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**The Benefits and Limitations of a Clinician Lead Sexual Education Program in Wisconsin  
Public Schools**

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Augsburg University, Master of Physician Assistant Studies

PA599: Directed Study PA Master's Project

Dr. Vanessa Bester

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## **Abstract**

**Background:** Abstinence-based sexual education is the primary method of sexual education in public schools.<sup>4</sup> The majority of public schools use teachers who may or not have proper training to teach the course. Comprehensive sexual education taught by clinicians could potentially decrease sexual risky behavior in the youth population.

**Purpose:** Identify potential benefits or limitations to a clinician-led sexual education program in Wisconsin public schools.

**Methods:** Articles 2017 or newer were reviewed utilizing search engines such as PubMed, Google Scholar, and NIH. A Google Form with 18 questions was sent out to 420 Wisconsin public school administrators. It was open for 7 days and yielded 49 responses. Ten of the responses were graphed and analyzed for data.

**Conclusions:** Due to the unequal sample size, the data cannot be properly analyzed to have a concrete conclusion.<sup>13</sup> Throughout the literature review it was found that teachers who had taken a course in teaching sexual education, yielded better outcomes with their students.

**Key Words:** Sexual Education, Abstinence-Based, Comprehensive Sexual Education, Evidence-Based Sexual Education, Wisconsin Public Schools, Clinician-Led Sexual Education.

## **The Benefits and Limitations of a Clinician-Led Sexual Education Program in Wisconsin Public Schools**

**Margaret Freiermuth, PA-S**

### **Introduction**

Sexual education courses have been taught for years by public schools. Many people remember being separated by gender to have the “birds and the bees” talk. However, the question is how effective were those incredibly short sessions? Sexual education is a topic that most people do not want to talk about, especially to children. Teaching children about it has become the responsibility of the school administration and teaching staff. However, most public school districts are only required to teach the bare minimum about the topic, which barely scratches the surface. School districts can decide what additional information they want to teach above the required material. Teachers are responsible for navigating the curricula to teach some of the most important and sensitive information students will receive throughout their education.

Some schools do not have a health teacher and rely on other educators to instruct the course. Some of these educators have never been trained to teach sexual education, some have had minimal training, and others have covered the material extensively. There are no guidelines when it comes to who can teach it as long as they have a teaching license. Many states including Wisconsin, require the course be taught using an abstinence-focused curriculum no matter who teaches it. Abstinence-focused or abstinence-based is a form of sexual education where students are only taught not to have sex until marriage.<sup>18</sup> The majority of the programs withhold information about sexually transmitted diseases, birth control methods, and safe sex practices. One of the biggest downfalls to this method is the medical information that is being withheld

from students. Valuable information regarding their physical health is not being provided to them with the abstinence-based method. Comprehensive or evidence-based sexual education is the complete opposite of abstinence-based. Comprehensive sexual education bases its practices off of giving students as much medically accurate information as possible. It focuses on different birth control methods, condom usage, information on sexually transmitted disease, consent, and overall helps students make smarter decisions.<sup>18</sup> Unfortunately, comprehensive sexual education is not always taught with medically accurate information, and that is partly because of who is teaching it.

When it comes to our health, most people turn to their healthcare provider. Why not turn to them to teach students about their sexual health and behaviors? If a clinician, whether that be a physician, physician assistant, nurse practitioner, or nurse were to teach sexual education, would it lead to better decision-making in teen populations? If an expert on health and the human body taught the information to students rather than an educator, could this lead to healthier and safer sexual activities for students? Would students have a better understanding and appreciation of the choices that they make and the risks that could occur alongside? The focus of this paper is to compare educator-led sexual education courses versus clinician-led courses in the state of Wisconsin. Are there any benefits to having a clinician teach a medicine-based sexual education curriculum, and what are the limitations?

## **Methods**

First, a literature review was conducted to find resources and relevant information for the study. Only articles 2017 or later were considered for this study. Articles were reviewed utilizing search engines such as PubMed, Google Scholar, and NIH. Credible website sources such as the

Center for Disease Control (CDC), Planned Parenthood, and the Guttmacher Institute were also used. A survey with 18 questions was created using Google Forms. A portion of the questions were gathered from the Kaiser Family Foundation. The survey was created to gather answers anonymously without collecting participants' information. Consent was added to the first portion of the survey and had to be agreed upon to continue with the survey. Using the Wisconsin Department of Public Instruction website, a list of 420 Wisconsin public school administrators was generated. The survey was emailed to all of them. Eleven of the administrators emailed were no longer in that position, therefore, the email was then forwarded to the new administrators. The survey was open for seven days and yielded 49 responses. Each question on the survey was optional and included both "skip" and "I don't know" answers. After the survey period closed, the data was analyzed by the researcher and grouped into two categories. Category one was for schools that have clinicians or other health professionals (such as school nurses) instructing the course. Category two was for the schools that had a teacher instructing the course. The two categories were compared and contrasted to find any key differences that could differentiate a benefit or disadvantage to a clinician lead program.

