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Dismantling Hegemony through Inclusive Sexual Health Education

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Dismantling Hegemony through Inclusive Sexual Health Education

by

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A thesis submitted in partial fulfillment
of the requirements for the degree of
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Abstract

This thesis examines the process of developing a sexual health education curriculum that is not only tailored to the unique needs of foster-engaged young women, but also those who may experience further marginalization from other mainstream programs due to their race, sexual orientation, gender identity, and/or their religious beliefs. In conjunction with the Adolescent Sexual Health Education and Research (ASHER) Program, I helped develop a sexual health education curriculum, "Choosing Myself," targeted toward foster-engaged young women and young women (ages 13-24) in the state of Florida. "Choosing Myself" is intended to be an inclusive program that empowers participants, improves their self-esteem, and provides them with the knowledge and agency to navigate sexual situations. Sexual health curricula that ignore the diversity of experiences and backgrounds perpetuate harmful hegemonic systems of oppression and leave students unprepared to navigate sex and sexuality. By incorporating how participants' race, sexuality, gender identity, and religion impacts their experiences with sex, sexual health, and sexuality, "Choosing Myself" aims to better meet their needs, support their sexual health, and decrease their risk of sexual violence and other adverse experiences. I utilize techniques from feminist and care pedagogy, reproductive justice, and trauma-informed care to incorporate important information and conversations that allow participants in "Choosing Myself" to connect the material with their own identities and experiences.

Introduction

Youth in the foster system are often at greater risk of sexual violence and human trafficking because they may be more likely to have traumatic experiences that can make them more vulnerable to exploitation (Gluck & Mathur, 2014; Hannon et al., 2017; Speckman, 2016). Black and Hispanic/Latine[1], as well as LGBTQ+ youth, are overrepresented in foster care (Fish et al., 2019; Grooms, 2020; Hannon et al., 2017), and in general, foster youth have a variety of unique needs, especially when it comes to their sexual health and education. Studies suggest that foster-engaged youth, as well as youth that identify as other marginalized groups (Lesbian, Gay, Bisexual, Transgender, Queer, Questioning, Pansexual, Intersex, Asexual (LGBTQ+), Black, Indigenous, and People of Color (BIPOC), or religious minorities), benefit from sexual health education that is tailored to their unique needs and circumstances (Ahrens et al., 2010; Boustani, Frazier, & Lesperance, 2017; Finigan-Carr, Steward, & Watson, 2018; Gattamorta, Salerno, & Castro, 2019; Harmon-Darrow, Burruss, & Finigan-Carr, 2018, Hoefer & Hoefer, 2017).

As part of the Adolescent Sexual Health Education and Research (ASHER) Program[2], my thesis documents my engagement in developing an inclusive sexual health education curriculum, "Choosing Myself," targeted toward foster-engaged girls and young women (ages 13-24) in the state of Florida. The program is open to all female-identifying youth, including

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[1] Latine is the preferred gender-neutral/inclusive term among native Spanish speakers. Latinx is a term that is more common in the US but is rarely used elsewhere.
[2] The Adolescent Sexual Health Education and Research (ASHER) Project provides comprehensive and inclusive sexual health education for youth who are marginalized and/or in high-risk situations. Through education and empowerment, ASHER places an individual's autonomy, choice, and values at the center to advance gender equity and prevent sexual violence and trafficking.

cisgender females, transgender females, and gender-non-conforming/non-binary people who were assigned female at birth. The program is intended to foster relationships among participants and between the participants and the facilitators. With this in mind, the class sizes are kept small with six to eight participants in each session, with those participants preferably close in age. Each class meets once a week for two hours, with the opportunity to add sessions or time at the request of the group. The curriculum is tailored to the unique needs of youth in these marginalized groups and designed to help them achieve the following five goals: 1) gain knowledge about anatomy, sexuality, identity, and sexual health; 2) discover and articulate their values, boundaries, and goals; 3) increase their ability to communicate and navigate sexual relationships; 4) increase their self-esteem and ability to assert their needs, values, and boundaries; and 5) decrease their risk of sexual violence.

In the United States, conversations about mainstream sex education do not, unfortunately, focus on meeting the needs of marginalized youth, but are more often focused on debating the binary between comprehensive sex education (CSE) and abstinence-only education (AOE) (Shannon, 2016). Abstinence-only education primarily focuses on abstinence as a way to prevent pregnancy and sexually transmitted infections (STIs) and promotes abstinence until marriage as the only acceptable sexual behavior for teens (Greslé-Favier, 2013). These programs are often funded by federal grant money (Lerner & Hawkins, 2016). The state of Florida defines abstinence as "abstaining from sexual behavior outside of marriage" and requires that abstinence be taught as part of a health curriculum about HIV/AIDS (Health Education; Instruction in Acquired Immune Deficiency Syndrome, 2019). However, districts are left to their own judgement whether or not to portray abstinence as the only option, or if they will incorporate it into a more comprehensive sexual health program. Comprehensive sex education, in comparison,

covers a wide array of topics relating to sexual health, including but not necessarily limited to, pregnancy, contraception, STIs, family planning, anatomy and physiology, sexual violence, and in some cases, information about LGBTQ+ sexualities. Unsurprisingly, sex education programs exist on a spectrum rather than the often-discussed binary. One example of this spectrum is a program that exists between AOE and CSE called abstinence-plus. These programs often go into more detail about various sexual health topics than a traditional AOE program, such as contraception, healthy relationships, consent, or violence prevention, to name a few. However, they still promote abstinence until marriage as the only acceptable sexual behavior (Kaiser Family Foundation, 2018), disparaging those who do not abide by that standard. Kantor, Levitz, & Holstrom (2020), find that the American people agree that some form of sex education should be taught in schools, though partisan disagreements exist regarding what should be included in the curriculum.

In addition to the undertones of Christian morality promoted by AOE programs, many foster agencies and group homes are religiously affiliated or associated with Christian and/or Catholic beliefs, which can create potential legal gray areas regarding the separation of church and state. Many social workers and child-welfare employees are agents of the state, though the free exercise clause (U.S. Const. amend. I) allows foster parents to practice religion how they choose and grants them the right to raise children religiously in the privacy of one's home. This freedom, combined with the prevalence of religion and faith-based practices in sexual health education, can further alienate youth who do not identify with the dominant religion in their home, school, or society.

When a sexual health education program is not tailored to be inclusive of racial, sexual, gender, and religious minorities, harmful stereotypes are perpetuated, marginalized youth are not

adequately prepared for sexual encounters they may experience, and hegemonic systems[3] are reinforced (Sanjakdar, 2002). Assumptions are often made about the sexual activity and promiscuity of Black and Hispanic/Latine youth versus the celibacy of Asian American and white youth, for example, which can lead to instructors teaching to the stereotype rather than the needs of the students. When sexual diversity is excluded from sexual health programs, it reifies homophobia and sends the message that intolerance and bigotry are allowed in that learning environment (Elia & Eliason, 2010). When curricula fail to adequately include LGBTQ+ health issues, LGBTQ+ youth face multiple challenges, including an increased risk of sexual violence, an unwelcome school environment, and social and mental health problems (Elia & Eliason, 2010; Gattamorta, Salerno, & Castro, 2019; Hoefer & Hoefer, 2017, Shannon, 2018). For example, a curriculum that emphasizes Christian ideology promotes Christian superiority in the culture, can alienate youth who identify with different belief systems, and ultimately can cause problems when presented to a group of students who are not all practicing members of that faith (Bialystok & Wright, 2019; Roodsaz, 2018; Sanjakdar, 2009). Instructors and curricula that focus on stereotypes and dominant social structures fail to fully educate diverse youth about sex and sexuality, and when a CSE curriculum does not address these gaps, it cannot actually be considered fully comprehensive. Given the many philosophical differences that result in material challenges that can further marginalize individuals face when sexual health curriculum is not fully inclusive and comprehensive, we must consider how sex education programs can be created in ways that are more inclusive for historically marginalized groups in order to better meet the needs of BIPOC, LGBTQ+ and religious minorities.

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[3] In the context of this thesis, I use hegemony/hegemonic systems to describe the dominant culture and power structures within the United States. Most often, this means white supremacy, patriarchy, Christian/Catholic, and cis- and heteronormativity.

For me, making this curriculum as inclusive as possible in these ways is extremely important. My sexual health education as a teenager, and even as an undergraduate student, did not demonstrate any sort of inclusion as far as race, gender, sexuality, or religion. I wanted to ensure that the participants in this program have a much better-quality experience with sex education than I had so participants leave the program feeling like the facilitators care about their lives and individual needs when it comes to sex and sexuality.

This thesis examines the process of developing a sexual health education curriculum that is not only tailored to the unique needs of foster-engaged young women, but also those who may experience further marginalization from other mainstream programs due to their race, sexual orientation, gender identity, and/or their religious beliefs. "Choosing Myself" is intended to be an inclusive program that empowers participants, improves their self-esteem, and provides them with the knowledge and agency to navigate sexual situations. In this thesis, I document and demonstrate how I adapted the curriculum at three levels: the program evaluation surveys, base level (visuals and word choice), and content level (drawing connections between sexual health and identity). I explain that incorporating participants' identities and centering their experiences within the curriculum ultimately creates a program that not only meets marginalized participants' unique needs but ultimately impacts their understanding of themselves and their values and how they want to choose to engage in sexual experiences and create their sexual health.

Review of the Literature

"Choosing Myself" serves as a test run for an inclusive sexual health education program that caters to foster youth and the diverse identities that these youth represent. Specifically, I examine how race, sexual orientation, and religion are neglected by mainstream sex education and how they can be better incorporated to create a more holistic and empowering program for youth. Here, I evaluate literature that discusses the status of mainstream sexual health education in the United States and the unique sexual health needs of marginalized youth, both in and out of the foster system, including intersections and gaps that exist to further create marginalized identities. I use the term *marginalized* here to describe participants who may not align or identify with the dominant culture or identities of American society (i.e., white, cisgender, heterosexual, and/or Christian, able-bodied, upper or middle class, etc), thus leaving them and their experiences to be considered as less significant than their peers. The intention here is to examine where these youth are left behind by mainstream sexual health education to inform the development of the "Choosing Myself" program and better meet their needs.

Mainstream Sex Education

The United States government has issued a variety of legislation and policies that impact how sex and sexuality are viewed in this country, which influences how sexual health education programs are taught, developed, and funded, especially within public schools. While the Global

Gag Rule[4], Hyde Amendment[5], and even the former Comstock Law[6] do not directly govern

sexual health education in America, they do set the tone for the conversations held on the

political stage, especially when combined with events in the 1980s, such as the AIDS epidemic

and welfare reform (Greslé-Favier, 2010). In 1981, the federal government passed the

Adolescent Family Life Act[7], which was the first federal promotion of abstinence in sexual

education (Walker, 1989). This legislation was then replaced by the more influential 1996

Section 510 of Title V of the Social Security Act (frequently called A-H), which incentivized

abstinence-only education programs with federal grant money (Lerner & Hawkins, 2016). A-H

went into effect in fiscal year 1998, has been renewed through fiscal year 2019, and promotes the

use of abstinence-only education as the only means to decrease the rates of teen pregnancy and

STI transmission. This policy led to a national push for AOE programs to be implemented in

schools, which served to ultimately restrict adolescents' autonomy (Lerner & Hawkins, 2016).

