FLASH HS L1: Climate Setting Rationale

The purpose of the climate-setting lesson is to develop a safe, respectful, and engaging learning environment for the FLASH unit. Developing a positive classroom climate is a common strategy in all fields of education. Sexual health educators find that establishing a positive classroom climate for the sexual health unit is an investment in high-quality learning experiences and respectful behavior between students for the remainder of the unit.

Positive classroom climate is one important aspect of positive school climate, which is associated with a host of positive outcomes, including effective risk prevention, health promotion, student learning and academic achievement.[i] This lesson strives to meet several indicators of the National School Climate Standards, including collaboratively developing codes of conduct; promoting the social, emotional and ethical development of students; and creating an environment where all students are welcomed, supported and feel socially and emotionally safe.[ii]

The curriculum as a whole rests heavily on risk and protective factor research related to the prevention of teen pregnancy, STDs and sexual violence.[iii] [iv] [v] [vi] These important evidence-based factors are introduced in the climate-setting lesson, and will be addressed in greater depth throughout the curriculum. For example, the 4-corners exercise begins building positive attitudes about abstinence, condoms, and other forms of contraception. Family Homework, which is introduced in Lesson 1 and reinforced in all subsequent lessons, is intended to increase parent communication with teens about condom use, increase comfort and skill talking with teens about sex, and increase clarity of values about adolescent sexual behavior. These family communication determinants play an important role in the prevention of teen pregnancy, STDs and HIV.[vii]

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[i] Thapa, A., Cohen, J., Guffey, H.,& Higgins-D'Alessandro, A. (2013). A review of school climate research. *Review of Educational Research, 83*, 3, 357–385.

[ii] National School Climate Standards. (2009). National School Climate Council. New York. www.schoolclimate.org.

[iii] Alford, S. (2008). *Science and success, second edition: Programs that work to prevent teen pregnancy, HIV & sexually transmitted infections.* Washington, DC: Advocates for Youth.

[iv] Kirby, D. (2007). *Emerging answers 2007: Research findings on programs to reduce teen pregnancy and sexually transmitted diseases.* Washington, DC: The National Campaign to Prevent Teen and Unplanned Pregnancy.

[v] Centers for Disease Control and Prevention. Division of Violence Prevention. www.cdc.gov/violenceprevention/sexualviolence/riskprotectivefactors.html. Accessed 12/31/2014.

[vi] Kirby, D., & Lepore, G. (2007). *A matrix of risk and protective factors affecting teen sexual behavior, pregnancy, childbearing and sexually transmitted disease*. Scotts Valley, CA: ETR Associates.

[vii] Kirby, D., Coyle, K., Alton, F., Rolleri, L., & Robin, L. (2011). *Reducing adolescent sexual risk: A theoretical guide for developing and adapting curriculum-based programs*. Scotts Valley, CA : ETR Associates.

FLASH HS L2: Reproductive System Rationale

Knowledge of the reproductive system helps students better understand later lessons on pregnancy, birth control, STDs and HIV. This lesson is primarily intended to be a review of previously covered material.

The National Sexuality Education Standards cover the reproductive system only at younger grades, with one standard on sexual response at the secondary level. The National Health Education Standards (SHECAT) related to the reproductive system at the high school level have to do with understanding the relationship between the menstrual cycle and conception and respecting individual differences in growth and development.

This lesson revisits standards for lower grades and covers the high school standards on the menstrual cycle, the human sexual response cycle, and respecting individual differences in sexuality, growth and development.

This lesson emphasizes similarities between the reproductive anatomy of most men and women. The purpose is twofold:

- First, it creates a schema for better comprehension (e.g., egg and sperm are both sex cells; the ovaries and testicles both produce sex hormones; the fallopian tube and vas deferens are both passageways for sex cells, etc.) The pairing of functions and processes, where they exist, makes the information about the reproductive system easier to understand and remember.

- Second, it supports sexual violence prevention concepts taught elsewhere in FLASH. According to the CDC, adherence to extreme gender stereotypes is a risk factor for perpetration of sexual violence.[i] Historically, these stereotypes are projected onto reproductive functions in health and science education (e.g. active sperm, passive egg). This lesson provides the framework and scripting to avoid unintentional gender stereotypes, to offer equitable and accurate information, and to discuss differences respectfully.

There is tension between the approaches of showing male and female reproductive similarities, and being inclusive of a range of gender identities and anatomical variations. Both approaches are critical to the goals of the FLASH curriculum. The intention of this lesson is to provide a clear understanding of human reproductive anatomy and sexual response; to show respect for all students' bodies, gender identities, sexual orientations, and families; and to counter male and female gender stereotypes.

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[i] Centers for Disease Control and Prevention. Division of Violence Prevention. www.cdc.gov/violenceprevention/sexualviolence/riskprotectivefactors.html. Accessed 12/31/2014.

FLASH HS L3: Pregnancy Rationale

This lesson provides basic information about conception, fertilization, chromosomes, and fetal development. Following the guidance of the National Sexuality Education Standards and National Health Education Standards (SHECAT), it includes information related to pregnancy testing, pregnancy options, safe surrender laws, prenatal care, and related laws and services.

