ASSESSING SEXUAL HEALTH INFORMATION & RESOURCE PROVISION IN INDIANA YOUTH-SERVING COMMUNITY-BASED ORGANIZATIONS UTILIZING COMMUNITY-BASED PARTICIPATORY RESEARCH METHODS

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ABSTRACT

Christopher M. Fisher

ASSESSING SEXUAL HEALTH INFORMATION & RESOURCE PROVISION IN INDIANA YOUTH-SERVING COMMUNITY-BASED ORGANIZATIONS UTILIZING COMMUNITY-BASED PARTICIPATORY RESEARCH METHODS

(Under the direction of Michael D. Reece)

Research into the provision of sexual health information for Indiana youth has demonstrated inadequate school support and little to no information exchange between Indiana parents and their children. Community leaders in Indiana have suggested that community-based organizations (CBOs) may play a role in providing sexual health information to young people. However, little is known about the nature of sexual health information resources among youth-serving Indiana community-based organizations.

The purpose of this study was to assess the provision of sexual health information by Indiana youth-serving community-based organizations. Specifically, the study looked to assess 1) the comfort, confidence, skills, and knowledge (CCSK) of youth development professionals (YDPs) in addressing questions from youth about sexuality, and 2) the potential for CBOs to provide sexuality-related programming, referrals, and resources to adolescents in Indiana.

Utilizing community-based participatory research (CBPR) methods, a community advisory board developed and implemented a 20-minute Internet survey. The survey measured constructs determined by the community advisory board to be relevant to the foci above.

Results of the study found a high level of CCSK among YDPs as well as a high level of desire for additional training. Less than half of participants indicated their organizations offered programming and resources on various sexuality-related topics. About half of participants indicated their organization had referral protocols in place for a variety of sexual health issues. Availability of programming, resources, and referrals varied by topic.

The capacity of YDPs to deliver sexual health information was high while existing organizational capacity was only moderate. Policy-makers and organizational leadership should consider supporting the training needs of YDPs and strengthening formal mechanisms for the delivery of sexual health information to adolescents. Future research should expand the geographical scope of the current study and look to validate in other populations the measurement of CCSK.

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CHAPTER ONE

INTRODUCTION

In 2001, then US Surgeon General, David Satcher, published the influential *Surgeon General's Call to Action to Promote Sexual Health and Responsible Sexual Behavior (*the *Call*). The document was the result of an intensive, community process that began dialoging about the state of sexual health in the United States, the rationale for addressing sexual health, and potential venues for addressing the sexual health needs of US citizens (US Department of Health and Human Services, 2001). Academicians, physicians, teachers, students, religious leaders, and many others came together to reach consensus on how best to address issues such as high rates of sexually transmitted diseases (STDs), human immunodeficiency virus (HIV) the virus which can lead to acquired immune deficiency syndrome (AIDS), unintended pregnancy, and sexual violence. The *Call* tied its mission to that of the larger Healthy People 2010 initiative (US Department of Health and Human Services, 2001).

The US Department of Health and Human Services' Healthy People 2010 was the third installment of a national initiative to identify public health priorities and the objectives to address those priorities over the course of a decade. Two central tenants to Healthy People 2010 included improving the length and quality of life and eliminating health disparities in the United States. Quality of life issues germane to the *Call* included the recognition that "Sexuality is an integral part of human life. It carries awesome potential to create new life. It can foster intimacy and bonding as well as shared pleasures in our relationships." (2001, p. 1) In other words, it was the belief of the group who developed the *Call* that all humans, and in particular US citizens, had a right to be not only free from that which may hamper one's experience of their sexuality, but to view it as contributing to their quality of life through bonding and pleasure. The elimination of health disparities as discussed in Healthy People 2010 referred to infectious diseases such as STDs, HIV and AIDS as well as issues of domestic violence and unintended pregnancy. The *Call* was intended to expand on the Healthy People 2010 initiative by explicating public health priorities around sexual health and by addressing its associated objectives.