AOE programs in the US are—in part—a response to a conservative moral panic about teaching

youth about sex and sexuality, as many parents believe such knowledge is the first step in "moral

degradation" (Fields, 2008, p. 38). Despite this moral push from parents and legislators, a

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[4] The Global Gag Rule, also known as The Mexico City Policy, was first implemented by Ronald Reagan in 1984 and bans US aid to go to foreign non-governmental organizations that provide abortion counseling or referrals. In order to receive this aid, NGOs cannot promote abortion legislation reform, even with funds not provided by the US. This policy has been enacted by presidents Reagan, Bush (41), Bush (43), and Trump. Presidents Clinton, Obama, and Biden repealed the policy during their terms, though it was reinstated through congressional action for one year during Clinton's second term (Kaiser Family Foundation, 2020).

[5] The Hyde Amendment (1977) prevents the use of federal funds for abortion services. The amendment was revised in 1993 to allow exceptions for rape, incest, and life-threatening complications from a pregnancy (Salganicoff, Sobel, & Ramaswamy, 2020).

[6] The Comstock Law (1873) made it a federal crime to distribute birth control, pornography, and other obscene materials. Since a 1936 court ruling, it is now legal to send birth control and contraceptive information through the mail and across state lines (PBS, 2003). This law has never been formally repealed.

[7] The American Family Life Act (1981) was the first federal abstinence-only education initiative, resulting from the influx of evangelical voters and politics in the 1980 election cycle. The act was deemed unconstitutional in 1985 for violating separation of church and state, though that decision was overturned by The Supreme Court in 1988 (Saul, 1998).

dominant narrative has also emerged within the US regarding AOE that argues it perpetuates harms and does not, in actuality, reduce unintended pregnancy or STI transmission as intended.

Multiple studies have shown that CSE programs are more beneficial for adolescents, as compared to AOE programs, because they lead to greater decreases in rates of unintended pregnancies and STIs (Boonstra, 2012; Potera, 2008; Starkman & Rajani, 2002). Lerner and Hawkins (2016) demonstrate that a major factor in this difference is that CSE programs provide adolescents with more of the necessary knowledge and tools required to navigate difficult situations and various sexual encounters. These authors argue that teaching adolescents abstinence-only education denies them certain liberties and welfare that correlate with the ability to make informed decisions about their physical well-being. Greslé-Favier (2013) argues that AOE programs are a form of childism and position children as property of their parents and the state, rather than autonomous individuals who can be exposed to a variety of consensual and non-consensual sexual experiences.

Experts continue to discuss what type of sex education is best for America's youth, though one's opinion on the matter is influenced by how one defines the problem which therefore impacts the proposed goals of the program (Kramer, 2019). Carr & Packham (2017) demonstrate no causal effect of abstinence-only state mandates on teen sexual health outcomes, meaning there were no changes for better or for worse. These studies illustrate that debates around AOE and CSE do not acknowledge the problems sex education in the United States exist in all types of curricula. This problem is further confounded by the fact that teens learn about sex education from a variety of places, not just the program their school provides.

Sexual health curricula across the spectrum can also neglect the communication and relationship aspects of sexuality (Kantor & Lindberg, 2020) which can lead to an insufficient understanding of consent and how to navigate such conversations (Willis, Jozkowski, & Read, 2019). Furthermore, there are prevalent gaps in many "comprehensive" programs. For example, many do not integrate the importance of online safety and sexting (Kachingwe, 2020), fail to address the influence of pornography on youth and sexual culture as a whole (Goldstein, 2020), or lack the ever-important concept of identity affirmation (Brandon-Freedman, 2020). Most glaring, many programs fail to address how experiences with race, gender, sexual orientation, ability, class, and culture impact one's sexuality, sexual experiences, and sexual expectations, (Bialystok & Wright, 2019; Fields, 2008; Roodsaz, 2018; Shannon, 2016). These issues remain unaddressed because many of them continue to be ignored or unacknowledged in the public dialogue. Additionally, many sex education curricula do not adequately explain pleasure, especially the role of the clitoris (Gunter, 2019). Often, fear tactics[8] are used, especially in AOE programs (Hoefer & Hoefer, 2017), but even CSE programs employ these tactics, which can ultimately lead to negative associations with what should be considered the pleasurable parts of sex (Lamb, Lustig, & Graling, 2013). When sex educators do not address these issues in their curricula, they can fail their students and inadequately prepare them to navigate sexual experiences and relationships in adolescence and adulthood. For a program like "Choosing Myself," which promotes inclusivity and violence prevention, CSE is the ideal format because it

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[8] Fear tactics that have been utilized in sex education include, but are not limited to, showing images of genitals that have been infected with sexually transmitted infections, creating a culture of shame around sexuality and behavior by stressing the importance of purity and one's reputation, discussing harmful stereotypes about the sexuality of people of color, encouraging students not to defy their gender expectations, emphasizing the importance of modesty based on fear of sexual assault, associating sexual pleasure and shame, and even sharing explicitly incorrect information about abortion, mental health, pregnancy, and other aspects of sexual health (Hoefer & Hoefer, 2017; Lamb, Lustig, & Gralig, 2013).

provides participants with comprehensive knowledge that will better prepare them to navigate sex and relationships in safer and healthier ways.

Sex Education for Foster Youth

When considering marginalized identities, foster youth isn't one that immediately jumps to mind, but these children and adolescents have additional, unique struggles and needs in addition to any adversity they may face based on their race, sexuality, gender, dis/ability, or socioeconomic status. In terms of sexual health education, it has been demonstrated that family involvement in sexual health education delays the first sexual experience for many adolescents (Grossman, 2014). However, this can get complicated for youth who are in out-of-home care for a variety of reasons.

Foster care is a social determinant of health that can impact one's quality of life (Finigan-Carr, Steward, & Watson, 2018). Foster-engaged youth have their own sexual health needs and risks that are different from their peers who have a more "traditional" home and family structure (Ahrens et al., 2010; Ahrens et al. 2012; Ahrens et al., 2013; Boustani, Frazier, & Lesperance, 2017; Finigan-Carr, Steward, & Watson, 2018; Harmon-Darrow, Burruss, & Finigan-Carr, 2020; Speckman, 2016). These unique health risks could include an earlier sexual debut (Finigan-Carr, Steward, & Watson, 2018), a history of childhood sexual abuse (Ahrens et al., 2012), an increased likelihood of engaging in transactional sexual behaviors (Ahrens et al. 2012), or struggles with emotional regulation and the ability to navigate emotions that come with relationships (Ahrens et al., 2016). Youth in the foster system are much more likely to be victims or targets of sexual trafficking than their peers who are in a more traditional home setting (Gluck & Mathur, 2014; Hannon et al., 2017; Speckman, 2016). These youth are particularly vulnerable to trafficking and revictimization, as they are much more likely to have past trauma or other

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adverse childhood experiences (Speckman, 2016). More often, however, unique risks to foster-engaged youth take the form of increased risk of unintended pregnancy or STIs (Ahrens et al., 2010; Ahrens et al., 2013; Harmon-Darrow, Burruss, & Finigan-Carr, 2020). Upon establishing the increased needs of this population, figuring out how to address their needs is the crucial next step to an effective sexual health program. Many experts conclude that the best way to create an intervention for marginalized youth, but specifically those in the foster system, is by tailoring any program or curriculum specifically to that group of people and their needs (Ahrens et al., 2010; Boustani, Frazier, & Lesperance, 2017; Finigan-Carr, Steward, & Watson, 2018; Gattamorta, Salerno, & Castro, 2019; Harmon-Darrow, Burruss, & Finigan-Carr, 2018, Hoefer & Hoefer, 2017).

The literature on sexual health education for foster youth seems to agree on four specific pedagogical strategies that can allow for a more effective program for this demographic. The first strategy for developing a strong program for foster-engaged youth is to utilize trauma-informed care. Trauma-informed care is a practice in which awareness of potential trauma is emphasized, and steps are taken to create a safer space for everyone involved to work through difficult and sensitive topics. As previously mentioned, current AOE programs can be associated with teens lack of knowledge to navigate sexual experiences, particularly those that could be considered violent, abusive, or traumatic, and the public discourse around such instances does not always create an environment where anyone (youth or adult) feels comfortable coming forward and asking for help (Wycoff & Matone, 2019). Many youth in foster care, specifically female-identified youth, have experienced childhood sexual abuse, trafficking, and/or transactional sex (Ahrens et al., 2012) and these potential past (or present) traumas must be taken into consideration when delivering a program or having discussions about potentially sensitive

topics (Albertson et al., 2020). This trauma may cause individuals to struggle to engage in discussions about challenging experiences, to regulate their emotions in a variety of stressful situations, and discussing sexual experiences can be especially triggering for some (Ahrens et al., 2016). Providing trauma-informed care can create a safer environment for these youth to work through their emotions and allow them to gain confidence and begin to feel like they have control over their body and their choices (Ahrens et al., 2016).

The second strategy is to try to create a learning environment that is safe and open for participants and facilitators to share experiences and demonstrate vulnerability. Albertson et al. (2020) acknowledge that these sorts of conversations can be awkward and uncomfortable to have, but it is important for the educator to power through, and even pretend they are comfortable when they are not. This behavior can then potentially help the youth feel more at ease and make them more inclined to ask questions and participate in the discussion. Additionally, these discussions can also lead to normalizing the conversations and making them easier and more comfortable for youth in the future. Failure to provide an open, judgement-free environment for conversations about sexual health can lead to fear and shame surrounding these topics (Hoefer & Hoefer, 2017), which is counter-productive at best. Most importantly, foster youth participants in sexual health education programs prefer to be in environments that establish open, safe, and judgement-free ground rules as the basis for all discussions (Ahrens et al., 2016).

The third strategy identified is to integrate peer involvement or mentorship. Foster youth prefer to interact with their peers and learn from their experiences (Albertson et al., 2020). Additionally, peer interaction within the programs allows for the co-construction of knowledge, making the participants feel more in control of what they are learning and that they have more of a say in their education as well as their lives (Frawley & O'Shea, 2020).

The final strategy involves caregivers in the sexual health education of the foster youth. Caregivers can include foster parents, other guardians, those who run/work in group homes, and social workers. The earlier claim that sexual health interventions work best with family involvement (Grossman, 2014) still applies to youth in out-of-home care, as foster youth also respond better to sexual health interventions when their caregivers are involved (Harmon-Darrow, Burruss, & Finigan-Carr, 2018). As caregivers are the ones that know the youth better than outside sex educators, they are the ones best suited to adapt the information to meet the individual needs of the youth, provided they are properly trained to do so (Albertson et al., 2018). And yet scholars find that one of the largest barriers to adequate caregiver involvement is a lack of appropriate and/or consistent guidelines on what caregivers' roles are in providing sexual health education to foster youth (Harmon-Darrow, Burruss, & Finigan-Carr, 2018). While these four strategies are all effective, combining them with a focus on trauma-informed care is going to be most effective in decreasing the risks that these adolescents face (Ahrens, 2016).