FLASH HS L4: Sexual Orientation and Gender Identity Rationale

This lesson is designed to help students understand that everyone has a sexual orientation and a gender identity, and to develop language to talk respectfully and competently about these aspects of sexuality. It is further designed to help students recognize that the stigma and discrimination often directed toward lesbian, gay, bisexual, transgender and queer (LGBTQ) people are harmful and limiting to everyone. This content is foundational for a comprehensive sexual health curriculum and aligns with National Health Education Standards (SHECAT) and National Sexuality Education Standards.

FLASH is inclusive of LGBTQ individuals throughout the curriculum. LGBTQ youth experience worse sexual health outcomes than their heterosexual and cisgender peers, including higher rates of pregnancy, STDs and sexual violence.[i] [ii] [iii] Evidence suggests that an LGBTQ-inclusive curriculum may help alleviate these outcomes.[3]

Every classroom has LGBTQ students and/or students who have LGBTQ loved ones.[3] All students must be supported and treated respectfully. The two biggest protective factors that help ensure LGBTQ students' success are the home and the school environment.

For more information on creating a welcoming and supportive school environment, see "Toolkit for LGBT Best Practices" from Learning for Justice at: learningforjustice.org/magazine/fall-2013/toolkit-for-lgbt-best-practices

For more information about creating a welcoming and supportive home environment, see the Family Acceptance Project's "Family Education Information" at: familyproject.sfsu.edu/publications

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[i] Centers for Disease Control and Prevention. Sexual Identity, Sex of Sexual Contacts, and Health-Risk Behaviors Among Students in Grades 9--12 --- Youth Risk Behavior Surveillance, Selected Sites, United States, 2001--2009Sexual Identity, Sex of Sexual Contacts, and Health-Risk Behaviors Among Students in Grades 9--12 --- Youth Risk Behavior Surveillance, Selected Sites, United States, 2001—2009. http://www.cdc.gov/mmwr/preview/mmwrhtml/ss60e0606a1.htm

[ii] EM Saewyc. Research on adolescent sexual orientation: Development, health disparities, stigma, and resilience. Journal of Research on Adolescence 21 (1), 256-272.

[iii] Administration for Children, Youth, and Families. Creating a Safe Space for LGBTQ Youth and Teens. http://ncfy-learn.jbsinternational.com/course/index.php?categoryid=12.

FLASH HS L5: Undoing Gender Stereotypes Rationale

Theoretical Basis for Sexual Violence Prevention Lessons
The prevention of sexual violence is both a behavioral goal of FLASH in its own right, and an important strategy for preventing teen pregnancy and STDs. Sexual violence is correlated with a host of acute and chronic health problems - amplified by high rates of victimization in the United States.[i] Sexual violence is also strongly linked to teen pregnancy and STDs. Pregnant teens have higher rate of previous sexual assault, as do teens who begin having intercourse at a young age, increasing their risk of teen pregnancy and STDs. [ii iii iv v] Moreover, young teens with much older male partners have greatly increased risk of pregnancy.[vi vii] Clearly, effective sexual violence prevention can reduce suffering and improve outcomes across many domains of health.

Sexual violence prevention programs have not been evaluated to the same extent as programs that reduce teen pregnancy and STDs. In the fields of public health and sexual violence prevention, the recommended approach to reduce sexual violence is to address "upstream" risk factors for perpetration.[viii] FLASH's sexual violence prevention lessons address the risk factors for perpetration identified by the CDC[ix] that are amenable to change through a school-based curriculum:

- Hostility towards women
- Hypermasculinity (exaggerated adherence to traits stereotypically attributed to men)
- General tolerance of sexual violence within the community
- Societal norms that support male superiority and sexual entitlement
- Societal norms that maintain women's inferiority and sexual submissiveness

Significantly, strategies to prevent victimization (e.g. how women can avoid risky situations for sexual assault) and to increase empathy for victims of sexual violence have had mixed results.[8] These approaches were also shown to have the unintended consequence of strengthening participants' beliefs in rape myths (e.g. women are responsible for being raped).[8] This further underscores the need to focus prevention efforts on reducing perpetration.

The CDC risk factors are specific to male-on-female violence. Importantly, research links these same risk factors to same-sex sexual harassment and sexual violence targeted at LGBT young people.[x] While the majority of sexual violence is perpetrated by men against women, there is much more to be learned about the risk factors for sexual violence perpetrated by women against men, and sexual violence perpetrated against someone of the same gender.

Undoing Gender Stereotypes
Undoing Gender Stereotypes is the foundation for FLASH's sexual violence prevention lessons. This lesson strives to prevent perpetration of sexual assault by addressing the risk factors for perpetration identified by the CDC: hypermasculinity; societal norms that support male superiority and sexual entitlement; and societal norms that maintain women's inferiority and sexual submissiveness.[1] The lesson allows students to uncover the unhealthy consequences of rigid gender norms,[1] and to develop health-enhancing alternatives.
This is the first of a four-part series of lessons which includes *Undoing Gender Stereotypes, Healthy Relationships*, *Coercion and Consent* and *Online Safety*. All of the lessons are designed to prevent the perpetration of sexual violence.

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[i] Teten Tharp, A., DeGue, S., Valle, L., Brookmeyer, K., Massetti, G., & Matjasko, J. (2013). A systematic qualitative review of risk and protective factors for sexual violence perpetration. *Trauma Violence Abuse, 14,* 2, 133-167.