Among many of the recommendations in *The Call* was the need to address sexual health priorities in adolescent populations. Also noted was the need to take an ecological approach. The state of Indiana provides a unique environment to look at addressing adolescent sexual health through innovative venues. Recent research into the provision of sexual health information for Indiana youth has demonstrated public schools may not be adequately addressing their needs (Tanner, Reece, Legocki, & Murray, 2007) despite parents wanting their children to have information on sexual health (Yarber, Milhausen, Crosby, & Torabi, 2005). Further, little to no information exchange between Indiana parents and their children appears to be occurring (n.a., 2003). Community leaders support providing Indiana youth with information about their bodies, boundaries, decision-making, growth and development, and healthy relationships at all ages from caring, skilled adults. These leaders also support a holistic, ecologically based approach to sexual health education; sources may include schools, parents, and youth-serving organizations. The politically treacherous terrain of sex education in the schools (C. M. Fisher, 2009; Irvine, 2002; Luker, 2006; Moran, 2000) and difficulty of reaching out to parents has left many community leaders to ponder the role of community-based organizations (CBOs) in providing sexual health information. However, little is known about the nature of sexual health information resources among youth-serving Indiana community-based organizations.

The purpose of this study is to assess the provision of sexual health information and resources to youth by Indiana youth-serving community-based organizations. Impetus for the project comes from leaders in youth-serving CBOs in Indiana as well as agencies that fund training for those working with youth. As such, a community-based participatory research (CBPR) framework will be used to conduct the study. Guiding principles of CBPR as identified by Israel, Schulz, Parker, Becker, Allen, & Guzman (2003) will be employed for this study. Exact methods will be determined in collaboration with an advisory board comprised of leaders and front-line workers in youth serving CBOs throughout the state.

There are several methods for providing sexual health information to youth. Primary educational sources have included parents and schools. Yet to be explored is the potential for community-based organizations to play a role in advancing sexual health. The current study will

work with Indiana CBOs to develop a better understanding of the roles they play in providing youth with sexual health information, the ways in which this is currently done, and the facilitating factors and barriers to providing such services. Specifically, the study will 1) assess the comfort and confidence of youth development professionals working in community-based organizations in the state of Indiana in providing sexuality-related information to young people and 2) describe the role and potential role of community-based organizations in providing sexuality-related information to youth.

Research questions to assess comfort and confidence of youth development professionals (YDPs) in providing sexuality-related information to youth are 1) what types of sexuality-related topics do young people ask YDPs about, 2) what are YDPs comfort and confidence in answering those questions, 3) are there correlations and predictability among comfort, confidence, and the topics asked about by youth, and 4) do other variables such as work-related stigma, training, sexual attitudes, and demographics contribute to the prediction of comfort and confidence in answering sexuality-related questions posed by youth.

The following research questions will help to map the role community-based organizations (CBOs) play in providing young people with sexuality-related information: 1) what types of sexuality-related resources, referrals, and programming are currently offered by CBOs, 2) how do CBOs philosophically approach the provision of sexuality-related information to youth, 3) how do YDPs perceive the acceptance by youth of the sexuality-related information they provide, and 4) does the organizational profile of a CBO predict the types of sexuality-related resources, referrals, and programming it provides to youth it serves.

CHAPTER TWO

LITERATURE REVIEW

State of adolescent sexual health

Priorities identified in the Surgeon General's *Call to Action* focused on a recent statistical history of current issues related to the sexual health of the nation. Table 1 details a list of issues identified in the *Call*. The *Call* also indicated disparities such as the disproportionate effect of STDs, HIV and AIDS on women, in particular, adolescent women, Blacks, Hispanics, and homosexual and bisexual men.

Objectives to address the sexual health priorities as described in the *Call* include engaging scientists, parents and other family members, schools, the community, the media, religious communities, health care providers, and the law in conversations about improving sexual health outcomes such as those indicated in Table 1. Delivery of evidence-based interventions and programs, as detailed by the *Call*, were to include programs based in communities, schools, clinics, and religious institutions. The future vision articulated increasing sexual literacy (i.e., awareness and knowledge), providing interventions to reduce negative outcomes, and investment in research to increase the repertoire of evidence-based solutions for sexual health problems in the United States as ways of measuring achievement of the stated objectives.