Sex Education for Racial, Sexual, and Religious Minorities

Race, sexual orientation, gender identity, and religion all intersect with the foster system in interesting ways. As discussed, Black, Hispanic/Latine, and LGBTQ+ youth are more likely to end up in foster care (Fish et al., 2019; Grooms, 2020; Hannon et al., 2017), and many foster-care agencies and group homes have some sort of religious affiliation. In developing a sexual health education curriculum for foster youth, it would be harmful to ignore how participants' race, sexuality/gender identity, and religion impacts their daily lives, as well as their experiences with sex. Bialystok and Wright (2019) state that sexual health curricula tend to reflect more upon the dominant culture than the sexual needs of the youth that are being taught. The needs of marginalized and minority youth are often ignored in sexual health curricula in favor of the

hegemonic culture, which encourages assimilation. Sanjakdar (2002) argues that an inclusive

sexual health education program must accommodate student diversity and promote acceptance

rather than expect assimilation. Here, I demonstrate the unique needs of various minority groups

in the US and how accommodating their needs can prove beneficial.

Prevalent racial stereotypes in the US serve to increase the harms associated with

incomplete sexual health education among non-white youth. If sexual health education serves as

a means of perpetuating dominant cultures, then it is possible the existing moral panics around

sexually active youth is also partially an extension of the moral panic of the increasing

multiculturalism happening in many Western countries (Bialystok & Wright, 2019). Fields

(2008) argues that the moral panic driving AOE is tied to anti-Black sentiments and fear that the

stereotypes of hypersexuality, welfare queens, and unfit parenting among the Black community

will spread to the pure, white suburbs. When sex education is used to perpetuate the dominant

culture and promote conformity, both marginalized and non-marginalized communities within

the dominant culture are harmed. While Fields' argument is specifically about abstinence-only

education, this problem persists in comprehensive sex education programs that are overly

generalized and do not acknowledge the diversity of the participants.

Historically, sexual health has been heavily influenced by racism and colonialism, and it

can be difficult to isolate medical fact from practitioner biases (Roodsaz, 2018). It is impossible

to completely remove biases from the curriculum or those who are delivering it, but measures

can be taken to appropriately include racial minorities in sexual health education and provide

youth with the most accurate information possible (Hoefer & Hoefer, 2017; Roodsaz, 2018).

These measures can take the form of utilizing inclusive language and diversity among the

educators themselves (Finigan-Carr, Steward, & Watson, 2018) and encouraging the participants

to potentially see themselves within the curriculum (Hoefer & Hoefer, 2017). It is also important to utilize a reproductive justice framework when discussing sexual health for BIPOC individuals in order to fully explain the history of sexual health and reproduction for these groups and explore with participants how that history and current practices can influence their experiences today.

Since its inception in the 1990s, the reproductive justice movement has revolutionized the way we look at rights and policy regarding reproduction, specifically for Black, Indigenous, and People of Color (Ross & Solinger, 2017). Loretta Ross, one of the movement's founders and most prominent activists, emphasizes the importance of utilizing a human rights framework to understand reproduction, rather than primarily from a health or legal framework. A health framework is mostly concerned with the medical aspects of reproduction, whereas a legal framework focuses on issues like *Roe v. Wade*. A human rights framework incorporates all of these issues and more, including culture, race, religious beliefs, and the Universal Declaration of Human Rights (United Nations General Assembly, 1948). In the context of sex education and the "Choosing Myself" curriculum, I integrate a reproductive justice framework to document how slavery, eugenics, policing, the school-to-prison pipeline, and medical racism impact the sexual boundaries and values of Black and other young women of color today.

The history of slavery and eugenics in the United States demonstrates the earliest attempts to control the reproduction of Black people in this country. Dorothy Roberts (1997) has written about the forced reproduction of slave women, and more contemporarily, federal programs that create financial incentives for Black women to utilize contraception or sterilization. In many instances, the incentives didn't matter, as medical professionals frequently implanted Norplant birth control or sterilized their patients without their consent or knowledge

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(Roberts 1997). These tactics were performed under the guise of welfare reform, or population control, or even promoting traditional family values. Even the development and widespread use of birth control has racist origins. Family planning and contraception were originally considered forms of population control, specifically for Black communities in America (Huss & Dwight, 2018). However, many proponents of the women's movement believed that access to contraception was a way to liberate women in society. Margaret Sanger, the founder of Planned Parenthood, like many feminists throughout history, compromised Black women in order to gain a little bit of freedom for white women. In order for white women to gain access to birth control, Sanger had to align herself with eugenicists, and even adopted some of their beliefs, so that birth control would be promoted as a way to reduce the number of Black children born in this country (Roberts, 1997).

Healthcare in the United States exists as one of the many institutions that make up the problem of "institutionalized racism," and reproductive healthcare is an especially significant part of the problem. Black women were actually used to build the field of gynecology, but not by doctors collecting the folk knowledge from midwives and doulas, but by doctors experimenting on the bodies of Black women and treating them as less than human. Dorothy Roberts (1997) explains the long history of experimenting on slave women's bodies without proper anesthesia in order to learn reproductive anatomy and develop techniques for gynecological surgery. Today, most healthcare providers have some sort of racial bias, whether they are aware of it or not. Dr. Dana-Ain Davis (2020) identifies seven different forms of racism that Black women can experience at the hands of their reproductive health providers. Davis argues these include:

> 1) professionals' critical lapses in diagnoses (a woman is not believed or taken seriously by medical professionals)

2) women are subjected to neglectful, dismissive, or disrespectful treatment

3) women are subjected to pain that was intentionally inflicted (due to the pervasive belief that Black people couldn't feel pain as much as white people and therefore didn't require as much anesthesia)

4) women were coerced into undergoing procedures (sterilization or contraception)

5) women experienced ceremonies of degradation (which represents the ways that Black women experience feeling or being degraded)

6) medical abuse (which involves a woman thinking or feeling that she was used for purposes of experimentation, and

7) 'racial reconnaissance' (where women must search for providers or practices where they feels least likely to experience racism).

The seventh one may not seem like the same sort of racism, but it demonstrates that Black people often have to dedicate more time and energy to finding an appropriate healthcare provider than their white peers. It also puts the burden on the patient to find a provider that isn't racist, rather than on the providers to be more inclusive.

Another way that Black women's reproduction is controlled through policing is through the school to prison pipeline. Sexologist Cindy Lee Alves cites the constant policing of young Black women's bodies in school and the resulting over-punishment (such as suspension, detention, even expulsion) as a leading cause of "acting out" sexually (Harley, Alves, and Gary-Smith, 2020). They find that unfortunately, this cause and effect often leads to assigning adult sexuality to Black girls at a much younger age than their peers. While there are many studies about how the policing of Black children in schools leads to higher rates of incarceration (hence the school-to-prison pipeline), Alves focuses on how this concept changes an individuals'

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understanding of her bodily autonomy and consent. For example, it can be hard to reconcile the concepts of "no means no" and "yes means yes" that one learns in a sex education classes with one's experience with authority figures outside of the bedroom (Kleppinger, 2019). In other words, if a young woman feels her body and freedom is almost always subjected to control by others (most especially outside authorities), when does she have the right to set her own boundaries and have control over her body in the bedroom or in any of her personal relationships?

Black and Hispanic/Latine youth are often treated as though they have little control over their sexuality (Hoefer & Hoefer, 2017), while Asian American youth are often assumed to be abstinent (Lee et al., 2013). When Black and Hispanic/Latine youth are assumed to be hypersexual, they are taught about contraception, but are often provided little other instruction about sexual health, since they are assumed to already know everything (Hoefer & Hoefer, 2017). Asian American youth are often perceived to be abstinent or less sexual and therefore can be neglected and not taught much beyond the importance of abstinence and occasionally about contraception (Lee et al., 2013). By making assumptions about youth groups based on race and failing to fully educate them about sex and sexuality, a curriculum that may be classified as CSE is no longer comprehensive for those students.

Roodsaz (2018) explains that sexual health education is often taught as though youth can make their own choices independent of outside influences and that one is either an active or passive sexual agent. However, Roodsaz argues most people lie somewhere in between these active and passive roles and that racial stereotypes often affect how active and passive someone is perceived to be when making choices about sex. Finally, when students who are not fully educated about sexual health behave in ways that fit these stereotypes (young

Black/Hispanic/Latine women getting pregnant, Asian teens not in relationships), it can reinforce that the teaching is correct and these stereotypes are true (Hoefer & Hoefer, 2017).

The intersection of race and sexual orientation adds even more complexity to the experiences of these youth. LGBTQ+ and BIPOC youth are at greater risk of sexual violence than their white, cisgender, and heterosexual peers (Atteberry-Ash et al., 2020). A study conducted by Gattamorta, Salerno, and Castro (2019) illustrates that Black and Hispanic/Latine youth who identify as non-heterosexual are more likely to engage in risky sexual behaviors than their white and/or heterosexual peers. This study also suggests that these youth have more barriers to overcome in order to gain access to appropriate sexual health education because parental consent, school beliefs, and politics can all influence what is and isn't taught to youth in a sex education classroom.

LGBTQ+ issues such as healthcare, STI Prevention, relationships, and stigmas are often purposefully excluded from sexual health curricula, and when they are present, they are often presented in a way that demonizes and "others" members of the community (Hoefer & Hoefer, 2017). When sexual diversity is excluded from sexual health programs, it reifies homophobia and sends the message that intolerance and bigotry are at best, allowed, and at worst, the norm in that learning environment (Elia & Eliason, 2010). When this happens, LGBTQ+ students are less likely to "come out" or feel safe at school, and adults in their lives are less likely to have appropriate guidelines to help or intervene when needed (Elia & Eliason, 2010; Hoefer & Hoefer, 2017).

Excluding LGBTQ+ content from sexual health curricula reinforces heteronormativity and creates shame surrounding homosexual behaviors and relationships (Elia & Eliason, 2010; Hoefer & Hofer, 2017; Shannon, 2018). The fear tactics used to perpetuate this shame affect all

students, but especially those who identify under the queer umbrella. Elia and Eliason (2010) state "heterosexual students are castigated for being sexual whereas LGBTQ students are castigated for being" (p. 22). A 2021 Gallup poll states that the percentage of LGBTQ+ identifying Americans has increased to 5.6% from 4.7% in 2017 (Jones, 2021). The poll also demonstrates that 1 in 6 Gen Z (someone born in the late 1990s to the mid/late 2000s) adults identify as LGBTQ+. While many people who are part of Gen Z are still minors, this trend indicates that younger generations are more likely to identify as LGBTQ+, emphasizing the need for LGBTQ+ inclusive sexual health education. The harms done to LGBTQ+ youth when heteronormativity is emphasized include an increased risk of sexual violence, increased dangers for trans youth in the community, medicalization of homosexuality, lack of role models and acceptance, homonormativity (assimilation of LGBTQ+ individuals to heterosexual cultures), and social and mental health problems (Elia & Eliason, 2010; Gattamorta, Salerno, & Castro, 2019; Hoefer & Hoefer, 2017, Shannon, 2018).