## **Literature Review**

Sexual education programs in public schools have been a topic of interest and debate since the early 1920s. Before it was introduced into the United States public school system in the 1920's it was the responsibility of family and religious groups to decide whether their children were educated or not. While our knowledge of medicine has significantly improved since the 1920s, sexual education courses in public schools have hardly changed. It was not until 1990 when the US mandated that all public schools must teach about acquired immunodeficiency

syndrome (AIDS), all other sexual education material was optional. One year later in 1991 the very first sexual education curriculum known as *Guidelines for Comprehensive Sexuality Education – Kindergarten-12th Grade* was published, but was still optional. As of November 2020, there are only seven states in the US that mandate a comprehensive sexual education course be taught in that state's public school system.<sup>8</sup>

The CDC recommends 16 essential topics be taught in comprehensive sexual education (CSE). However, according to an article, *The role of policy on sexual health education in schools: Review*, they report that “fewer than 50% of high school students and only 20% of middle school students receive instruction on all 16 essential topics of CSE recommended by the CDC”.<sup>5</sup> The 16 criteria cover topics such as abstinence, how to prevent STIs and pregnancy, preventative care, birth control and condom usage, and tips on how to reduce risk overall. They also talk about healthy boundary making, maintaining relationships, and goal-setting.<sup>5</sup> The 16 criteria are a great resource for an all inclusive comprehensive sexual education program.

Not only are these 16 essential topics not being discussed, the material given to students may not be medically accurate. According to the yearly study performed by the Guttmacher Institute, currently in 2023, only 17 states require sexual education program content to be medically accurate. That means 33 states are not teaching students the proper medical information they need to make healthy and safe decisions for themselves. According to *Sex Ed for Social Change (SIECUS)*, teaching sexual education is not mandated in Wisconsin. When it is taught, they are required to teach an abstinence-focused curriculum.<sup>7</sup> The only mandated requirement for Wisconsin public schools is to teach about sexually transmitted diseases. However, when a school district in Wisconsin does teach a comprehensive sexual education program, it is required to be taught medically accurate.

Medically accurate sexual education programs also known as comprehensive sexual education programs have been proven when compared to abstinence-based programs to decrease risky sexual practices in the adolescent population. When students are given medically accurate information they can make smarter and safer sexual decisions. In the study, Delaying sexual onset: outcome of a comprehensive sexuality education initiative for adolescents in public schools, they found that with students who took comprehensive sexual education programs, their sexual debuts were delayed over those who took abstinence-only programs. They state, “These interventions have shown results in reducing risky sexual behaviors and preventing teenage pregnancy. Comprehensive sexuality education is effective in influencing adolescents' decisions such as delaying sexual debut” (Ramírez-Villalobos et al. 2021).<sup>10</sup> Along with favorable outcomes already mentioned, they also demonstrate improved interactions between the teachers and students. The additional training interventions enhanced teachers skills to optimize the course effectiveness.

One of the factors behind the lack of comprehensive sexual education programs in the United States, and Wisconsin, is the lack of education for teachers. The study previously mentioned in the last paragraph, put teachers through a comprehensive sexual education course. The teachers then took what they learned in that course and brought it to the classroom for their students. This method could be implemented more because most teachers are not trained to specifically teach sexual education in a classroom. A majority of the time it falls on the responsibility of the health educator to teach the sexual education curriculum, and for the most part it falls within the health or physical education course curriculum. To become a health education teacher you must obtain a health education certification through a bachelor's degree. “However only 61% of colleges and universities require sexuality education courses for health



education certification and nearly one-third of teachers responsible for sexuality education report receiving no pre-service or in-service training in this area” (SIECUS, 2018).<sup>11</sup> So why are school districts relying on teachers to teach about a topic that one-third of them have never learned about properly? Many districts are pushing to have school nurses or other clinicians teach the programs. There would be less stress on the teaching staff to write a curriculum outside of their expertise, and the students would benefit from a professional in the medical field to give them the most accurate and up-to-date information.