Soon after the publication of the *Call*, Dr. Satcher was relieved of his duties as US Surgeon General. Since that time, the sexual health initiatives outlined have received less attention than the fervor with which it was received by advocates for sexual health. As the decade comes to a close, revisiting the public health priorities identified in the call and providing an update to those issues is important in framing the coming decades' issues in relation to the promotion of sexual health in the US. Further, examination of the roles played by various institutions identified for achieving the objectives may provide guidance for future interventions and research.

Table 1 provides a list of the sexual health issues identified in the *Call* and rates for each issue from the document compared with the most recent available data. Where possible, the

Table 1. *Comparison of sexual health issues: 2001 and now*

Sexual Health Issue	Data from the Surgeon General's *Call to Action* (2001)	Recent Data
AIDS cases	774,467 since 1981	992,865 from 1981 to 2006 (CDC, 2008)
HIV Prevalence	Estimated 800,000-900,000	Estimated 1,015,000 (CDC, 2008)
HIV incidence per year	Estimated 40,000	Estimated 36,000 (CDC, 2008)
STDs	STDs infect approximately 12 million people each year	STDs infect approximately 19 million people each year (CDC, 2007c)
Chlamydia	659,441 cases reported in 1999 (CDC, 2000); Rates are highest among women aged 15-19 with Black and Hispanic women having higher rates than White women	1,030,911 cases reported in 2006 (CDC, 2007c); Rates continue to be highest among women aged 15-19 with disproportionate impacts on Black and Hispanic women
Gonorrhea	360,076 cases reported in 1999(CDC, 2000); highest among women aged 15-19	358, 366 cases reported in 2006 (CDC, 2007c); continues to be highest among women aged 15-19 (CDC, 2007a)
HPV	Approximately 220,000 cases of genital warts (caused by HPV virus) reported in 2000 (CDC, 2007a)	Approximately 422,000 cases of genital warts reported in 2006 (CDC, 2007a)
Homophobia	In 2001, 83% of LGBT youth experienced verbal harassment based on orientation, 41% experience physical harassment, and 21% experienced physical assault (Kosciw & Cullen, 2002)	In 2005, 83% of LGBT youth experienced verbal harassment based on orientation, 38% experienced physical harassment, and 18% experienced physical assault (Kosciw & Diaz, 2005)
Abortion	Estimated 1,366,000 in 1996; 22.9 abortions per 1000 women aged 15-19	Estimated, 1,220,000 in 2004; 19.8 abortions per 1000 women aged 15-19 (Ventura, Abma, Mosher, & Henshaw, 2008)
Unintended Pregnancy	49% of all pregnancies are unintended (Henshaw, 1998)	Estimated that half of all pregnancies are unintended (Gold, 2006)
Forced Sexual Act	22% of women 2% of men	10.6% of women 2.1% of men (Basile, Chen, Lynberg, & Saltzman, 2007)
Sexual Abuse	99,278 reports of childhood sexual abuse in 1998 (U.S. Department of Health and Human Services, 2000a)	78,120 reports of childhood sexual abuse in 2006 (U.S. Department of Health and Human Services, 2008)

data for the timeframe in which the *Call* was issued were pulled directly from the *Call*. Where analogous statements from more recent data were not available, comparable data was pulled

from other sources for both the time around the publication of the *Call* and more recent times and are noted with citations. For example, the *Call* includes sexual health issues related to homophobia and points to statistics culled from multiple sources. Since no comparable data exists for recent trends in the outcomes associated with homophobia, data on equivalent statements in the *Call* were pulled from the National School Climate Survey conducted by the Gay, Lesbian, & Straight Education Network (GLSEN) and used for comparison.