These challenges are then even further exacerbated when combined with the existence of the primarily Christian religious beliefs that are already heavily incorporated into sexuality and sexual health education in the US. Religion intends to provide an extra layer of moral protection from the "sins" of sexual behavior and deviancy (Martin, Baralt, & Garrido-Ortega, 2018), though in reality, the addition of religion can compound the existing moral panic surrounding sexuality, and by extension, religious multiculturalism (Allen et al., 2014; Bialystok & Wright, 2019). This extra layer of moral protection (The Adolescent Family Life Act of 1981 and Section 510 of Title V of the Social Security Act of 1996) was implemented by officials elected by evangelical voters (Lerner & Hawkins, 2015; Saul, 1998) and does not consider the religious beliefs of those who do not subscribe to the hegemonic religious culture of the country. For

example, Bialystok and Wright (2019) share an example of Christian/Catholic parents protesting a comprehensive sex education program as being accepted and understood within their community, whereas Muslim parents doing the same thing can be viewed as attempting to change the culture of their community and enact Sharia law within the school district. This is once again a case of assimilation, rather than accommodation. While it may seem like religion itself hinders quality sex education (Allen et al., 2014), some suggest that teaching certain sexual issues as cultural issues may be a reasonable alternative (Sanjakdar et al., 2015). This approach would require educators to introduce topics with minimal bias and acknowledge that their students' cultures and backgrounds will lead them to form different opinions and make different choices regarding their sexuality. Rather than promote one belief system over another, this method brings awareness to the fact that each person will have a unique value system based on a variety of influences. Most importantly, sexual health curricula must be designed to prevent alienating youth and encourage them to apply the content to their individual cultures and traditions (Roodsaz, 2018).

There are many simple steps that can be taken to accommodate minority religious beliefs into the sex education classroom. In the cases of Islam and Reform Judaism, there are specific religious tenets that can be applied to sexual health education that can make the curriculum more inclusive without drastically changing the content. In Islam, the texts teach about sex and encourage people to ask questions without shame, though there may be a cultural taboo around the subject (Sanjakdar, 2002; 2009). Islam also emphasizes modesty—viewing the body more personally and connected to honor and integrity—as an important religious tenet (Sanjakdar, 2009). Incorporating discussions about modesty with various topics in a sexual health curriculum, providing resources that utilize more modest imagery, and encouraging questions

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and open discussions would allow for a more inclusive environment for Muslim youth (Sanjakdar, 2009). A curriculum that is inclusive of modesty may seem as though it can only be a "prude" AOE program, but that is far from the truth. If modesty is important to Muslims in all facets of life, including sexual behavior, then modesty can be incorporated into all topics of a comprehensive program such as relationships and empowerment/self-esteem, just to name a few.

Reform Judaism, on the other hand, places an emphasis on the religious tenet of respect (Winer, 2011). Sexual education programs that are designed for Jewish youth encourage respect and acceptance of everyone and encourage youth to employ critical thinking and come to their own conclusions and beliefs (Winer, 2011). Emphasizing respect for yourself, your partner(s), and others in a sexual health curriculum can make an environment more inclusive to Jewish youth. While these examples are not representative of the religious diversity and beliefs in America, they do demonstrate that belief systems are not as incompatible as they may seem and show how they can be incorporated into a much more inclusive and comprehensive sexual health education program.

In order to make a comprehensive program inclusive for all participants, one has to understand that ideologies and cultures cannot be isolated from each other entirely in the United States (Bialystok & Wright, 2019). The conflict of ideologies (e.g., religious/secular or indigenous/colonial) leads to conflicts of morals and beliefs about sexuality. The key is not to present one ideology as superior, but rather to integrate elements of many belief systems and encourage youth to make their own choices according to their own beliefs and values (Bialystok & Wright, 2019; Roodsaz, 2018; Sanjakdar, 2009). Demonstrating diversity and inclusion in sexual health education can lead youth to develop more critical thinking skills and become more open-minded and accepting of others (Sanjakdar et al., 2015).

While the content of a successful sexual health education program is still widely debated, it is clear that there are specific aspects of a program that must be included in order to fully benefit foster-engaged and other marginalized youth. Such a program should be tailored to their individual needs and identities, incorporate trauma-informed care, and address their behaviors through a multi-level ecological lens. However, the literature fails to demonstrate this fully, as the majority of the literature either focuses on theory or identifies successful programs that only utilize one or two of these ideas. The literature does not yet explain if it is possible to develop a curriculum that meets all of these criteria while still providing a quality comprehensive sexual health education. "Choosing Myself" had already implemented many of these criteria before I joined the program, but I have been able to build upon the foundation and further adapt the program to the diverse needs of the individuals in Florida's foster system.

Methodology

<u>Background</u>

The ASHER team began implementing the "Choosing Myself" program during 2020, which, due to the Covid-19 pandemic, transitioned fully to online learning. However, based on the stage of development the program was in at the start of the pandemic, there was enough time to fully develop this online curriculum to ensure the content and activities in each lesson plan align with feminist pedagogical principles. Bozkurt & Sharma (2020), discuss the unique challenges of education during a pandemic and explain that current experiences should not be considered online learning or traditional distance learning, but rather "emergency remote learning." I have identified three important pedagogical practices that I have utilized in the development of the curriculum, while keeping in mind the new challenges that are created by an online learning environment. These practices are implemented in the program delivery and evaluation stages as well. These key practices are to 1) maintain awareness of individual and cultural needs of the students; 2) create an open and non-judgmental space for students; and 3) take steps to prevent reinforcing systems of oppression.

Throughout my work, I have taken steps to ensure that the curriculum contains inclusive language, images, concepts, and content for people that identify as racial, religious, or sexual minorities. A curriculum such as "Choosing Myself" must be tailored to the needs of the participants, which is unique in every group (Aneja, 2017; Koseoglu et al., 2020). The work I have done thus far is only a baseline of inclusion. I intend for this project to evolve beyond the work of this thesis and exhibit flexibility based on the feedback we receive from participants in

the future. This flexibility allows for the program to become more inclusive over time, as well as allow the participants to contribute to the program itself.

Current events such as the COVID-19 pandemic and the increased awareness around the Black Lives Matter movement can exacerbate existing trauma among youth and necessitate the use of care pedagogy in the class setting. Care pedagogy occurs when a teacher takes on a caregiver role for their students to address needs beyond the typical classroom setting. Students require empathy in all circumstances, but it should be emphasized that a globally traumatic event specifically alters the learning environment and requires more levels of care, empathy, and patience than "usual" (Bozkurt & Sharma, 2020). Sanjakdar et al., (2015) add that care pedagogy requires educators to make material relevant to their students' needs and be aware of their "cultural characteristics and contributions of different ethnic groups" (p. 60). Elements of care pedagogy are integrated in the "Choosing Myself" program in multiple ways: 1) spaces are created for participants to ask questions without judgement, whether anonymously or not; 2) discussions about current events, including the pandemic and the Black Lives Matter movements are incorporated into the curriculum; and 3) participants are encouraged to explore how all of these challenges impact the mental and physical aspects of their sexual health.

When teaching about sexual health—a potentially sensitive subject—it is important to create a space that is open and judgement-free for the participants so that they are responsive to the material, can ask questions, and share their personal experiences (Bailey, 2019). This space is primarily created when a trauma-informed care approach is employed. Broussard, Eitmann, and Shervington (2019) have identified six key principles of trauma informed sex education, 1) safety; 2) trustworthiness and transparency; 3) peer support; 4) collaboration and mutuality; 5) empowerment, voice and choice; and 6) cultural, historical, and gender issues. The "Choosing

Myself" curriculum incorporates the principles of empowerment, voice and choice, and the cultural, historical, and gender issues into the existing materials. The other four principles currently exist as a guideline for the facilitators when leading the classes, but also require the understanding and cooperation of the participants during the classes to create the desired environment. Some of the ways that facilitators are prepared for safety and trustworthiness is by understanding the variety and intersectionality of trauma that the participants may have experienced, as well as how their own trauma and experiences can influence their role as a facilitator (Auteri, 2015; Wycoff & Matone, 2019). This awareness can help facilitators prepare students for potentially upsetting and triggering content and read their body language for cues that they should pause the discussion in order to avoid re-traumatization (Auteri, 2015; Fava & Bey-Cheng, 2013; Montgomery et al., 2018). These techniques can demonstrate to the participants that the facilitators are committed to their safety and wellness and ideally that they can be trusted to not re-victimize them. Additional techniques that should be incorporated into trauma-informed sex education include utilizing a sex-positive framework; using positive language; avoiding fear tactics and shame; being prepared with resources for mental and physical health referrals; and emphasizing empowerment and goal-setting in the course (Auteri, 2015; Fava & Bey-Cheng, 2013; Montgomery et al., 2018; Ross, Kools, & Laughon, 2020; Wycoff & Matone, 2019).

Another way to create an open, judgment-free space is for educators to work to remove existing hierarchies (Bailey, 2019). At first, the only identifiable hierarchy may be between the teacher and student, but that is not all that exists in the classroom. One should also work to identify the hegemonic cultures and ideologies that may be present and to create space so that these hegemonic ideas are not treated as "better" or more important than the experiences of those

who are marginalized. Educators can take steps towards this inclusion and share their personal experiences, demonstrate vulnerability, and then encourage their students to do the same (Bailey, 2019). This openness creates an environment that validates personal experiences and works to prevent students from feeling alienated (Aneja, 2017). Validating the experiences of each student fosters an environment where all experiences and backgrounds are equal and thus takes steps to eliminate existing hierarchies.

In the "Choosing Myself" program, each session has ground rules that establish the virtual classroom as a space where the participants can share openly and ask questions free from judgement. At multiple points throughout the program, participants are asked to reflect upon how the topics intersect with their own lives, and share—if they are willing—their own experiences. The curriculum is also designed so that participants are introduced to a variety of lifestyles and decisions, each presented in a manner that does not shame anyone for embracing their sexuality in their own way. By exemplifying diversity in the curriculum, the program works to decrease existing inequalities.

The COVID-19 pandemic has also illustrated that inequalities and inequities can be exacerbated by online learning and therefore must be addressed (Bozkurt et al., 2020). This is not to say there aren't inequalities in face-to-face learning as well, but those inequalities can carry over and even compound when the switch to online learning is made (Bailey, 2019). For instance, the online classroom can lead to an inadvertent marginalization of students beyond the inequalities of resources and access to technology, as the impersonal environment can make it harder to manage the conversation and show support for students (Bailey, 2019). If a tool is being used to reach the previously unreachable, then the most responsible thing to do is ensure that those individuals are welcomed and not further marginalized or oppressed (Aneja, 2017).

This requires facilitators to utilize a multi-level ecological approach, which means understanding and interacting with a participant's environmental influences in order to understand how the environment can lead to risky versus safer sexual decisions (Berglas et al., 2016). When educators acknowledge they can try to understand a variety of influential factors in participants' lives, they facilitate engagement with the material and demonstrate how the participants can utilize the material in their daily lives.