[ii] Landry, D.J., & Forrest, J.D. (1995). How old are U.S. fathers?" *Family Planning Perspectives, 27,* 159-161 & 165.

[iii] Ryan, S., Franzetta, K., Manlove, J.S., & Schelar, E. (2008). Older sexual partners during adolescence: Links to reproductive health outcomes in young adulthood. *Perspectives on Sexual and Reproductive Health, 40,* 1, 17–26.

[iv] Kirby, D., Lepore, G., & Ryan, J. (2005). *Sexual risk and protective factors: Factors affecting teen sexual behavior, pregnancy, childbearing, and sexually transmitted disease: Which are important? which can you change?* Washington, DC: The National Campaign to Prevent Teen Pregnancy.

[v] Ford, K., & Lepkowski, J. (2004). Characteristics of sexual partners and STD infection among American adolescents. *International Journal of STD and AIDS, 15,* 4, 260–265.

[vi] Saul, R. (1999). Using—and misusing—data on age differences between minors and their sexual partners. *Guttmacher Report on Public Policy, 2,* 4.

[vii] Duberstein Lindberg, L., Sonenstein, F.L., Leighton, K., & Martinez, G. (1997). Age differences between minors who give birth and their adult partners. *Family Planning Perspectives, 29,* 2.

[viii] World Health Organization/London School of Hygiene and Tropical Medicine. (2010). *Preventing intimate partner and sexual violence against women: Taking action and generating evidence.* Geneva: World Health Organization.

[ix] Centers for Disease Control and Prevention, Division of Violence Prevention.www.cdc.gov/violenceprevention/sexualviolence/riskprotectivefactors.html. Accessed 12/31/2014.

[x] Shakeshaft, C., Barber, E., Hergenrother, M., Johnson, Y., Mandel, L., & Sawyer, J. (1995). Peer harassment in schools. *Journal for a Just and Caring Education, 1,* 30–44.

FLASH HS L6: Healthy Relationships Rationale

Theoretical Basis for Sexual Violence Prevention Lessons
The prevention of sexual violence is both a behavioral goal of FLASH in its own right, and an important strategy for preventing teen pregnancy and STDs. Sexual violence is correlated with a host of acute and chronic health problems - amplified by high rates of victimization in the United States.[i] Sexual violence is also strongly linked to teen pregnancy and STDs. Pregnant teens have higher rate of previous sexual assault, as do teens who begin having intercourse at a young age, increasing their risk of teen pregnancy and STDs. [ii iii iv v] Moreover, young teens with much older male partners have greatly increased risk of pregnancy.[vi vii] Clearly, effective sexual violence prevention can reduce suffering and improve outcomes across many domains of health.

Sexual violence prevention programs have not been evaluated to the same extent as programs that reduce teen pregnancy and STDs. In the fields of public health and sexual violence prevention, the recommended approach to reduce sexual violence is to address "upstream" risk factors for perpetration.[viii] FLASH's sexual violence prevention lessons address the risk factors for perpetration identified by the CDC[ix] that are amenable to change through a school-based curriculum:

- Hostility towards women
- Hypermasculinity (exaggerated adherence to traits stereotypically attributed to men)
- General tolerance of sexual violence within the community
- Societal norms that support male superiority and sexual entitlement
- Societal norms that maintain women's inferiority and sexual submissiveness

Significantly, strategies to prevent victimization (e.g. how women can avoid risky situations for sexual assault) and to increase empathy for victims of sexual violence have had mixed results.[8] These approaches were also shown to have the unintended consequence of strengthening participants' beliefs in rape myths (e.g. women are responsible for being raped).[8] This further underscores the need to focus prevention efforts on reducing perpetration.

The CDC risk factors are specific to male-on-female violence. Importantly, research links these same risk factors to same-sex sexual harassment and sexual violence targeted at LGBT young people.[x] While the majority of sexual violence is perpetrated by men against women, there is much more to be learned about the risk factors for sexual violence perpetrated by women against men, and sexual violence perpetrated against someone of the same gender.

Healthy Relationships
The goal of the *Healthy Relationships* lesson is to reduce abusive communication and behavior and replace them with healthy alternatives. Students identify healthy, unhealthy and abusive behaviors within relationships, and practice using healthy communication skills. Students also receive tips and resources for helping a friend who is experiencing dating abuse. The lesson builds social norms in favor of healthy relationships, and rejects general tolerance of abuse of violence.[1]

This is the second of a four-part series of lessons which includes *Undoing Gender Stereotypes, Healthy Relationships, Coercion and Consent* and *Online Safety*. All of the lessons are designed to prevent the perpetration of sexual violence.

[i] Teten Tharp, A., DeGue, S., Valle, L., Brookmeyer, K., Massetti, G., & Matjasko, J. (2013). A systematic qualitative review of risk and protective factors for sexual violence perpetration. *Trauma Violence Abuse, 14,* 2, 133-167.

[ii] Landry, D.J., & Forrest, J.D. (1995). How old are U.S. fathers?" *Family Planning Perspectives, 27,* 159-161 & 165

[iii] Ryan, S., Franzetta, K., Manlove, J.S., & Schelar, E. (2008). Older sexual partners during adolescence: Links to reproductive health outcomes in young adulthood. *Perspectives on Sexual and Reproductive Health, 40,* 1, 17–26.