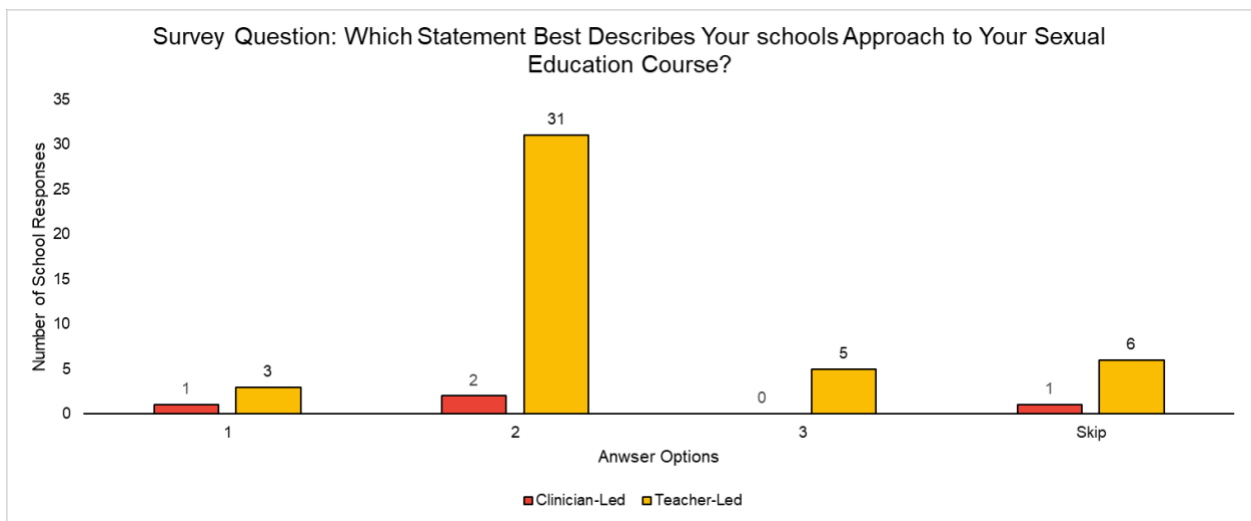
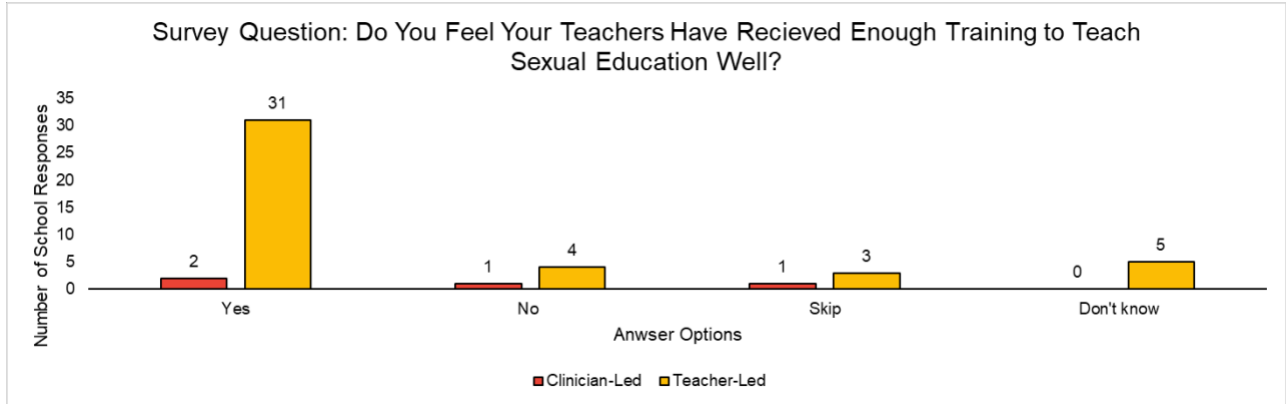
According to the American College of Obstetricians and Gynecologists (ACOG), clinicians can play an important and unique role in sexual education for students and parents. They have the knowledge and the ability to provide information in a professional, non-judgemental, and clear way. They could support both the students and their parents by providing a guideline that focuses on optimizing health goals with preventative health initiatives. In an article written by ACOG, they state “-because of their knowledge, experience, and awareness of a community’s unique challenges, obstetrician-gynecologists can be an important resource for sexuality education programs” (American College of Obstetricians and Gynecologists).<sup>9</sup> This does not have to be limited to obstetricians and gynecologists, this could be expanded to include any physician, physician assistant, nurse practitioner, or nurse.