Caution must also be employed in the online classroom to ensure that the power dynamics between teacher and student are not shifted too far out of balance (Bailey, 2019). It can be easy for teachers to fall more into the traditional role of "depositing" knowledge (Friere, 1970) into the students in an online setting, shifting too much power to the teacher. On the other hand, it can also be harder for a teacher to manage an online classroom and prevent disempowerment or marginalization of students within discussions, which can unfairly shift the balance towards the students, who might be complicit in the disempowerment and marginalization of their peers. It is more important than ever to utilize the feminist technique of co-construction of knowledge in order to mitigate many of the disparities that occur in the online classroom.

Building upon theoretical frameworks and community inclusion in programs, utilizing feminist pedagogical techniques such as peer education and co-construction of knowledge allows students to engage with the program and see themselves in the material (Frawley & O'Shea, 2020). These techniques are especially important when developing programs for groups that identify with any marginalized identity often left behind by or forced to assimilate to mainstream sexual health education. Allowing the participants/stakeholders to be this involved in the curriculum and lend their voices regarding their own unique experiences, removes some of the

hierarchical structures and allows this process to become a feminist program evaluation (Beardsley & Hughes Miller, 2002). These approaches overlap to demonstrate the necessity of moving beyond the structure and content of mainstream sex education in schools in order to more directly reach the participants and encourage an engagement with the material that can create lasting impact in their lives.

In the development of the "Choosing Myself" curriculum, I have taken steps to ensure that the hegemonic culture in our society is not the only one presented to the youth. Participants in the program are presented with diverse examples and viewpoints in the content and encouraged to think critically, ask questions, and develop their own values about sexuality. Participants are also provided with ample opportunities for discussions, group activities, and self-reflection in order to see themselves in the program, as well as to learn about the diverse experiences of their peers.

Methods

This thesis documents and explains my contributions to the development of the "Choosing Myself" curriculum. I have identified three stages of the curriculum building process: program evaluation measures, aesthetics, and curriculum content. Within each of these areas, I outline the adaptations, document the rationale for these changes, and explore the hegemonic belief systems encountered that led to these adaptations.

Incorporating Inclusion

Throughout this section, I discuss my contributions and efforts to develop the "Choosing Myself" curriculum to make it more inclusive. However, this project is very collaborative, with a team of three (formerly four) individuals including myself and Dr. McCracken, director of ASHER and my major professor. When I use the term, *we* in this section, I am indicating that this was part of a collaborative effort, where multiple members of the team discussed this particular aspect of inclusion and decided on the best way to incorporate it. When I say *I*, I am referring to specific choices and actions that I took on my own, though they had to be approved by the team before anything was finalized.

Program Evaluation Measures

The program evaluation aspect of "Choosing Myself" includes a series of pre and post surveys used to measure the impact of the program on sexual knowledge, behaviors, and risk. When I came into the project, there was an existing collection of potential measures to use, and I was tasked with sorting through them to determine which would best measure the goals of our program and to determine existing overlap. Going through the measures, it became clear that many were heteronormative and presumed that the only perpetrators of sexual violence were men. Several of the measures, Most Recent Sexual Experience (Vanable et al., 2004), Sexual Behavior (Morrison-Beedy et al., 2010) Sexual History (Morrison-Beedy et al., 2013), and an adapted version of the Sexual Experiences Survey (Koss & Oros, 1982; Morrison-Beedy et al., 2013) were worth potentially including in the program evaluation but required adaptation before they could be used. The measures in the initial survey (Table 1) needed to demonstrate

inclusivity in order to establish a foundation for a trusting relationship in the online setting

before the participants meet the facilitators. For more information about the program evaluation,

see Appendix A.

Table 1: A list of all measures included in the "Choosing Myself" program evaluation. The demographics survey is only taken once at the beginning of the program. The next twelve measures are the baseline survey that is taken before and after the program. CES-D and Diary of Daily Behaviors are filled out weekly.

Program Evaluation Measures
Demographics and Background Information Survey
Rosenberg Self-Esteem Scale (Rosenberg, 1965)
Sexual Knowledge and Attitude Test for Adolescents (SKAT-A) (Fullard, Scheier, & Lief, 2005)
Sexual Experience Survey (Koss & Oros, 1982)
Sexual Consent Scale-Revised (Humphreys, 2011)
Behavioral Intentions (Blake et al., 2001)
Condom Attitude Scale - Adolescent Version (St. Lawrence et al., 1994)
Adolescent and Young Adult Condom Self-Efficacy Scale (Hanna, 1990)
Condom Influence Strategies [Short Form-CISQ-S] (Noar, Morokoff, & Harlow, 2002; Noar, Morokoff, & Harlow, 2004)
ACE (Adverse Childhood Experiences) (Felitti et al., 1998)
Human Trafficking Risk Assessment Tool (Williamson & Andretta, 2019)
HIV - Knowledge Questionnaire (Volpe et. al, 2007)
Center for Epidemiological Studies- Depression Scale (Radloff, 1997) - included in weekly behavior diary
Diary of Daily Behaviors
Focus Group Questions

The changes made to adapt these measures included updating the definitions of oral, anal,

and vaginal sex (Table 2) to avoid the use of cis- and heteronormative language and modifying

the pronouns, descriptions, and answer stems to include gender-neutral terms to accommodate 1) gender-non-conforming individuals; and 2) people whose relationships do not fit more mainstream definitions. Most of these changes were straightforward to implement, replacing *he/she* instances with the singular *they*, or using *partner* instead of *boyfriend/girlfriend*. The pre-program survey is the first experience the participants have with the curriculum, and it is important not to alienate anyone before they get to know the facilitators and the curriculum as a whole.

When considering the language of the measures, the primary concern was to avoid alienating the participants by touting "Choosing Myself" as an inclusive program but failing to demonstrate inclusivity from the beginning. For example, the Sexual Experiences Scale (Koss & Oros, 1982), as well as the 2013 adaptation (Morrison-Beedy et al., 2013) included language about sexual violence and pressure and all of the language demonstrates the assumption that men are the only perpetrators of sexual violence and that participants are straight and cisgender (see Appendices B & C). Perpetuating this idea can alienate program participants or mislead them into believing that if they are victims of violence from a woman or a non-binary person, then it was not really violence/rape. This belief could then encourage them to feel they cannot open up to the facilitators or be honest about their experiences without judgement. While the inclusivity benefits the youth when taking the survey, it is even more beneficial to the researchers to gain a more thorough understanding of sexual violence experienced by females and gender-non-conforming youth. Ultimately, we chose to further adapt the Sexual Experiences Survey (Koss & Oros, 1982) so that it covered a more comprehensive range of topics, including victimization and perpetration of violence (see Appendix D).

Table 2: Sample question from Sexual Experiences Scale (Koss & Oros, 1982) compared with the Morrison-Beedy et al. (2013) adaptation, and the updated "Choosing Myself" adaptation. This question presumes that the perpetrator of sexual violence is a cisgender male. No other questions in this ten-question survey indicate that people of other genders commit sexual violence. For the full original survey, see Appendix B. For the full Morrison-Beedy et al. (2013) adaptation, see Appendix C.

Koss & Oros (1982) Original	Morrison-Beedy et al. (2013) Adaptation	"Choosing Myself" Adaptation
Have you ever been in a situation where a man (you) tried to get sexual intercourse with you (a woman) when you (she) didn't want to by threatening to use physical force (twisting your [her] arm, holding you [her] down, etc.) if you (she) didn't cooperate, but for various reasons sexual intercourse did not occur?	How often have you had a man attempt sexual intercourse (get on top of you, attempt to insert his penis) when you didn't want to by threatening or using some degree of force but intercourse *did not* occur (for instance, such as he twisted your arm, or held you down, etc)?	Have you ever been in a situation where someone tried to get sexual intercourse when you didn't want to by threatening to use physical force (twisting your arm, holding you down, etc.) if you didn't cooperate, but for various reasons sexual intercourse did not occur?
N/A	N/A	Have you ever been in a situation where you tried to get sexual intercourse with someone when they didn't want to by threatening to use physical force (twisting their arm, holding them down, etc.) if they didn't cooperate, but for various reasons sexual intercourse did not occur?

Another example modification of language in the program evaluation measures is how

the definitions of sexual behaviors were updated to be more inclusive of trans and nonbinary

people, as well as utilizing the definitions to ask about a larger variety of partners than just

cisgender males. In Sexual Behavior (Morrison-Beedy et al., 2010), the survey asks specifically

about cisgender partnerships with penis-in-vagina sex. Respondents are only asked to consider

cisgender male partners, and anal, vaginal, and oral sex are defined correspondingly. While this

measure was eventually excluded in favor of Sexual Knowledge and Attitude Test for

Adolescents (SKAT-A) (Fullard, Scheier, & Lief, 2005), it was beneficial because it prompted

the ASHER team to come up with working definitions for these behaviors, as well the terms *sex*

and *masturbation* in a way that is inclusive of diverse genders and sexualities.

Table 3: Compares the definitions of types of sexual behaviors provided in Sexual
Behavior (Morrison-Beedy et al., 2010) which specifically asks female participants about male
partners with the definitions "Choosing Myself" uses to ask about sexual behaviors.

Original Definition (Morrison-Beedy et al., 2010)	**"Choosing Myself" Inclusive Definition**
Vaginal sex is when a man puts his penis in a woman's vagina.	Vaginal Sex: when the clitoris, labia, or vagina is involved in a sexual act, including fingers, mouths, a sex toy, and/or a penis
Anal sex is when a man puts his penis in another person's bottom.	Anal Sex: when the anus is involved in a sexual act, including fingers, mouths, a sex toy, and/or a penis
Oral sex is when a person puts his or her mouth on another person's penis or vagina.	Oral Sex: when mouths and genitals or anus touch in a sexual act
No working definition for masturbation	Masturbation: when fingers and genitals are involved in a sexual act; this can occur alone, with a partner, or with sex toys
No working definition for sex	Sex (Action): any act involving contact with the vulva, clitoris, vagina, anus, penis, or testicles that requires all parties consent

When reviewing the Sexual Knowledge and Attitude Test for Adolescents (SKAT-A)

(Fullard, Scheier, & Lief, 2005) questionnaire, I noticed multiple questions about religious

beliefs. The questionnaire asks, "Childhood Religious Background," "How often do you attend

religious services?" "How important is religion to you?" and also provides "religious beliefs" as

an answer stem regarding the reasoning behind what choices the person has made regarding

sexual behaviors. This survey was the impetus for including religion as an area of focus within

my research. For many people, religion plays an important role in their sexuality, their choices, and even any guilt they may feel about their different choices. Religion should be part of sexuality education, as to many people, it is part of their sexuality. Religious beliefs and customs often influence or even dictate many sexual values and boundaries (Adamczyk & Hayes, 2012; McFarland, Uecker, & Regnerus, 2011; Yip, 2018). These can include attitudes towards homosexual behaviors, premarital sex, extramarital sex, virginity, purpose of sex, contraception, and so much more. Christian morality exists as an undercurrent in many sex education curricula and discussions, even the ones that are not explicitly religious. By asking our participants about their religious beliefs in the initial survey, we can be better prepared to incorporate key cultural values from their belief system into the program without imposing any specific morals or beliefs on them.