[iv] Kirby, D., Lepore, G., & Ryan, J. (2005). *Sexual risk and protective factors: Factors affecting teen sexual behavior, pregnancy, childbearing, and sexually transmitted disease: Which are important? which can you change?* Washington, DC: The National Campaign to Prevent Teen Pregnancy.

[v] Ford, K., & Lepkowski, J. (2004). Characteristics of sexual partners and STD infection among American adolescents. *International Journal of STD and AIDS, 15,* 4, 260–265.

[vi] Saul, R. (1999). Using—and misusing—data on age differences between minors and their sexual partners. *Guttmacher Report on Public Policy, 2,* 4.

[vii] Duberstein Lindberg, L., Sonenstein, F.L., Leighton, K., & Martinez, G. (1997). Age differences between minors who give birth and their adult partners. *Family Planning Perspectives, 29,* 2.

[viii] World Health Organization/London School of Hygiene and Tropical Medicine. (2010). *Preventing intimate partner and sexual violence against women: Taking action and generating evidence.* Geneva: World Health Organization.

[ix] Centers for Disease Control and Prevention, Division of Violence Prevention.www.cdc.gov/violenceprevention/sexualviolence/riskprotectivefactors.html. Accessed 12/31/2014.

[x] Shakeshaft, C., Barber, E., Hergenrother, M., Johnson, Y., Mandel, L., & Sawyer, J. (1995). Peer harassment in schools. *Journal for a Just and Caring Education, 1,* 30–44.

FLASH HS L7: Coercion and Consent Rationale

Theoretical Basis for Sexual Violence Prevention Lessons
The prevention of sexual violence is both a behavioral goal of FLASH in its own right, and an important strategy for preventing teen pregnancy and STDs. Sexual violence is correlated with a host of acute and chronic health problems - amplified by high rates of victimization in the United States.[i] Sexual violence is also strongly linked to teen pregnancy and STDs. Pregnant teens have higher rate of previous sexual assault, as do teens who begin having intercourse at a young age, increasing their risk of teen pregnancy and STDs. [ii iii iv v] Moreover, young teens with much older male partners have greatly increased risk of pregnancy.[vi vii] Clearly, effective sexual violence prevention can reduce suffering and improve outcomes across many domains of health.

Sexual violence prevention programs have not been evaluated to the same extent as programs that reduce teen pregnancy and STDs. In the fields of public health and sexual violence prevention, the recommended approach to reduce sexual violence is to address "upstream" risk factors for perpetration.[viii] FLASH's sexual violence prevention lessons address the risk factors for perpetration identified by the CDC[ix] that are amenable to change through a school-based curriculum:

- Hostility towards women
- Hypermasculinity (exaggerated adherence to traits stereotypically attributed to men)
- General tolerance of sexual violence within the community
- Societal norms that support male superiority and sexual entitlement
- Societal norms that maintain women's inferiority and sexual submissiveness

Significantly, strategies to prevent victimization (e.g. how women can avoid risky situations for sexual assault) and to increase empathy for victims of sexual violence have had mixed results.[8] These approaches were also shown to have the unintended consequence of strengthening participants' beliefs in rape myths (e.g. women are responsible for being raped).[8] This further underscores the need to focus prevention efforts on reducing perpetration.

The CDC risk factors are specific to male-on-female violence. Importantly, research links these same risk factors to same-sex sexual harassment and sexual violence targeted at LGBT young people.[x] While the majority of sexual violence is perpetrated by men against women, there is much more to be learned about the risk factors for sexual violence perpetrated by women against men, and sexual violence perpetrated against someone of the same gender.

Coercion and Consent
Coercion and Consent focuses on resetting societal norms that lead to perpetration of sexual violence, and on identifying and recognizing sexual assault and consent. Students gain skills in recognizing when consent is given or not given in sexual situations, and increase their understanding of the laws about consent. This lesson focuses on the following CDC risk factors for perpetration: (1) general tolerance of sexual violence within the community, and (2) societal norms that support male superiority and sexual entitlement.

This is the third of a four-part series of lessons which includes *Undoing Gender Stereotypes, Healthy Relationships*, *Coercion and Consent* and *Online Safety*. All of the lessons are designed to prevent the perpetration of sexual violence.

[i] Teten Tharp, A., DeGue, S., Valle, L., Brookmeyer, K., Massetti, G., & Matjasko, J. (2013). A systematic qualitative review of risk and protective factors for sexual violence perpetration. *Trauma Violence Abuse, 14,* 2, 133-167.

[ii] Landry, D.J., & Forrest, J.D. (1995). How old are U.S. fathers?" *Family Planning Perspectives, 27,* 159-161 & 165.

[iii] Ryan, S., Franzetta, K., Manlove, J.S., & Schelar, E. (2008). Older sexual partners during adolescence: Links to reproductive health outcomes in young adulthood. *Perspectives on Sexual and Reproductive Health, 40,* 1, 17–26.

[iv] Kirby, D., Lepore, G., & Ryan, J. (2005). *Sexual risk and protective factors: Factors affecting teen sexual behavior, pregnancy, childbearing, and sexually transmitted disease: Which are important? which can you change?* Washington, DC: The National Campaign to Prevent Teen Pregnancy.