In a pilot study performed in Slovakia, The need for nurse interventions in sex education in adolescents, they found that school nurses were a great resource for implementing evidence-based sexual education programs over educator lead programs. They found that students were more comfortable talking with the school nurse about this sensitive topic and were more willing to listen. They stated, “Nurses can use their unique combination of knowledge and skills to make a positive impact on adolescent sexual and reproductive outcomes. Nurses have the capacity and

opportunity to disseminate information about sexual and reproductive health to adolescents” (Pavelová, L., Archalousová et al. 2021).<sup>12</sup> They also found that after the nurse-led course, the students had fewer questions about sexually transmitted diseases, anatomy, and other topics covered, than students who took the educator-led course. They also stated, “Students who participated in sessions that were taught by school nurses were more likely to report significant and sustainable changes in a broad range of sex-related cognitive mediators, including self-efficacy, condom-related beliefs, and peer behavior beliefs” (Pavelová, L., Archalousová et al. 2021).<sup>12</sup> The group of students who were taught by a teacher reported that condom knowledge was the only memorable lesson of the course. One of the biggest takeaways from their study was that students who took the nurse-led program overall had lower levels of sexual activity. This demonstrated that the nurse-led comprehensive evidence-based sexual education course was effective in reducing risky behavior and increasing students' knowledge to allow them to make smart sexual decisions.