<u>Aesthetic Inclusion in the Curriculum</u>

After adapting the measures used to evaluate the program, the next step was to start developing parts of the curriculum. Here, I talk about the work I did on the first two lessons of the program, "Choosing My Sexual Self: What is Sex? What do I Like, Want, & Need?" and "Finding My Sexual Identity: Who am I as a Sexual Person?" (For the full curriculum outline, see Appendix E.) While building the slide decks and gathering resources, I focused on representation and inclusion on the aesthetic level, meaning the inclusion would be visible to anyone looking at the materials without necessarily digging into the content. An outline lesson plan served as a framework, but it hadn't been fully fleshed out at this time.

The easiest way to demonstrate inclusion in the curriculum was through the images utilized in the slide decks and other materials. The graphics chosen focused on the inclusion of racial minorities and LGBTQ+ individuals, as religious diversity can be difficult to illustrate in

this context. Figure 1 demonstrates both racial and gender diversity with its claim that "genitals come in all shapes and sizes." Other images used in the curriculum include queer couples, gender-non-conforming individuals, people of color, and a variety of body shapes, sizes, and colors to depict anatomy and physiology.

Figure 1. Adapted from Isabella Rotman, originally published in S.E.X. (Corinna, 2016). An example of images used to demonstrate racial, gender, and physical diversity throughout the curriculum.

Figure 2: Image depicting two women in an intimate position. Source: Pexels

Figure 3: Image depicting three individuals in bed together, presumably a polyamorous relationship. Source: Pexels
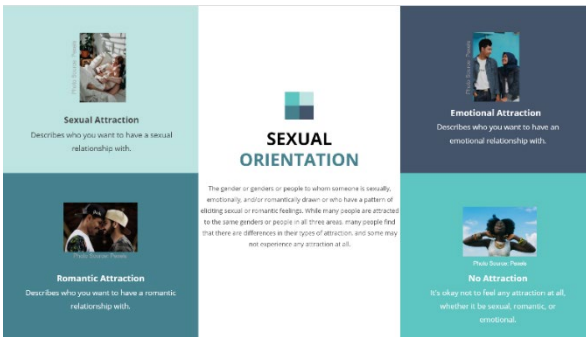
Figure 4: Sample orientation slide using diverse bodies, individuals, and relationships. Photos: Pexels
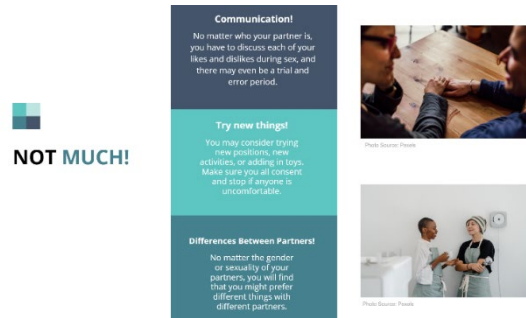
Figure 5: Sample queer slide using diverse bodies, individuals, and relationships. Photos: Pexels
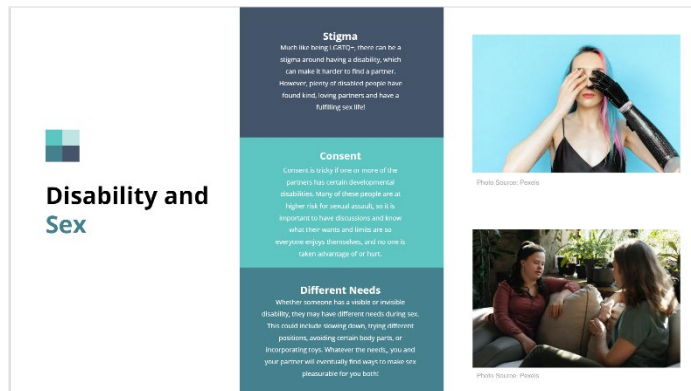
Figure 6: Sample disability slide using diverse bodies, individuals, and relationships. Photos: Pexels

The next step of the aesthetic inclusion was to continue the use of gender-neutral language from the measures and make sure it remained consistent throughout the materials. At the beginning of the course, we encourage participants to include their use of pronouns in their introductions as a means of demonstrating inclusion of those who may not identify as cisgender. In the anatomy lesson, this took the form of labelling anatomy as *people with penises, people with vaginas,* and *intersex anatomy* instead of *male* or *female.* And when discussing condoms,

we describe them as *internal* and *external* rather than *male* or *female.* This language also extends into the section on menstruation when we do not assume a person who menstruates identifies as female.

Throughout the curriculum, steps have been taken to never presume the gender or sexuality of the participants or their partners. As mentioned previously regarding the measures, the term *partner* is used to replace the traditional boyfriend/girlfriend terminology. When necessary, we specify primary partner, in case the participant is non-monogamous. This is especially apparent when discussing communication skills and boundary setting when we prepare participants to have conversations with any potential partner, regardless of gender or sexual orientation. When discussing intimate partner violence, we use gender neutral terms so as not to reinforce the stereotype that only men are violent and that only women are victims. By using this language, we have more opportunities to explore intimate partner violence in queer relationships, violence against trans and gender-non-conforming individuals, and how those experiences are the same and different from cisgender, heterosexual relationships.

Inclusion within Curriculum Content

While the use of inclusive images and language is important within the curriculum, it is not indicative of a deeper level of inclusion, which is what I strived to achieve while working on this curriculum. The content within each of the lessons of the curriculum is where I was able to place more emphasis on race, gender/sexuality, and religion and their influences on sexual experiences.

Starting with Lesson 1, "Choosing My Sexual Self: What is Sex? What do I Like, Want, & Need?" I identify the specific instances of inclusion that I incorporated to better reach participants of the marginalized and minority identities included in this thesis.

This lesson opens with a discussion about families and support. While we expect the participants to come from some form of engagement with the foster system or Guardian Ad Litem program, we cannot presume to understand their relationship or history with their family or what the term *family* means to them. Often, family structures vary based on cultural background, which can include race and religion. Additionally, many LGBTQ+ individuals find their own family structure that may or may not include blood relatives. This particular instance is where I encountered one of my own biases. I have my own beliefs about what is a healthy and supportive family dynamic, but I am aware that this is my viewpoint based on my upbringing and culture. In developing this discussion, I wanted to ensure that I was not preaching my beliefs about families upon the participants, but rather opening a dialogue so that they can understand what their own beliefs are, and how that may influence their boundaries and values. By opening the program with this discussion, we as facilitators can gain an understanding of the experiences and values of the participants, but the participants can also start to understand how their family and cultural background influence their sexual experiences and values.

What About Me?

-What is a family?
-What does my family look like?
-Do we get to choose who is in our family?
-How does that work?
-Who do you consider to be your family?
-Who can help support you?

Figure 7: Slide depicting discussion questions about families.

The next section of Lesson 1 focuses on anatomy. "Choosing Myself" is a program for female-identified youth, but that includes cisgender, transgender, intersex, and gender-non-conforming individuals who were assigned female at birth. Since we do not wish to out anybody, the curriculum discusses anatomy for people with penises, people with vaginas, and people with intersex anatomy. Ideally, everyone can learn about their own anatomy, as well as the anatomy of potential partners without feeling alienated by our curriculum.
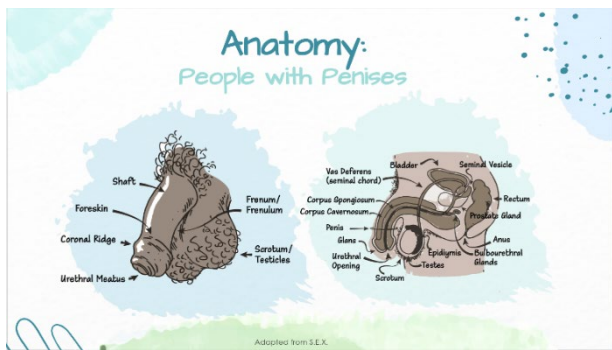

Figure 8: Penis anatomy depicted without gendered language. Adapted from Isabella Rotman, originally published in S.E.X. (Corinna, 2016).
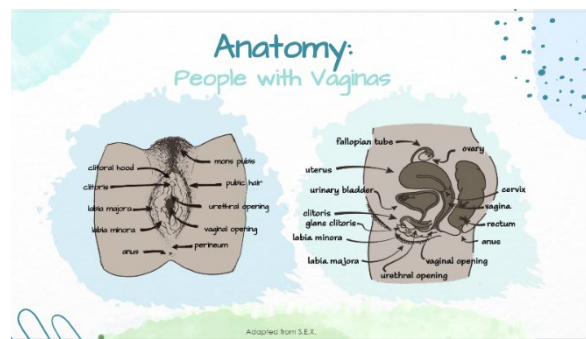
Figure 9: Vagina anatomy depicted without gendered language. Adapted from Isabella Rotman, originally published in S.E.X. (Corinna, 2016).
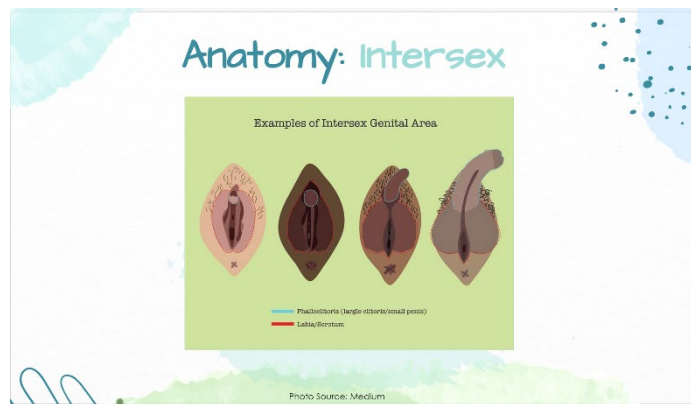
Figure 10: Intersex anatomy depicted without gendered language. Source: Medium

When we get to menstruation and sexual hygiene, once again, we do not presume to know what any of the participants experience. We teach proper hygiene (meaning prevention of urogenital infections, smegma, and toxic shock syndrome) for all types of anatomy, as well as discussing the fact that "not all women menstruate and not all people who menstruate are women."

Figure 11: Photo from @Tonithetampon. This image is used to demonstrate that menstruation is not an issue exclusive to cisgender women.

Lesson 1 ends with an introduction to consent, a topic that will be present in the remainder of the curriculum. In researching and developing this portion of the lesson, I encountered another personal bias, which was more ignorance than anything else. While I know that there is some variety in how different people or organizations define consent, I had never once considered that consent has historically different meanings to people who have been historically enslaved, oppressed, or otherwise denied agency. Using the work from Kleppinger (2019) opened my eyes to what now feels like common sense and developed what I believe is a much more racially inclusive conversation about consent and establishing boundaries.

Lesson 2: "Finding My Sexual Identity: Who am I as a Sexual Person?" has a heavy focus on LGBTQ+ issues, but in this lesson, I also made sure to take the time to address how race and religion intersect with gender and sexuality. The main portion of this lesson focuses on understanding sexual and gender identities. The content around gender identity discusses male, female, non-binary, and agender identities, as well as a conversation about pronouns. I also included a section about alternative gender identities, such as the Two-Spirit in many Native American/First Nation tribes and the Hijra in India, and gender expressions such as the Stud in Black and Hispanic lesbian culture. Even if we do not have any participants who are of these cultures, I included this section to demonstrate that the concepts of gender in America are not universal to the rest of the world and that gender is much more diverse than they may have been taught previously.