[v] Ford, K., & Lepkowski, J. (2004). Characteristics of sexual partners and STD infection among American adolescents. *International Journal of STD and AIDS, 15,* 4, 260–265.

[vi] Saul, R. (1999). Using—and misusing—data on age differences between minors and their sexual partners. *Guttmacher Report on Public Policy, 2,* 4.

[vii] Duberstein Lindberg, L., Sonenstein, F.L., Leighton, K., & Martinez, G. (1997). Age differences between minors who give birth and their adult partners. *Family Planning Perspectives, 29,* 2.

[viii] World Health Organization/London School of Hygiene and Tropical Medicine. (2010). *Preventing intimate partner and sexual violence against women: Taking action and generating evidence.* Geneva: World Health Organization.

[ix] Centers for Disease Control and Prevention, Division of Violence Prevention.www.cdc.gov/violenceprevention/sexualviolence/riskprotectivefactors.html. Accessed 12/31/2014.

[x] Shakeshaft, C., Barber, E., Hergenrother, M., Johnson, Y., Mandel, L., & Sawyer, J. (1995). Peer harassment in schools. *Journal for a Just and Caring Education, 1,* 30–44.

FLASH HS L8: Online Safety Rationale

Theoretical Basis for Sexual Violence Prevention Lessons
The prevention of sexual violence is both a behavioral goal of FLASH in its own right, and an important strategy for preventing teen pregnancy and STDs. Sexual violence is correlated with a host of acute and chronic health problems - amplified by high rates of victimization in the U.S.[i] Sexual violence is also strongly linked to teen pregnancy and STDs. Pregnant teens have higher rate of previous sexual assault, as do teens who begin having intercourse at a young age, increasing their risk of teen pregnancy and STDs. [ii iii iv v] Moreover, young teens with much older male partners have greatly increased risk of pregnancy.[vi vii] Clearly, effective sexual violence prevention can reduce suffering and improve outcomes across many domains of health.

Sexual violence prevention programs have not been evaluated to the same extent as programs that reduce teen pregnancy and STDs. In the fields of public health and sexual violence prevention, the recommended approach to reduce sexual violence is to address "upstream" risk factors for perpetration.[viii] FLASH's sexual violence prevention lessons address the risk factors for perpetration identified by the CDC[ix] that are amenable to change through a school-based curriculum:

- Hostility towards women
- Hypermasculinity (exaggerated adherence to traits stereotypically attributed to men)
- General tolerance of sexual violence within the community
- Societal norms that support male superiority and sexual entitlement
- Societal norms that maintain women's inferiority and sexual submissiveness.

Significantly, strategies to prevent victimization (e.g. how women can avoid risky situations for sexual assault) and to increase empathy for victims of sexual violence have had mixed results.[8] These approaches were also shown to have the unintended consequence of strengthening participants' beliefs in rape myths (e.g. women are responsible for being raped).[8] This further underscores the need to focus prevention efforts on reducing perpetration.

The CDC risk factors are specific to male-on-female violence. Importantly, research links these same risk factors to same-sex sexual harassment and sexual violence targeted at LGBT young people.[x] While the majority of sexual violence is perpetrated by men against women, there is much more to be learned about the risk factors for sexual violence perpetrated by women against men, and sexual violence perpetrated against someone of the same gender.

Online Safety
The *Online Safety* lesson reinforces the anti-perpetration messages and norm resetting that takes place in the previous three lessons. It focuses on preventing perpetration of sexual assault and online bullying, and educating students about behaviors that may put them at greater risk for perpetration and victimization.

This lesson centers students as experts in the realm of online communication, and allows them to come up with strategies to prevent perpetration of online and in-person violence. Teens today are digital natives,[xi] people who have grown up with digital communication and media, and who are highly knowledgeable about these forms of media. Additionally, research shows that not all youth are equally at risk for sexual violence committed or initiated online.[xii] This lesson focuses on helping youth avoid specific online behaviors that are most amenable to change and have been identified by research as increasing the risk for perpetration or victimization (e.g.

requesting or posting nude pictures, visiting porn sites, using sexy sounding screen names, etc.)[12]

This is the fourth of a four-part series of lessons which includes *Undoing Gender Stereotypes, Healthy Relationships*, *Coercion and Consent* and *Online Safety*. All of the lessons are designed to prevent the perpetration of sexual violence.

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[i] Teten Tharp, A., DeGue, S., Valle, L., Brookmeyer, K., Massetti, G., & Matjasko, J. (2013). A systematic qualitative review of risk and protective factors for sexual violence perpetration. *Trauma Violence Abuse, 14,* 2, 133-167.

[ii] Landry, D.J., & Forrest, J.D. (1995). How old are U.S. fathers?" *Family Planning Perspectives, 27,* 159-161 & 165.

[iii] Ryan, S., Franzetta, K., Manlove, J.S., & Schelar, E. (2008). Older sexual partners during adolescence: Links to reproductive health outcomes in young adulthood. *Perspectives on Sexual and Reproductive Health, 40,* 1, 17–26.

[iv] Kirby, D., Lepore, G., & Ryan, J. (2005). *Sexual risk and protective factors: Factors affecting teen sexual behavior, pregnancy, childbearing, and sexually transmitted disease: Which are important? which can you change?* Washington, DC: The National Campaign to Prevent Teen Pregnancy.