## **Results**

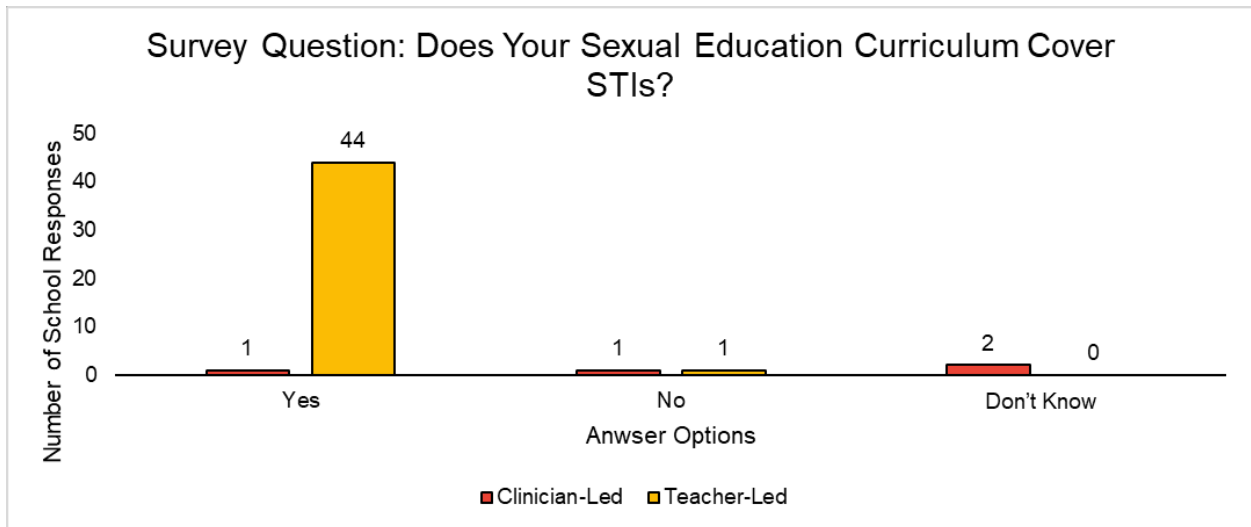
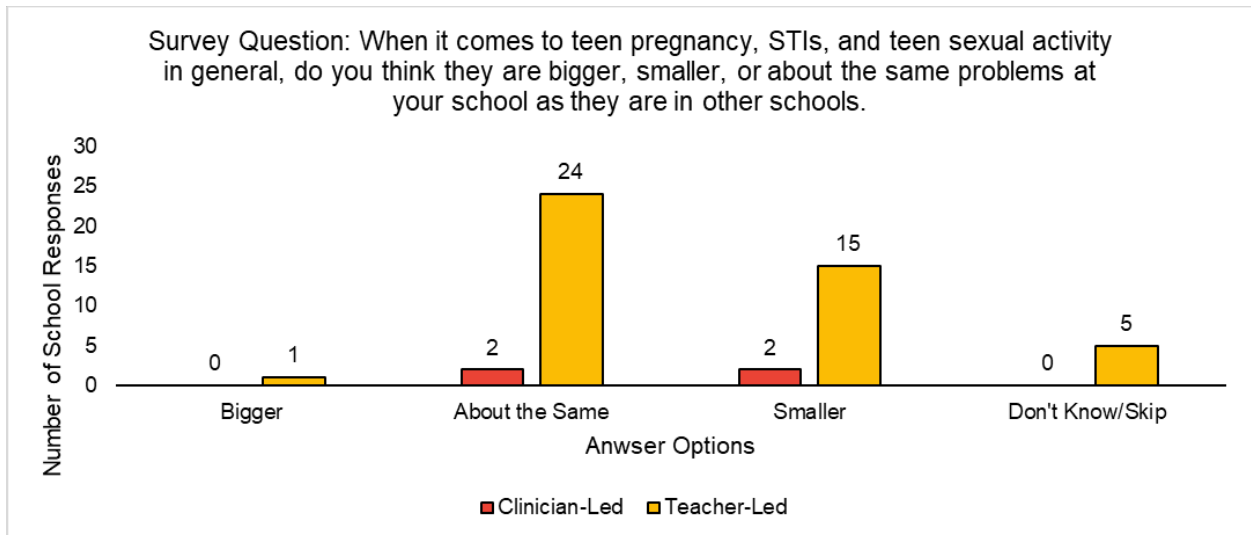
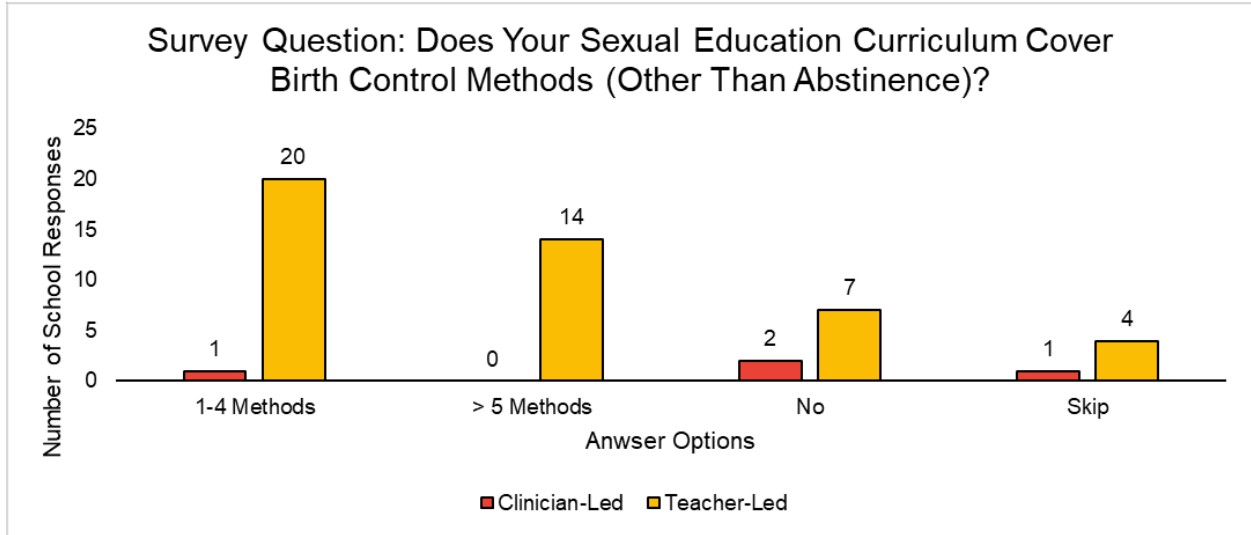
The survey yielded 49 responses. Only four out of the 49 schools that responded have a clinician that teaches the sexual education course. The other 45 schools reported having teachers that were trained to teach the curriculum running the course. Resulting in 8.2% of the schools that responded have a clinician teaching sexual education, while the remaining 91.8% of schools have a teacher instructing the course.