Figure 12. Slide depicting alternative genders, Two-Spirit, Hijra, and Stud.

When moving onto sexuality, we introduce what it means to be heterosexual vs homosexual, as well as identities such as gay, lesbian, bisexual, pansexual, demisexual, asexual, aromantic, queer, and questioning. However, I know that many LGBTQ+ individuals face different levels of acceptance based on their communities and cultural backgrounds and therefore

I integrated this intersection as well. To do so, I created a section that addresses four types of stigma against the LGBTQ+ community, the first of which is religious stigma. We discuss how many religious people use their religion to justify homophobia and discrimination against the community. However, I emphasize that every religion has LGBTQ+ people who practice and that there is a community out there for each person. Next we discuss medical stigma. We explore how homosexual and transgender identities have historically been viewed as forms of mental illness and that this idea still persists among some medical providers. We address how this leads to discrimination by medical providers and the importance of finding an affirming provider. The third type of stigma discussed is scientific stigma and includes how many people use faulty science to argue that LGBTQ+ identities are "unnatural" (Kinney, 2015). I made sure to debunk some of those claims and discuss how there is plenty of science that demonstrates that LGBTQ+ identities are not only natural, but way more common than previously thought (Roughgarden 2004).

The last stigma discussed is cultural stigma. This one is the most tricky to address because it carries the greatest potential to upset or offend the participants, though it is necessary to discuss. Here, I integrate how different cultures may be unaccepting of LGBTQ+ identities for a variety of reasons that can include financial responsibilities, marriage expectations, family traditions, politics, and social status, among others. I also discuss how it's not uncommon for people who are BIPOC to experience backlash from family and community members for having an LGBTQ+ identity on top of a racial minority identity. Often, this is the result of many parents fearing for their children because their racial identity makes life more difficult in society, and the added level of difficulty of identifying as LGBTQ+ seems like an "unnecessary" struggle. We follow this up by discussing how there are many opportunities to create acceptance in a variety

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of communities and cultures, but that it is important to understand the context of the stigma individuals may experience or even hold themselves.

Perhaps the most important area of inclusion in "Choosing Myself" is the incorporation of WAM! (What About Me?) discussions. Periodically throughout each lesson, we pause the lecture and provide the participants with some discussion questions to think about. These questions allow them to consider what they have just learned and start to use it to develop their understanding of their own sexuality, values, and boundaries. These questions include "Where do I see myself in this?" "Where do I want to see more of myself in this lesson?" "How do I talk about my identity with friends and family?" "Does my culture/religion have any norms about sex or consent?" "How do I decide what norms to follow?" as well as many more. We as facilitators know that these questions can be very personal and that the participants may not want to answer in the moment, or that they may not even have an answer at that time. We therefore do not require anyone to answer any questions, but rather pose them so that participants can answer, and perhaps even more importantly, think about how they might like to answer as they continue to think about and experience their own sexual choices. In addition to providing spaces for inclusion, these spaces serve as the primary source of feedback regarding the quality of inclusion in the program. The measures help us to understand if we have adequately provided them with the knowledge and skills they need to navigate sexual situations, but they don't measure how well the participants see themselves represented in the program. Therefore, our inclusion of WAM is intended to make our awareness of this inclusion most explicit.

The last area of inclusion that I have incorporated into the curriculum is the external resources that are provided to every participant in the program. I am aware that as a cisgender, white woman, I cannot answer every question that our participants will have, and I am not going

to be the best resource at all times. Each lesson has a resource sheet that goes beyond what we

talk about in that lesson and helps bridge existing gaps for the participants. Some of these

resources include websites to locate LGBTQ+ affirming healthcare providers, healthcare

providers that are Black and specialize in treating Black patients, guides to safe sex among queer

and trans individuals, gender affirming menstruation information, and more.

Discussion

<u>Implications</u>

 The steps that I have taken to adapt existing materials to help make an entirely new curriculum more inclusive indicates the existence of a large-scale problem with sexual health education throughout America. Existing curricula primarily focus on the hegemonic social structures and expectations rather than to acknowledge the diversity of youth experiences. Sexual health instruction in the United States (or lack thereof) serves to reinforce existing hegemonic structures such as cis- and heteronormativity, white supremacy, and Christian beliefs and morality (Bialystok & Wright, 2019; Fields, 2008; Roodsaz, 2018; Sanjakdar, 2002; Shannon, 2016).

 Comprehensive sex education programs are often misrepresented because they are not truly comprehensive if they do not acknowledge that students' identities and backgrounds influence their sexual experiences and values. "Choosing Myself" is an example of a truly comprehensive program because it addresses a variety of sexual health topics while also incorporating race, sexuality, gender, and religion into multiple aspects of the program and asks the participants to connect the material to their own lives and experiences.

 There is a need for comprehensive sex education programs that focus more on the needs of marginalized youth (Bialystok & Wright, 2019; Fields, 2008; Hoefer & Hoefer, 2017; Roodsaz, 2018; Shannon, 2016). Such programs empower and prepare these youth for experiences that may differ from those of their peers who belong to the dominant social group. Ideally, this more inclusive education aims to create a more "level playing field" where every

adolescent is equally prepared for what they may face, even if their experiences in life are different. Youth that are equipped to navigate sex, sexual violence, and relationships can then begin to disrupt the existing social structures that use sex and sexual violence to maintain the status quo.

Limitations

Due to COVID-19 and other delays, "Choosing Myself" has not yet been delivered to a group of participants. This means I have not yet had the opportunity to gain participant feedback or determine whether or not the program is beneficial to the marginalized youth who are represented within my work. Once this feedback is obtained, then "Choosing Myself" can continue its evolution, becoming inclusive based on the needs expressed by the participants themselves.

Future Directions

The next step in this project is to move forward with the program evaluation and gather feedback and data from the participants regarding the efficacy of the program. Not only is this an important part to the evolution of "Choosing Myself" as a whole, but it is an important component of the pedagogy and inclusivity of the program. The program is designed to incorporate co-construction of knowledge and encourage participants to engage and provide feedback at every step of the process. The curriculum is at its most inclusive when it is in session, fostering interaction between the participants and the facilitators.

After the program evaluation of "Choosing Myself," the curriculum will become more solidified, while still allowing for continued feedback and engagement with future participants. A proposed next stage after the program evaluation is to develop a companion training and curriculum for parents and guardians. Existing research demonstrates that sexual health

education is most effective when conversations happen at home between youth and their parental

figures (Albertson et al., 2018; Grossman, 2014; Harmon-Darrow, Burruss, & Finigan-Carr,

2018). Many of these guardians, especially those that work in the foster system, feel at a loss

when trying to have these conversations with youth, especially those that have identities different

from their own (Harmon-Darrow, Burruss, & Finigan-Carr, 2018). A parental companion to

"Choosing Myself" would serve as a guide for parental figures to engage with teens, especially

those who are marginalized, to further connect the curriculum to their real-life experiences and

create opportunities for first-hand conversations to be had about how one's cultural background

influences sexuality.

Conclusion

This thesis set out to determine and document the process of developing a sexual health education curriculum that is inclusive and better meets the needs of groups that have been historically marginalized in American society, including racial minorities (BIPOC), sexual and gender minorities (LGBTQ+), and religious minorities. Existing research demonstrates that members of these groups benefit from programs that are catered to their specific needs (Bialystok & Wright, 2019; Fields, 2008; Hoefer & Hoefer, 2017; Roodsaz, 2018; Shannon, 2016), but most existing programs do not address these needs or only focus on a specific subgroup rather than encouraging the participants to integrate their own culture and experiences with the content. While "Choosing Myself" has yet to be evaluated as an inclusive program, it demonstrates inclusivity throughout all areas of the curriculum and program evaluation.

While there were challenges in developing an inclusive curriculum, we are fortunate to live in an era where people are developing amazing, inclusive resources that made my work easier and allowed me to gather and use information from a variety of marginalized groups. One of my personal favorite resources was Pexels, a free stock photo website that is intended to showcase more inclusion and diversity than other stock photo banks. Many of the images used in the slides came from Pexels and allowed us to illustrate concepts using diverse bodies, people, and relationships. One of the biggest challenges I faced while working on this curriculum is to acknowledge my own biases and to avoid unintentionally perpetuating harmful stereotypes and ideas. I have had many conversations with a variety of people regarding the measures of inclusion I developed and have made changes accordingly. I am aware that my efforts are far

from perfect, and I intend to rely on the feedback from participants to improve not only the curriculum, but my own worldview as well.

Experts continue to debate what the content of a comprehensive sex education program should include, but the emphasis is less on diversity and inclusivity than it is on specific topics of sexual health. The privilege demonstrated by many of these experts who ignore the needs of marginalized youth is indicative of sex education's role in maintaining the hegemonic structure of American society. This thesis serves as a road map to dismantle white supremacy and other hegemonic systems in American culture by empowering marginalized youth where they are most neglected. By incorporating the needs of racial, sexual, gender, and religious minorities into the curriculum, "Choosing Myself" takes an important step towards drawing attention to the role of sex education as a tool to dismantle hegemony and create structures that are more inclusive and egalitarian.

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Appendix A

"Choosing Myself" Program Evaluation

The program evaluation aspect of "Choosing Myself" includes a focus group before and after the five-week curriculum. In these focus groups, participants are asked about their experiences and knowledge surrounding sex and sexuality, as well as the curriculum itself. The purpose of the initial focus group is to determine how much sexual health education participants have had, what their primary concerns around sexual health and/or experiences are, and what they hope to gain from the program. The final focus group asks them to reflect on what they learned from and liked and disliked about the program. It also asks them to reflect on violence they may have experienced and how that violence could be avoided or reduced.

Participant responses are analyzed to determine any changes in knowledge as a result of the program. The primary program evaluation is based on the initial baseline survey which combines twelve different measures (see Table 1) and a demographics questionnaire. Participants fill out this survey before the initial focus group as well as a post-test version of the survey, and the responses are analyzed to determine any changes in knowledge or behavior as a result of the program. The surveys are be anonymous, but each participant has a unique an identification code, so that the study team can determine changes in specific individuals without knowing who they are.

In addition to the pre and post surveys, participants are also asked to fill out a survey each week, the Daily Behavior Log, that tracks their daily behaviors. The behavior log prompts them to state how many times they've had sex, information about the partner, whether or not a condom

was used, whether or not substances were used, and whether or not the sex was transactional (if sex was offered in exchange for money or other personal gain). The behavior log also asks about other risky behaviors such as substance use not in conjunction with sexual acts. In addition to the daily behaviors, participants fill out the Center for Epidemiological Studies- Depression Scale (CES-D) (Radloff, 1997) each week as part of the diary. The behavior log is extremely important to the program evaluation, as it will provide the most accurate depiction of behavioral changes during and after the curriculum. All members of the ASHER team are mandated reporters in the state of Florida. The Daily Behavior Log is designed to be anonymous so that the data can be tracked without being considered a disclosure that requires reporting. Disclosures shared in focus groups, class sessions, or in communication with a member of the ASHER team are reported in accordance with Florida law.