[v] Ford, K., & Lepkowski, J. (2004). Characteristics of sexual partners and STD infection among American adolescents. *International Journal of STD and AIDS, 15,* 4, 260–265.

[vi] Saul, R. (1999). Using—and misusing—data on age differences between minors and their sexual partners. *Guttmacher Report on Public Policy, 2,* 4.*Guttmacher Report on Public Policy*, 2(4)

[vii] Duberstein Lindberg, L., Sonenstein, F.L., Leighton, K., & Martinez, G. (1997). Age differences between minors who give birth and their adult partners. *Family Planning Perspectives, 29,* 2.

[viii] World Health Organization/London School of Hygiene and Tropical Medicine. (2010). *Preventing intimate partner and sexual violence against women: Taking action and generating evidence.* Geneva: World Health Organization.

[ix] Centers for Disease Control and Prevention, Division of Violence Prevention. www.cdc.gov/violenceprevention/sexualviolence/riskprotectivefactors.html. Accessed 12/31/2014.

[x] Shakeshaft, C., Barber, E., Hergenrother, M., Johnson, Y., Mandel, L., & Sawyer, J. (1995). Peer harassment in schools. *Journal for a Just and Caring Education, 1,* 30–44.

[xi] Boyd, D. (2014). *It's complicated: The social lives of networked teens.* New Haven: Yale University Press.

[xii] Wolak, J., Finkelhor, D., Mitchell, K., & Ybarra, M. (2008). Online “predators” and their victims: Myths, realities and implications for prevention and treatment. *American Psychologist, 63,* 2, 111-128.

FLASH HS L9: Abstinence Rationale

Supporting young people to be abstinent is an important component of teen pregnancy and STD prevention. The FLASH curriculum's approach to abstinence has benefited greatly from recent research on abstinence education. The FLASH curriculum encourages positive attitudes and positive peer norms about abstinence, builds confidence to remain abstinent, teaches refusal skills, avoids denigrating condoms and birth control, and avoids putting down students who are sexually active.[i] [ii] [iii]

Research has shown that most abstinence-only programs are ineffective and can have negative effects on teens' sexual health and behavior. These programs do not delay sexual initiation, reduce the number of sexual partners, or increase abstinence.[iv] Some actually decrease contraception and condom use when teens do have sex, and decrease the likelihood of STD testing and treatment.[v] [vi] [vii] The FLASH curriculum seeks to avoid these unintended outcomes by employing a different approach, relying heavily on recent research about abstinence programs with positive outcomes.[i]

Gender stereotypes are intentionally avoided throughout the abstinence lesson in an effort to support the sexual violence prevention goals of the curriculum.

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[i] Jemmott, J.B., Jemmott, L.S., & Fong, G.T. (2009). Efficacy of a theory-based abstinence-only intervention over 24 months: A randomized controlled trial with young adolescents. *Archives of Pediatrics and Adolescent Medicine,164,* 2, 152-159.

[ii] Alford, S. (2003). *Science and success: Sex education and other programs that work to prevent teen pregnancy, HIV & sexually transmitted infections.* Washington, DC: Advocates for Youth.

[iii] Alford, S. (2008). *Science and success, second edition: Programs that work to prevent teen pregnancy, HIV & sexually transmitted infections.* Washington, DC: Advocates for Youth.

[iv] Kirby, D. (2007). *Emerging Answers 2007: Research Findings on Programs to Reduce Teen Pregnancy and Sexually Transmitted Diseases.* The National Campaign to Prevent Teen and Unplanned Pregnancy.

[v] U.S. House of Representatives, Committee on Government Reform. (2004). *The Content of Federally Funded Abstinence-Only Education Programs, Prepared for Rep. Henry A. Waxman.* Washington, DC.

[vi] Bearman, P., & Brückner, H. (2004). Promising the future: Virginity pledges and the transition to first intercourse. *American Journal of Sociology, 106*, 4, 859-912.

[vii] Bearman, P., & Brückner, H. (2005). After the promise: The STD consequences of adolescent virginity pledges. *Journal of Adolescent Health* 36, 4, 271-2.

FLASH HS L10: Birth Control Methods Rationale

The FLASH curriculum includes birth control methods and abstinence in full lessons of their own, based on the effectiveness of both approaches[i]. Research has repeatedly shown that sexual health education, including teaching about birth control, does not cause teens to have sex sooner or more often.[i ii iii iv v vi] Its only impact is preventative.

In this lesson, birth control is framed positively. Multiple teen pregnancy prevention studies demonstrate that having "more positive attitudes towards contraception, including condoms" and "perceiving more benefits of using contraception" are important protective factors against teen pregnancy.[vii] Hence, in this lesson, students develop commercials to emphasize the positive aspects of birth control using medically accurate information. Students are not expected to memorize effectiveness rates, how each method of birth control works, or contraindications. If students should be interested in a prescription method at some point in their life, their medical providers will cover this information.

Selection of methods in the lesson
This lesson focuses on a subset of birth control methods, rather than every method, in order to achieve sufficient depth in one class period and to achieve teen pregnancy prevention goals. The nine methods focused on in this lesson were based on King County and national data on teen contraceptive use.[viii ix] The type of condom that is worn in the vagina or anus (sometimes called a female condom) is addressed in STD and HIV prevention lessons.