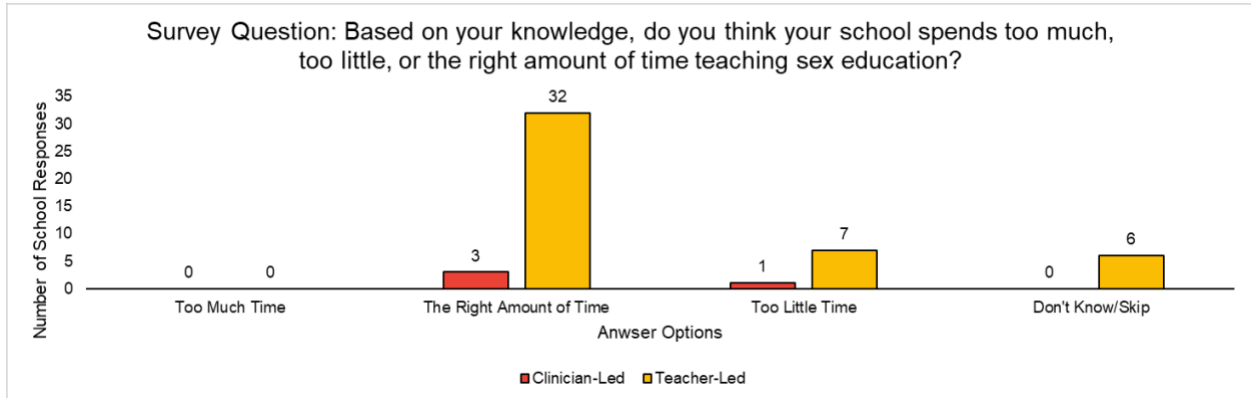
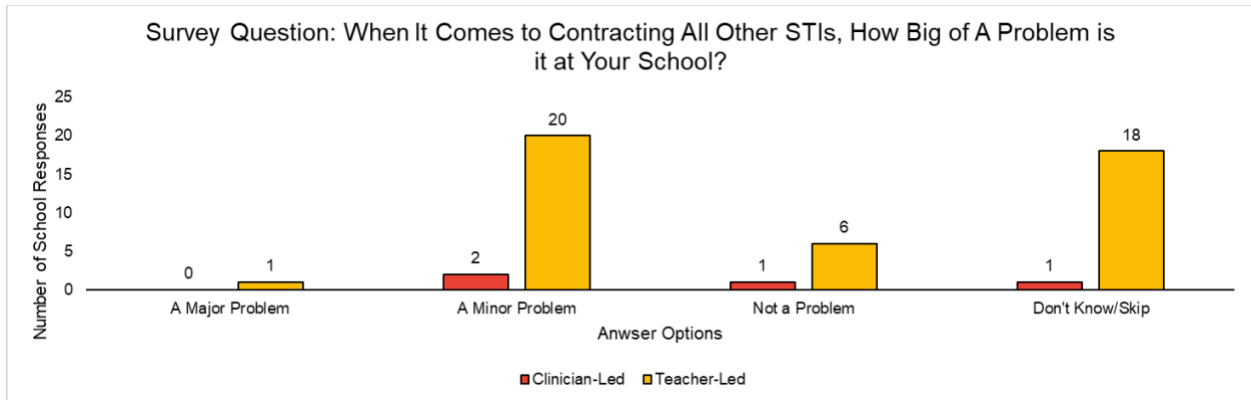
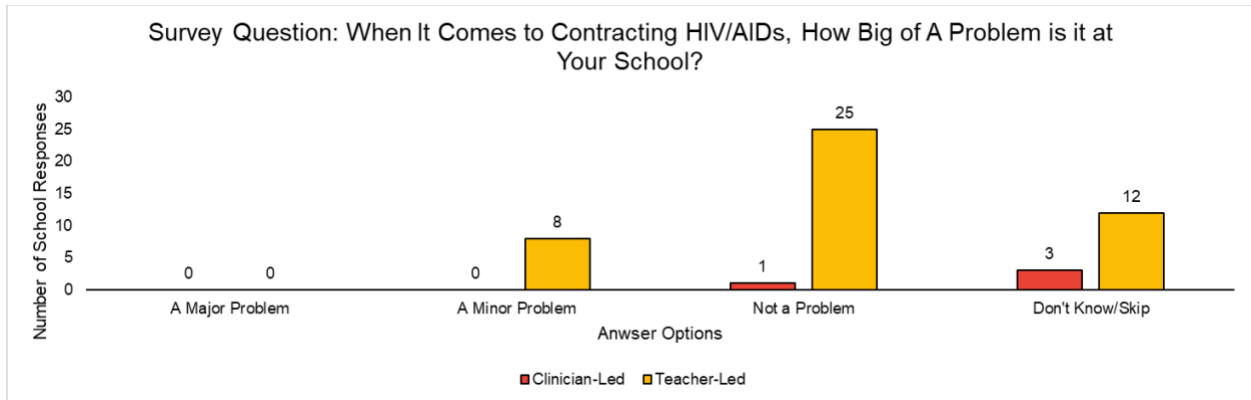
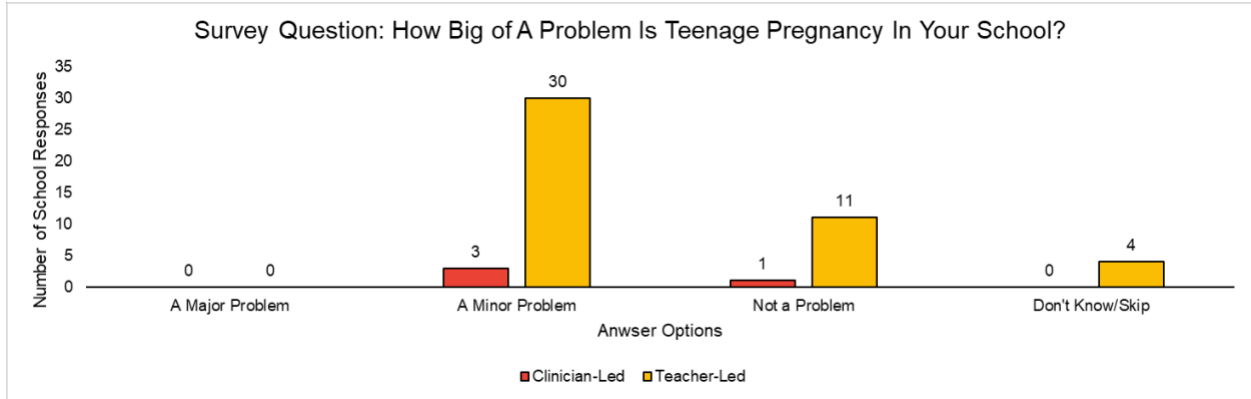