Program evaluation participants are be paid $20 for completing the pre and post surveys, the focus groups. and the class sessions they attend, with a $25 bonus for completing all seven sessions. Participants are asked to participate in follow up interviews at three, six, and twelve months after program completion, and are compensated $20 for each of those interviews as well.

Appendix B

Sexual Experiences Survey (Koss & Oros, 1982)

Have you ever:

1. Had sexual intercourse with a man (woman) when you both wanted to?

2. Had a man (woman) misinterpret the level of sexual intimacy you desired?

3. Been in a situation where a man (you) became so sexually aroused that you felt it was useless to stop him even though you did not want to have sexual intercourse? (could not stop yourself even though the woman didn't want to?)

4. Had sexual intercourse with a man (woman) even though you (she) didn't really want to because he (you) threatened to end your relationship otherwise?

5. Had sexual intercourse with a man (woman) when you (she) didn't really want to because you (she) felt pressured by his (your) continual arguments?

6. Found out that a man had obtained sexual intercourse with you by saying things he didn't really mean? (Obtained sexual intercourse by saying things you didn't really mean?)

7. Been in a situation where a man (you) used some degree of physical force (twisting your [her] arm, holding you [her] down, etc.) to try to make you (a woman) engage in kissing or petting when you (she) didn't want to?

8. Been in a situation where a man (you) tried to get sexual intercourse with you (a woman) when you (she) didn't want to by threatening to use physical force (twisting your [her] arm, holding you [her] down, etc.) if you (she) didn't cooperate, but for various reasons sexual intercourse did not occur?

9. Been in a situation where a man (you) used some degree of physical force (twisting your [her] arm, holding you [her] down, etc.) to try to get you (a woman) to have sexual intercourse with him (you) when you (she) didn't want to, but for various reasons sexual intercourse did not occur?

10. Had sexual intercourse with a man (woman) when you (she) didn't want to because he (you) threatened to use physical force (twisting your [her] arm, holding you [her] down, etc.) if you (she) didn't cooperate?

11. Had sexual intercourse with a man (woman) when you (she) didn't want to because he (you) used some degree of physical force (twisting your [her] arm, holding you [her] down, etc.)?

12. Been in a situation where a man (you) obtained sexual acts with you (a woman) such as anal or oral intercourse when you (she) didn't want to by using threats or physical force (twisting your [her] arm, holding you [her] down, etc.)?

13. Have you ever been raped? (women only)

Appendix C

Adaptation of Sexual Experiences Survey (Morrison-Beedy et al., 2013)

The next section contains some very personal questions. Please try to answer as honestly as possibly, remembering that all your information is kept confidential. Using the 0-5 scale, please indicate whether you have had any of the following experiences.

1. How often have you given into sex play (fondling, kissing or petting, but not intercourse) when you didn't want to because you were overwhelmed by a man's continual arguments and pressure?

0	Never
1	One Time
2	Two Times
3	Three Times
4	Four Times
5	Five Times or more
8	Refuse to Answer

We know some of the questions we're asking are personal, but remember that we're going to keep your answers confidential. Please consider answering the question.

2.   How often have you had sex play (fondling, kissing or petting but not intercourse) when you didn't want to because a man used his position of authority (boss, teacher, camp counselor, supervisor) to make you?

0	Never
1	One Time
2	Two Times
3	Three Times
4	Four Times
5	Five Times or more
8	Refuse to Answer

We know some of the questions we're asking are personal, but remember that we're going to keep your answers confidential. Please consider answering the question.

3.   How often have you had sex play (fondling, kissing or petting but not intercourse) when you didn't want to because a man threatened or used some degree of physical force to make you (such as twisting your arm holding you down, etc.) ?

0	Never
1	One Time
2	Two Times
3	Three Times
4	Four Times
5	Five Times or more
8	Refuse to Answer

We know some of the questions we're asking are personal, but remember that we're going to keep your answers confidential. Please consider answering the question.

4.   How often have you had a man attempt sexual intercourse (get on top of you, attempt to insert his penis) when you didn't want to by threatening or using some degree of force but intercourse *did not* occur (for instance, such as he twisted your arm, or held you down, etc.) ?

0	Never
1	One Time
2	Two Times
3	Three Times
4	Four Times
5	Five Times or more
8	Refuse to Answer

We know some of the questions we're asking are personal, but remember that we're going to keep your answers confidential. Please consider answering the question.

5.   How often have you had a man attempt sexual intercourse (get on top of you, attempt to insert his penis) when you didn't want to by giving you alcohol or drugs, but intercourse *did not* occur?

0	Never
1	One Time
2	Two Times
3	Three Times
4	Four Times
5	Five Times or more
8	Refuse to Answer

We know some of the questions we're asking are personal, but remember that we're going to keep your answers confidential. Please consider answering the question.

This next set of questions talks about situations when intercourse **did** occur.

6.   How often have you given in to sexual intercourse when you didn't want to because you were overwhelmed by a man's continual arguments and pressure?

0	Never
1	One Time
2	Two Times
3	Three Times
4	Four Times
5	Five Times or more
8	Refuse to Answer

We know some of the questions we're asking are personal, but remember that we're going to keep your answers confidential. Please consider answering the question.

7.   How often have you had sexual intercourse when you didn't want to because a man used his position of authority (boss, teacher, camp counselor, supervisor) to make you?

0	Never
1	One Time
2	Two Times
3	Three Times
4	Four Times
5	Five Times or more
8	Refuse to Answer

We know some of the questions we're asking are personal, but remember that we're going to keep your answers confidential. Please consider answering the question.

8.   How often have you had sexual intercourse when you didn't want to because a man gave you alcohol or drugs?

0	Never
1	One Time
2	Two Times
3	Three Times
4	Four Times
5	Five Times or more
8	Refuse to Answer

We know some of the questions we're asking are personal, but remember that we're going to keep your answers confidential. Please consider answering the question.

9. How often have you had sexual intercourse when you didn't want to because a man threatened or used some degree of physical force to make you (twisting your arm, holding you down, etc.)?

0	Never
1	One Time
2	Two Times
3	Three Times
4	Four Times
5	Five Times or more
8	Refuse to Answer

We know some of the questions we're asking are personal, but remember that we're going to keep your answers confidential. Please consider answering the question.

10. How often have you had sex acts (anal or oral intercourse or penetration by objects other than a penis) when you didn't want to because a man threatened or used some degree of physical force to make you (twisting your arm, holding you down, etc.)?

0	Never
1	One Time
2	Two Times
3	Three Times
4	Four Times
5	Five Times or more
8	Refuse to Answer

Appendix D

"Choosing Myself" Adaptation of Sexual Experiences Survey (Koss & Oros, 1982)

Have you ever:	Yes	No
1. Had sex with someone when you both wanted to?		
2. Had a partner misinterpret the level of sexual intimacy you desired?		
3. Been in a situation where a sexual partner became so sexually aroused that you felt it was useless to stop them even though you did not want to have sex? (could not stop yourself even though wanted to?)		
4. Been in a situation where you became so sexually aroused that **you** could not stop yourself even though wanted to?		
5. Had sexual intercourse with a person when **you** didn't really want to because **they** threatened to end your relationship otherwise?		
6. Had sexual intercourse with someone when **they** didn't really want to because **you** threatened to end your relationship otherwise?		
7. Had sexual intercourse with someone when **you** didn't really want to because you felt pressured by **their** continual arguments?		
8. Had sexual intercourse with someone who didn't really want to because **they** felt pressured by your continual arguments?		
9. Found out that someone had obtained sex with you by saying things **they** didn't really mean?		
10. Obtained sex with someone by saying things **you** didn't really mean?		
11. Been in a situation where someone used some degree of physical force (twisting your arm, holding you down, etc.) to try to make you engage in kissing or touching when **you** didn't want to?		
12. Been in a situation where you used some degree of physical force (twisting their arm, holding them down, etc.) to try to make them engage in kissing or touching when **they** didn't want to?		

13. Been in a situation where someone tried to get sex with you when **you** didn't want to by threatening to use physical force (twisting your arm, holding you down, etc.) if you didn't cooperate, but for various reasons sex did not occur?		
14. Been in a situation where you tried to get sex with someone when **they** didn't want to by threatening to use physical force (twisting their arm, holding them down, etc.) if they didn't cooperate, but for various reasons sex did not occur?		
15. Been in a situation where someone used some degree of physical force (twisting your arm, holding you down, etc.) to try to make **you** engage in kissing or touching when you didn't want to, but for various reasons sex did not occur?		
16. Been in a situation where you used some degree of physical force (twisting their arm, holding them down, etc.) to try to make **them** engage in kissing or touching when they didn't want to, but for various reasons sex did not occur?		
17. Had sex with someone when **you** didn't want to because they used physical force (twisting your arm, holding you down, etc.) if you didn't cooperate?		
18. Had sex with someone when **they** didn't want to because you used physical force (twisting their arm, holding them down, etc.) if they didn't cooperate?		
19. Had sex with someone when **you** didn't want to because they used physical force (twisting your arm, holding you down, etc.)?		
20. Had sex with someone when **they** didn't want to because you used physical force (twisting their arm, holding her down, etc.)?		
21. Been in a situation where someone obtained sexual acts with you when **you** didn't want to by using threats or physical force (twisting your arm, holding you down, etc.)?		
22. Been in a situation where you obtained sexual acts with someone when **they** didn't want to by using threats or physical force (twisting their arm, holding them down, etc.)?		
23. Have you ever been raped?		

Appendix E

Adolescent Sexual Health Education and Research (ASHER)
"Choosing Myself" Curriculum
Table of Contents

Introduction Session: Initial Focus Group
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    B. Discussion
Class One: Choosing My Sexual Self: What is sex? What do I like, want, and need?
    A. What is sex?
    B. Anatomy
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    D. Pleasure, Masturbation and Sex Positivity
    E. Menstruation
    F. Hygiene
Class Two: Finding My Sexual Identity: Who am I as a sexual person?
    A. Sexuality
    B. Sexual Orientations
    C. Sex in the LGBTQ+ Community
    D. Body Image Empowerment
    E. Self-Esteem
Class Three: What is Safe Sex and Reproductive Health?
    A. Safe Sex and STIs
    B. Family Planning and Reproductive Rights
    C. Sex with No Risk of Pregnancy
Class Four: Discovering Sexual Boundaries: What are they and why would I want them?
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    B. Assertive Communication
    C. Sexual Values and Goals
Class Five: Understanding Violence and Safety: What is a "Healthy" Sexual Relationship?
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    B. "Unhealthy" Relationships
    C. Visible and Invisible Signs of Violence
    D. Violence Prevention
    E. Trafficking
    F. Self-Esteem and Empowerment
Concluding Session: Closing Focus Group
    A. Measure
    B. Discussion

Appendix F

Pexels Fair Use Statement

Figure 1A: Pexels fair use statement. Pexels is a stock photo website known for its diverse representation. Many photos used in this thesis and the "Choosing Myself" curriculum are from Pexels.