Teachers are encouraged to have information, samples or reference material about all methods of birth control, including those that the lesson doesn't directly address, so they can answer questions that may arise. Medically updated websites are suggested in teacher preparation section of this lesson and in the Sexual Health Resources student handout and the, for teacher background and for students who wish to learn more in-depth information about all FDA approved methods.

Inclusion of IUD
IUDs are now known to be safe and appropriate birth control for teens. They have been redesigned from IUDs used in the past. They are safe and effective for people who have been pregnant and those who haven't, including teens. Not only are they extremely safe, IUDs are among the most effective methods of birth control available; the hormonal ones are more effective than sterilization. They do not impair future fertility, and they do not increase the risk of STDs or HIV.[x xi xii]

Inclusion of withdrawal
Despite the physical challenges inherent in using withdrawal effectively, we include it because withdrawal is more effective than previously thought and withdrawal is common among teens, free,and always available. In fact, when withdrawal is used correctly for vaginal sex, experts calculate that only 4% of couples are likely to get pregnant in a year. Taking typical human error into account, 22% would get pregnant, which is comparable to the diaphragm, sponge and other spermicides.[xiii]

In contrast, over three times as many couples (85%) would get pregnant using no method for a year, making withdrawal *significantly* more effective than using nothing. It should also be noted that withdrawal reduces the risk of sexually transmitted diseases (STD) and the human immunodeficiency virus (HIV) by about half,[xiv] which is better than most other methods of birth control, excluding condoms.

In contrast to previous assumptions, research shows that most pre-ejaculate fluid contains no sperm. Some men have a small amount of sperm in their pre-ejaculate fluid,[xiv] which may account for the 4% pregnancy rate in perfect use.

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FLASH HS L11: Preventing HIV and other STDs Rationale

This lesson focuses on big-picture concepts related to STD prevention—transmission, testing and condom use. As such, it does not contain detailed information about individual STDs. Health behavior change research shows that focusing on skills, attitudes and behaviors is more effective at improving health outcomes than memorizing facts.[i] Therefore, FLASH deemphasizes memorizing details related to specific STDs.

FLASH does not use graphic images of genitals infected with STDs**.** These images produce visceral, negative reactions in students and falsely lead them to believe that end-stage or worst-case scenario symptoms are the sign of sexually transmitted infection.[ii] End-stage pictures of STDs may also discourage young people from getting tested if they do not have these same symptoms. Given that the majority of STDs are asymptomatic, many students with STDs may falsely believe that they are not infected after viewing these kinds of pictures. It's very important for students to understand that they can get STDs, that a test at a clinic is the only sure way to know if they have an STD, and that completing treatment is imperative if a person is diagnosed with an STD.

Sexually transmitted diseases are referred to as STDs in this lesson, as opposed to the also acceptable term sexually transmitted infection (STI). Both terms can be used interchangeably and are medically accurate. This lesson follows the guidance of the CDC in choosing to use STD.

FLASH focuses on abstinence and the use of condoms for vaginal and anal sex to prevent STDs. This is because unprotected vaginal and anal sex are the most common way that STDs including HIV are transmitted. There is very little risk of getting or transmitting HIV from oral sex.[iii]

STDs that are spread through oral sex mostly cause infections of the throat. Oral infections do not have the same negative consequences as infections in the reproductive system. Other modes of transmission include genital skin-to-skin contact (HPV and herpes) and cold sore on the mouth to genitals (herpes). Using condoms during anal or vaginal sex substantially decreases the risk of spreading STDs, although they do not completely eliminate the risk. Based on current information about STD transmission, FLASH stresses the importance of condom use for couples having vaginal or anal sex, and abstaining from oral, anal and vaginal sex.

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FLASH HS L12: Condoms to Prevent Pregnancy, HIV, and other STDs

Approximately half of all teens are sexually active,[i] making high school an important time to both support abstinence and to teach students condom skills. Condoms are the most effective technology to reduce the transmission of HIV and other STDs;[ii] they are also effective barriers against unplanned pregnancy.[iii]

Students who have had a chance to practice condom skills, especially before they are sexually active, are far more likely to use condoms correctly.[iv] [v] This is especially important since condoms are one of the most commonly used methods of birth control by teens.[vi] A large body of research clearly shows that sexual health education, including condom skill practice, does not encourage earlier sexual activity among teens. Instead, these programs can actually help students to postpone sexual activity, decrease their number of sexual partners and increase their condom use. Studies also reveal that when youth have positive attitudes about condoms and the knowledge to use them correctly, they are more likely to use them consistently.[vii] [viii] [ix]

This lesson purposefully avoids labeling condoms as "male condoms" or "female condoms," in order to be more inclusive of transgender and intersex individuals. Instead, the lesson describes condoms that are worn on the penis, and condoms that are worn in the vagina or anus. For ease they are also simply called a "penis condom" or a "vagina condom." Teachers may have also heard condoms referred to elsewhere as external condoms or internal condoms. Although accurate, these terms are potentially confusing. For the sake of both clarity and inclusivity, FLASH instead relies on plain language and definitions that are specific to the body parts the condoms were designed for.