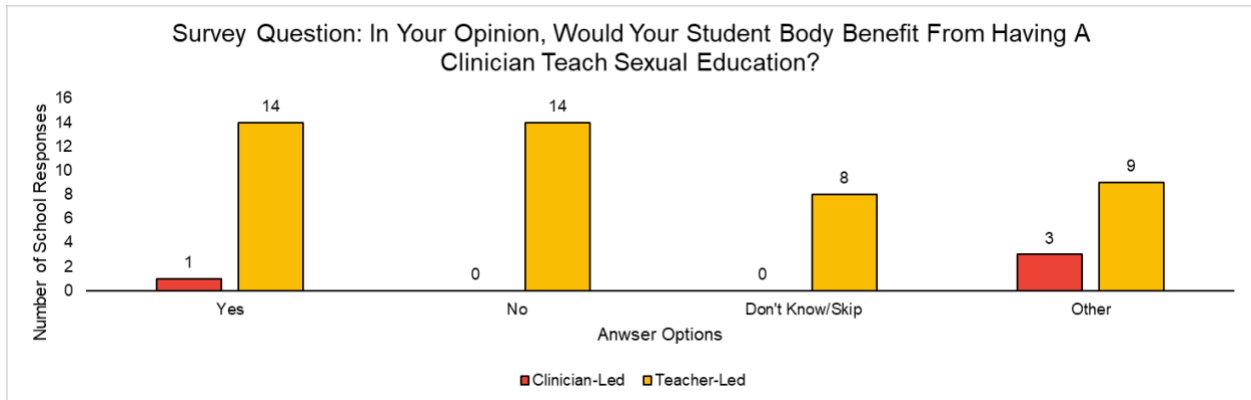
\*Data set 1 statement: Abstinence from sexual intercourse is best for teens. Sex education classes do not provide information about condoms and other contraceptives.

\*Data set 2 statement: Abstinence from sexual intercourse is best for teens but some teens do not abstain, so information about condoms and other contraception is provided.

\*Data set 3 statement: Abstinence from sexual intercourse is not the most important thing. We teach teens to make responsible decisions about sex.







\*Some of the write-in answers for others included:

1. By law, public educators in Wisconsin must hold either a lifetime teaching license or a 3 or 5-year substitute teaching license. Unless a clinician held this certification in addition to their medical degree, it would be unlawful for them to teach in our public school system.
2. Clinicians are available to talk to students at a parent’s request.
3. One of our teachers partners with a health professional to share some of this information.
4. Our school nurse does co-teach certain topics or units.
5. There is a partnership between teachers and nurses.
6. Any speakers on human growth and development need to be pre-approved by our advisory board and possibly the school board.