Table 1 provides insights into the progress made on US sexual health issues over the last several years. In some instances, progress has been achieved. For example, the yearly incidence rate of estimated HIV infection has dropped by 4,000 and the number of reports of childhood sexual abuse has dropped by 21%. Overall, however, it may be argued that total progress towards reducing sexual health concerns has been minimal. Perhaps the best example of "stalled progress" (Gold, 2006, p. 2) comes from unintended pregnancy estimates. The *Healthy People 2010* goal was to reduce unintended pregnancy from 49% to 30% (U.S. Department of Health and Human Services, 2000b). While recent data for comparison has yet to be published, reliable estimates indicate there has been no reduction in the number of unintended pregnancies in the US (Gold, 2006).

A closer examination of the existing literature suggests that in addition to the lack of progress in the overall state of sexual health over the last 8-10 years, the sexual health disparities experienced by adolescents has not dissipated at a pace reflective of the urgency with which the *Call* was issued. Adolescents continue to experience high rates of STI and HIV infection (CDC, 2005, 2007b) and unintended pregnancy (B. Hamilton, Martin, & Ventura, 2007). Of particular concern is the continued disparity in sexual health for US adolescents compared to their peers in other nations (n.a., 2001). For example, compared to European countries, US adolescents experience gonorrhea and chlamydia rates approximately ten times higher than their European counterparts (Panchaud, Singh, Feivelson, & Darroch, 2000). Abortion rates for US adolescents continue to be considerably higher than that for European youth (Singh & Darroch, 2000). Why adolescent sexual health has not improved much since the *Call* and remains far behind that of

European youth may be explained, in part, by the ideological battle over sexuality education for youth in the US.

The sexuality education debate

Sexuality education in the United States has had a varied and complex history. The earliest form of sex education in public schools took on a question and answer format with medical professionals in the early 1900's (Moran, 2000). Despite its initial failings, World War I brought sex and the need for education around it firmly into the American purview through training of armed forces going overseas; the primary focus at the time was on prevention of syphilis and gonorrhea transmission (D'Emilio & Freedman, 1997; Moran, 2000). By the 1950s, sex education was quickly becoming a staple of American high schools and beginning to be included in middle school curricula (Irvine, 2002; Luker, 2006). In the late 1970s, the question no longer was whether sexuality education should be included in public school curricula, but what the contents of that curriculum should be (Irvine, 2002; Luker, 2006). Today, the content debate continues with the primary contenders being abstinence-only sexuality education and comprehensive sexuality education (C. M. Fisher, 2009; Irvine, 2002; Luker, 2006).

Unique to abstinence-only curricula is the force of federal policy behind it. Specifically, the 1981 Public Health Service Act and the 1996 re-authorization of Personal Responsibility and Work Opportunity Reconciliation (Welfare Reform) Act brought into national discourse a full definition of abstinence-only sexuality education and provided funding to support the development and implementation of such curricula in public schools throughout the United States. Title XX of the 1981 Act provided block grants to states to provide abstinence-only sexuality education for development, implementation, and maintenance of curricula. Title V, section 510 of the Act also provided funding mechanisms and section 912 included an 8 point definition of abstinence-only education commonly referred to as a-h (see Table 2). The funding, in excess of $1 billion dollars over the life of the policies (C. M. Fisher, 2009), from both mechanisms was only to be used for programs that met all 8 points of the definition. In essence, the policy set in place a national standard that marriage was the only place in which human sexual activity should occur (Young & Goldfarb, 2000).

