed. Among the AP schools, 11% wanted more opportunities for teacher, student, and parent input.

Discussion

This study is based on a random sample of middle and high schools across the state of Mississippi. Over 75% of principals responded to the 22-item ISREP survey. Data collected through the earlier Profiles study from the same sample of schools provided context for the ISREP study. According to the Profiles study, a broad array of school health policies, activities, and programs exist in middle and high schools across the state. The vast majority of these schools have been coordinating school health services, yet very few were providing preventive services related directly to teenage pregnancy.

By June 30, 2012, all local schools boards of every public school district were to adopt a policy to implement abstinence-only or abstinence-plus education into its local school district's curriculum by June 30, 2012, or to adopt the program developed by the Mississippi Department of Human Services and the Department of Health. It should be noted that over 10% of the schools (3.8% of middle schools and 20.8% of the high schools) reported that they were not implementing the policy. Many respondents clarified that while the district had to adopt a policy, not every school in the district would be implementing it.

There were differences among middle and high schools in the selection of sex-related policy or curriculum. Among high schools, 46.9% adopted AO and 32.3% adopted AP. Among middle schools 50.5% adopted AO and 40.6% adopted AP.

According to the principals who responded to the ISREP survey, the majority selected AO (51.8%). Another 34.4% selected AP. It should be noted that 39% of the AP reported using the same curriculum (Choosing the Best) as the AO. A small percentage of both AO and AP

schools used the Wait Training. Another related finding was a wide range in the number of hours per week and the number of weeks in which the sex-related education curriculum was being provided.

Many differences emerged between the AO and the AP and middle and high schools in the persons responsible for oversight of the policy and the teaching of the curriculum. Higher percentages of AP and high schools used health education teachers in adopting the policy and in teaching the curriculum. Middle schools were more likely to use PE and other teachers in teaching the curriculum. High schools were much more likely to offer the curriculum both fall and spring (58.1%) than middle schools (31.0%), and teach the curriculum identically in all grades (83.8%) than middle schools (54.5%). Middle schools were more likely to separate by gender (95.9% vs. 67.6%) and seek parental approval (99.0% vs. 81.1%).

A difference was noted between the AO and the AP as well as the middle and high schools in the influence in process of adopting the policy, with politicians rated higher than School Health Councils among the AO and high schools. It was the other way around for the AP schools. When it came to selecting materials to teach, parents were ranked higher than politicians among the middle schools.

Approximately one-third of both AO and AP schools reported that being mandated by the state to provide sex-related education was the factor that weighed most heavily in decisions on implementing the policy. Yet much higher percentages of the AP schools reported “teen pregnancy rates” and “effectiveness/what was best for the students” as factors weighing heavily in their decisions. Changes in existing policy were much higher among the AP schools in contrast to the AO schools.

A large majority of both AO and AP schools did not report barriers or challenges to implementing the policy and teaching the curriculum, and a majority did not report modifications or resources needed. However, when asked what they would be doing if the law had not passed, over one-third reported that they would not be providing sex-related education at all. When compared by educational level, much higher percentages of middle schools (42.7%) than high schools (23.5%) would not being doing anything.

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