FLASH focuses on abstinence and the use of condoms for vaginal and anal sex to prevent STDs. This is because unprotected vaginal and anal sex are the most common way that STDs including HIV are transmitted. There is very little risk of getting or transmitting HIV from oral sex.[x]

STDs that are spread through oral sex mostly cause infections of the throat. Oral infections do not have the same negative consequences as infections in the reproductive system. Other modes of transmission include genital skin-to-skin contact (HPV and herpes) and cold sore on the mouth to genitals (herpes). Using condoms during anal or vaginal sex substantially decreases the risk of spreading STDs, although they do not completely eliminate the risk. Based on current information about STD transmission, FLASH stresses the importance of condom use for couples having vaginal or anal sex, and abstaining from oral, anal and vaginal sex.

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FLASH HS L13: Testing for HIV and other STDs Rationale

The purpose of this lesson is the prevention of HIV and other STDs. From a public health perspective, testing for HIV and other STDs is a key strategy in reducing the spread of these infections. There is treatment for all STDs, including HIV; there is a cure for most STDs. In all cases, prompt identification and treatment for STDs, including HIV, not only improves the health and well-being of the person treated, but greatly reduces chances of transmission to others. Additionally, people who are tested for HIV and other STDs typically receive counseling in reducing their future risk of acquiring an infection and in preventing transmission.

From an educational perspective, increasing testing and treatment for STDs is a key behavioral goal toward STD reduction, along with increased condom use and abstinence. This lesson addresses the main protective factors that have been found to impact testing[i]:

- Knowledge of the availability of confidential and low-cost STD testing and treatment services
- Positive attitudes toward and comfort with being tested and treated for STDs
- Self-efficacy to know when to visit a clinic to be tested and treated
- Self-efficacy to visit a clinic and be tested and treated

The CDC Health Education Curriculum Analysis Tool (SHECAT) and the National Sexuality Education Standards include many standards related to the importance of testing for HIV and other STDs, as well as accessing sexual healthcare services, which are met by this lesson.

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FLASH HS L14: Communication and Decision Making Rationale

The communication and decision making lesson brings together the communication and refusal skills that have been covered in previous FLASH lessons and applies them to important sexual health-related situations, such as deciding to remain abstinent, using condoms and birth control, and preventing sexual violence. This lesson also incorporates new research on adolescent decision making, which shows that rather than teaching a decision-making model that stresses weighing risks and benefits, a more effective strategy is to build young people's ability to utilize "gist-based" decision making.

Gist-based decision making relies on understanding the bottom line of a situation and using that information to make decisions. It can be especially useful for teens in situations where the benefits, such as sexual pleasure or pleasing a partner, can seem high. This lesson provides students with "bottom-line" statements that they can apply to the hypothetical situations in this lesson, as well as to situations they may face in their own lives. Strong communication and refusal skills and a solid understanding of the bottom line are necessary if young people are to prevent pregnancy, STDs and sexual violence. This lesson powerfully combines these elements in order to shift peer norms and to improve individual student's self-efficacy with regard to healthy decision making.[i] [ii] [iii]

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FLASH HS L15: Improving School Health Rationale

This lesson utilizes a social norms approach to impact young people's risky behaviors. The social norms approach is an effective, evidence-based intervention that has been widely used to target substance abuse and problem drinking behaviors, and is increasingly being used to improve sexual health outcomes and decrease sexual violence.[i] [ii] The approach is based on the fact that young people generally overestimate the percentage of their peers who are engaging in risky behaviors. For example, teens overestimate the number of their peers who are having sex, as well as overestimating the percentage of sexually active teens who are having unprotected sex.[iii] [iv]

Research shows that teens overestimation of their peers' risky behaviors is related to their own likelihood of engaging in that behavior themselves.[v] Therefore, social norms campaigns are designed to introduce more accurate data about the actual occurrence of the risky behaviors, in order to positively influence teens' sexual behavior. In this lesson, research-based norm statements are provided for students' use. Each statement is designed to directly counter a common misperception related to the behavioral goals of this curriculum: the prevention of pregnancy, STDs and sexual violence. As such, the statements address misperceptions about abstinence, condom use, birth control use and rape.

This lesson impacts the students who create the posters by creating buy-in for the new norm, especially since they are engaged in the creation of persuasive materials containing these messages. Additionally, the posters are placed in public locations in the school, influencing all students in the school to shift their beliefs toward the new norm. The posters have greater influence because they were created by peers, who are deemed to be more credible on these topics than adults. In this way, the impact of the FLASH curriculum can be deepened and broadened, creating a school-wide environmental shift.

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[ii] Planned Parenthood of New York City (PPNYC) conducted research with middle school students and identified large discrepancies between what young adolescents actually believe and what they think the norm is for their peers.

[iii] Robinson, K. L., Telljohann, S. K., & Price, J. H. (1999). Predictors of sixth graders engaging in sexual intercourse. *Journal of School Health, 69,* 369-375.

[iv] Romer, D., Black, M., Ricardo, I., Feigelman, S., Kaljee, L., Galbraith, J., Nesbit, R., Hornik, R. C., & Stanton, B. (1994). Social influences on the sexual behavior of youth at risk for HIV exposure. *American Journal of Public Health, 84,* 977-985.

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