Table 2. *(a) - (h) abstinence definition*

Section 912 of the Welfare Reform Act of 1996 (as cited in Young & Goldfarb, 2000) defines "abstinence education" as an educational or motivational program which—
(A) Has as its exclusive purpose, teaching the social, psychological, and health gains to be realized by abstaining from sexual activity;
(B) Teaches abstinence from sexual activity outside marriage as the expected standard for all school age children;
(C) Teaches that abstinence from sexual activity is the only certain way to avoid out-of-wedlock pregnancy, sexually transmitted diseases, and other associated health problems;
(D) Teaches that a mutually faithful monogamous relationship in context of marriage is the expected standard of human sexual activity;
(E) Teaches that sexual activity outside of the context of marriage is likely to have harmful psychological and physical effects;
(F) Teaches that bearing children out-of-wedlock is likely to have harmful consequences for the child, the child's parents, and society;
(G) Teaches young people how to reject sexual advances and how alcohol and drug use increases vulnerability to sexual advances; and

The social and cultural influences which led to the deployment of an abstinence-only ethos give context to the socio-political environment which continues to support the policy, though less and less today as the number of states rejecting abstinence-only monies increase. Three converging events in recent US history reveal the forces at work: 1) the sexual revolution of the late 1960s, 2) the founding of SIECUS, and 3) the rise of the New Right.

The sexual revolution of the late 1960s brought about historic changes in the way American's viewed and expressed their sexuality. Historians D'Emilio and Freedman attribute much of the "sudden" shift in attitudes to the pill (1997). For the first time, women could completely separate sex (and sexuality) from reproduction, something men had been able to do to some extent for centuries. No longer afraid of becoming pregnant, women (and men) began to embrace their sexuality like never before. Additionally, years of gender equality battles yielded

more and more couples marrying later in life or not at all. Finally, while called a revolution, the shift in sexual values was really a simmering rebellion against decades of values centered on sexual piety and repression, a carryover from Victorian days and Freudian notions of sexuality (Foucault, 1990).

As the sexual revolution was preparing to explode, many sexual health advocates were witnessing the solidification of American youth culture, particularly around public high schools. The mixing of genders in high school coupled with the mass production of automobiles birthed a whole new class of citizens, the adolescent (Moran, 2000). The adolescent, unlike the child or adult, was burden with larger and larger amounts of free time. Required to spend more and more time with the opposite sex in high schools, adolescent sexual proclivities emerged and became more readily visible to the world. Witnessing these events, Mary Calderone founded the Sexuality Information and Education Council of the United States (SIECUS) (Irvine, 2002).

Dr. Calderone had worked for Planned Parenthood for a number of years. She had witnessed firsthand the results of a lack of accurate sex information for adolescents, namely sexually transmitted infections and unplanned pregnancies. A firm believer in education, Dr. Calderone saw the need for an educational resource for teachers struggling with the changing sexual values of their pupils. Not only was SIECUS to be a resource, but it was the first national organization to push for mandatory inclusion of sex education in public high schools (Irvine, 2002).

At the same time Dr. Calderone and her colleagues were converging on the side of sex education for all, the New Right was coalescing around an idealized notion of the good ole days where sex was not talked about and only occurred within the context of marriage. Janice Irvine (2002) details an account of the rise of the New Right that illuminates the political and social goals of the leaders of the movement. The primary aim was to “regain” a select-minority rule of America through the various power structures in government and the public sector. This power-hungry movement used moral issues like sex to reign in the masses. Irvine recounts the use of what she calls depravity narratives to instill fear in the public. These narratives typically included half-truths or out-right lies about how teaching sex in public schools was ruining the moral fiber of

America; for example, rumors were spread by the New Right that accused teachers of having sex during class to demonstrate how to do it. The result was a moral panic in various communities that eventually led to the installation of government officials favorable to the New Right and their quest for power (Irvine, 2002).

The New Right, using the debates around sex and sex education to lay the foundations for a long-term power grab, had formidable, albeit not well-funded, opponents in Dr. Calderone and the sexual revolution. Over the course of the debates about whether sex education should or should not be included in public school curriculum, those in favor of inclusion were winning, but only within varying locales (Luker, 2006). For example, those sympathetic to SIECUS' plight, found their way into seats of power in the New Jersey school systems. What resulted was a statewide curriculum focused on a comprehensive, whole life approach to sexuality education known as Family Life Education (FLE) (Irvine, 2002). The New Right, however, was successful at limiting sex education debates to the local stage as of the late 1970s. But a new, and deadly, player was about to enter the stage, forever changing the terms of the debate.