Eight of the survey questions were not graphed. The results of seven of them were not valuable to this research and for future purposes could be deleted from the survey. The first question was to gain insight on who was taking the survey by asking their role in education. This helped the researcher ensure the response was from a legitimate participant.

Of the questions that were not reported on, one question was used to categorize the sample groups into who teaches the course. Asking about study body population was to have a potential way to segregate data if needed. Another question asked about which course sexual education was a part of, and it was unanimously a part of the health/physical education course for all 49 responses. A question was asked about the duration of the course and it was decided

that the information gained from that question was not valuable to this paper. The last two questions asked about what grade level students take sexual education and if the course is required or not. Both were not necessary questions to add to this report.

## **Discussion**

This research ended up being an unbalanced research design because of the disproportionate sample sizes. We cannot assume the homogeneity of the variances in each group due to the unequal sample size. It is ethically and statistically wrong to compare a group that has a sample size so small. The huge difference in sample size causes violations of homogeneity of variances in statistical analysis. This experiment is extremely sensitive to heteroskedasticity. Essentially resulting in data that is not accurate. Typically when it comes to small sample sizes the probability of a type 1 error can be exacerbated, and using the mean sample size can underestimate the variance of the sample. Another possible effect of balancing the sample size data would be introducing estimation bias.<sup>14</sup> One possible way to salvage the data would be to go back out and collect more. Specifically, collect more from schools that have a clinician-led sexual education program. To properly and ethically analyze the data, the sample sizes have to be proportionate to each other.

Overall the material for this paper was limited. Finding information for the literature review was a challenge. Clinician-led sexual education programs have not been fully studied or explored, so the material was sparse. There is an endless amount of information regarding abstinence-focused curricula vs comprehensive sexual education curriculums. The evidence shows that comprehensive sexual education also known as evidence-based has far more benefits than teaching abstinence focused. Students who are fully educated can make safer and smarter

decisions about their sexual health. The studies also demonstrated that the students waited longer to engage in sexual activities when they had comprehensive sexual education. Due to the enormous outcomes of comprehensive sexual education, it can be theorized that having a clinician teach the course would yield benefits.

The survey was sent out to 420 school districts and yielded 49 answers. The goal was to compare and contrast public schools in Wisconsin that utilize clinicians or teachers as their sexual education instructors. From the responses only four schools out of the 49 that responded utilize clinicians to teach sexual education. The other 45 schools utilize their educators to teach the course. Due to the significant difference in numbers, it is hard to do a fair comparison. Statistically, the study is flawed and needs more samples to be considered a legitimate study. The small sample size is one of the largest limitations this paper realized. It was also hard to get quantitative data from open-ended questions. If this survey were to be performed again, only a select few answers would be used, without the option to write in. Another change for future studies would be to seek out sexual education programs that are clinician-led and focus on their statistics alone. Further, consider how an even amount of schools with non-clinician-led and clinician -led programs could be picked with even distribution and properly compared. This method would be preferred for the future and would yield more legitimate results. Another approach would be to survey the students themselves to see how they value the education they received after a clinician-led program and compare it to a non-clinician-led program. This method would take many months of planning and preparation as well as an extensive IRB application and approval process.

Alongside the limitations of this study, there are still limitations when it comes to sexual education no matter who is teaching it. All school districts are limited by the laws implemented



by each state. With any of the mentioned sexual education curricula, the parents still have the right to decide whether or not their child takes the course. Health and physical education are required courses, but parents can restrict the child's access to the sexual education unit. This still allows the student to complete the requirements for graduation without taking sexual education. So unless the laws are changed to eliminate the ability to pull a child from the course, sexual education will still be limited in public schools to those who are allowed to have it.

### **Conclusion**

In theory, a clinician-led sexual education program would yield results such as lower rates of risky sexual behavior, later sexual debuts, and overall more educated decision-making. This assumption can be made by observations made by comparing abstinence-based programs and evidence-based or comprehensive sexual education programs. Students who receive more medically accurate information in non-abstinence-focused programs are showing the results previously mentioned. By adding a clinician to teach the program, those results may only improve. However, with the data collected in this project, it is impossible to analyze the results, leading to a failed experiment. However, during the literature review, it was found that when teachers attended a course in teaching comprehensive-based sexual education, they were better able to teach their students, and the outcomes were desirable. Therefore, whether a teacher who is properly trained or a clinician teaches sexual education with an evidence-based curriculum, students are making wiser decisions when it comes to their physical and mental health.

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