In early 1981, several gay men in New York and San Francisco were coming down with a debilitating and ultimately deadly disease that soon became known as AIDS. In 1983, the virus was beginning to show up in heterosexuals. One mode of transmission was determined to be through sex. Suddenly, the question of whether or not sex education should occur in schools became what kind of sex education (Irvine, 2002; Luker, 2006; Moran, 2000). The New Right had lost the battle over inclusion of sex ed as all agreed that lives were now at stake. However, the New Right did not lose its "moral compass" in the debates. They found a way to talk about sex without talking about it in the new abstinence-only curriculum. And the battles of the 1970s were not a complete loss as the New Right had been successful in building from the ground up a large coalition of supporters which swept them into powerful positions (Irvine, 2002).

The positions included several congressional seats in the US congress. From the legislative arm of government and with a sympathetic ear in the executive branch, the New Right planted the seeds for their new tactic for sex education and created a standard of heterosexual marriage for the nation vis-à-vis abstinence-only until marriage sex education policy. However,

research on sexuality education in schools would soon shed light on the complexities of such an offering bringing into question the feasibility of in-school sex education.

Evaluation studies of sex education efficacy in schools are numerous. More recent literature reflects the debates between abstinence-only based programs and comprehensive sexuality education. Some studies have compared formal high school sex courses finding that having comprehensive sexuality education correlates to improved sexual health outcomes (i.e., delayed onset of sexual activity, reduced unintended pregnancy) while abstinence-based or having no formal sex instruction does not (Jemmott, Jemmott, & Fong, 1998; Kirby, 2007; Kirby, Korpi, Barth, & Cagampang, 1997; Kirby & Weiss, 1997; P. Kohler, L. Manhart, & W. Lafferty, 2008; P. K. Kohler, L. E. Manhart, & W. E. Lafferty, 2008; Pittman & Gahungu, 2006). Far more studies have sought to understand the outcomes associated with either an abstinence-based or comprehensive curriculum. Similar to comparative studies, research finds abstinence-based curricula lead to no changes in sexual health outcomes (Barnett & Hurst, 2003; Jorgensen, 1991; E. Smith, Dariotis, & Potter, 2003; Trenholm et al., 2007; Wilson, Goodson, Pruitt, Buhj, & Davis-Gunnels, 2005) and may leave young people at risk for greater negative outcomes (Devaney, Johnson, Maynard, & Trenholm, 2002; C. M. Fisher, 2009).

Despite evidence supporting a comprehensive sexuality education curriculum, the political and moral nature of the debate continues to skew funding sources toward abstinence-based teaching. The Institute of Medicine suggests that “Congress, as well as other federal, state, and local policymakers, eliminate requirements that public funds be used for abstinence-only education, and that states and local school districts implement and continue to support age-appropriate comprehensive sex education and condom availability programs in schools.” (as cited in Collins, Alagiri, Summers, & Morin, 2002, p. 8) However, others realize the contentious nature of the debates and suggest that while evidence-based research should guide public policy regarding sex education in the schools, “No quantity of research will settle the moral and religious disputes that circle around the sex education debate.” (Collins et al., 2002, p. 16) Perhaps because the debates are located in public schools, institutions which have historically been chosen for their ability to reach the masses (Moran, 2000), they continue to be contentious sites

for the sex education discourse; the vast majority of citizens are impacted by policy decisions. Since advocates on all sides of the debate will likely not come to consensus any time soon, it may be worth considering alternative avenues for providing sexuality information and education to adolescents. Community-based organizations (CBOs) may be one such alternative.

Community-based organizations as sources of sexuality information

Historically, community-based organizations (CBOs) have a long history of providing sexuality information and resources. Perhaps the best example is the Planned Parenthood Federation of America. Planned Parenthood and other similar organizations, however, operated primarily as community clinics. Only people concerned about sexually transmitted diseases or pregnancy sought out their services. Those services were typically focused on clinical treatment and did not provide a more comprehensive, holistic program of sexuality education.

The AIDS epidemic appeared to shift the nature of sexual health information provided by CBOs. Not long after the initial outbreak of the AIDS epidemic in the United States, several community organizations began coalescing to provide support, services, and education. The response was, in part, a reaction to the lack of intervention by governmental agencies at the local, state, and federal level. The gay and lesbian community was at the forefront of the movement to address the epidemic. Many existing organizations, such as the Gay Liberation Front (GLF), either took on the issue of HIV and AIDS in local communities or had members split off to form new organizations, such as ACT UP (AIDS Coalition To Unleash Power) and the Gay Men's Health Crisis (GMHC) (Loughery, 1998). These organizations were specifically created to tackle various issues related to HIV and AIDS, including a more ecological sexuality education that included discussions about heretofore unmentioned sexual behaviors and larger socio-political, cultural, and economic issues related to sexuality.

CBO involvement in providing sexual health information has received significant attention from researchers, particularly in the field of public health. However, a large portion of the research has been conducted from a disease prevention perspective. What is known from this research is that CBOs play a vital role in addressing sexual health disparities for the communities in which they operate. CBOs have helped to address concerns about HIV and AIDS (Hamdallah, Vargo, &

Herrera, 2006; Oliva, Rienks, Udoh, & Smith, 2005; B. D. Smith & Bride, 2004), unintended pregnancy (Kramer et al., 2005; Simkin, Radosh, Nelsesteun, Silverstein, & Academy for Educational Development, 2003), STDs (Alstead et al., 1999; Okwumabua, Glover, Bolden, & Edwards, 2001), and sexual violence (Itzhaky & York, 2001; Specktor, Stafford, & Minnesota State Dept. of Corrections St Paul, 1988). Research in this area has typically focused on adult populations, though a few have extensively looked at adolescent populations (see for example Wright, Gonzalez, Werner, Laughner, & Wallace, 1998). Little is known about CBO efforts on other, more holistic topics of sexual health, such as pleasure, communication, and general sexuality knowledge (e.g., anatomy and physiology). Little is also known about how CBOs have addressed sexuality issues for adolescents. More recently, some experts have proposed utilizing community-based participatory research to better understand the role CBOs play in providing adolescents with a holistic sexuality education (K. Baldwin, personal communication, January 16, 2008).

Community-based participatory research (CBPR)

Community-based participatory research (CBPR) is a framework for conducting research focused on and explicitly engaging a community. Although CBPR has a relatively short history in public health research (Strickland, 2006), its beginnings date back several decades. Lewin, in the 1940s, made the distinction between research and action and recognized the importance of linking the two (Lewin, 1948). Later, work in critical and social theories (Habermas, 1989; Unger, 1987) as well as Marxists conflict theory (M. Minkler, 2000) laid a foundation of new intellectual thought based outside of typical positivist paradigms (Strickland, 2006). The call for public health research that engaged the communities it served was sounded (Israel, Schulz, Parker, & Becker, 1998).

According to Israel et al. (1998), research in public health had become focused on the individual and had forgotten the importance of social and environmental factors that influence health. “The emphasis on individual-level risk factors tends to obscure the contributions of social and environmental conditions to health and disease, most visible in the growing gap between the health status of rich and poor, white and non-white.” (Israel et al., 1998, p. 174) She and her

colleagues believed an appropriate framework for addressing these factors, particularly in disenfranchised or understudied communities, was CBPR.

Participatory research, having originated in the social sciences, had a language unfamiliar to public health researchers and practitioners. Therefore, Israel and colleagues, through their work, developed eight guiding principles (Israel et al., 1998) more specific to community and public health for those engaging in what would come to be called CBPR. They later added a ninth principle addressing the longitudinal nature of CBPR relationships (Israel et al., 2003). These principles, detailed in Table 3, have come to be a commonly accepted framework for researchers wanting to engage in CBPR.

The principles detail a partnership approach to research that is equitable, involving researchers, organizational representatives and community members in all aspects of the project (Strickland, 2006); in other words, power is shared. CBPR principles are ideal for research that seeks a more holistic and comprehensive approach to understanding health (Reece & Dodge, 2004). CBPR also encourages capacity building within the communities (Israel, Eng, Schultz, & Parker, 2005) as well as reflects the voices of the community (Israel et al., 2003; M Minkler & Wallerstein, 2003).

CBPR lends itself to conducting research with community-based organizations (CBO). Opposed to a positivist approach to researching CBOs, CBPR helps to ensure the results of research are actionable. Several recent studies have used CBPR to study, for example, disability (M Minkler et al., 2008; Mwachofi, 2007), environmental and occupational health (Cook, 2008; Crowe, Keifer, & Salazar, 2008), asthma (Freeman, Brugge, Bennett-Bradley, Levy, & Carrasco, 2006; Parker et al., 2008), health issues related to aging (Carrasquillo & Chadiha, 2007; Stahl & Hahn, 2007), cancer (Beck, Young, Ahmed, & Wolff, 2007; Tanjasiri, Tran, Palmer, & Valente, 2007) and sexual health (Chung et al., 2005; Reece & Dodge, 2004; Rhodes, Yee, & Hergenrather, 2006; Satinsky et al., 2008). In each of these studies, the focus was on understanding a health disparity and providing empirical information to assist in ameliorating the issue in the community of study.

Table 3 *CBPR principles*

CBPR Principles as Outlined by Israel et al.(2003)
Recognizes community as a unit of identity
Builds on strengths and resources within the community
Facilitates collaborative partnerships in all phases of the research
Integrates knowledge and action for mutual benefit of all partners
Promotes a co-learning and empowering process that attends to social inequalities
Involves a cyclical and iterative process
Addresses health from both positive and ecological perspectives
Disseminates findings and knowledge gained to all partners
Involves a long-term process and commitment

Despite several studies examining sexual health utilizing a CBPR framework, very few have done so for adolescent populations. Of the sexual health studies mentioned above, only Chung et al. (2005) specifically looked at adolescents; however, this study investigated parent-child communication. Wright et al. (1998) utilized a CBPR approach to study adolescent sexuality and the role a CBO played in providing services, education, and information. No other known studies have looked at this subfield of sexual health. However, some have suggested that not only is CBPR a feasible approach to studying sexual health (Reece & Dodge, 2004), community leaders of CBOs focused on adolescents believe community-based participatory research is ideal for better understanding the role of CBOs in providing adolescents with sexual health information and resources.

CHAPTER THREE

METHODS

Background

In the fall of 2007, a community gatekeeper who had been involved in recent research projects with the Center for Sexual Health Promotion approached our research team with a new project of interest to herself, several community leaders, and funding institutions of youth-serving community-based organizations (CBOs) in the state of Indiana. The initial idea was to "assess the challenges and barriers youth workers face in their efforts to promote healthy adolescent sexuality and sexual development."(K. Baldwin, personal communication, January 16, 2008) No known studies have looked at this topic for the intended group of study or for any other group. An intense collaboration would be needed to undertake such a project.

The project required a community-based participatory research (CBPR) approach because 1) results from the study needed to be actionable for community partners, 2) the community had strengths and the capacity needed to develop an appropriate study, 3) the focus of the study was ecological in perspective, and 4) it required recognizing a diverse group of organizations as a unit of identity. Additionally, the gatekeeper had successful experiences with CBPR in past projects. As with many CBPR projects, the process needed to be cyclical and iterative; to plot out a solid, detailed research plan without several rounds of community input would be antithetical to the principles (Israel et al., 2005).

The gatekeeper and research team met in January 2008 to plan the trajectory of the project. The conversation elicited a four phase process: 1) engage the community in conversations about CBO roles in promoting adolescent sexual health and develop a study purpose and research questions, 2) collaborate with the community to design appropriate measures and methods to address the issue, 3) data collection, treatment and analysis, and 4) work with the community to disseminate findings in a mutually beneficial manner.

We developed a synopsis of recent research findings surrounding sexuality education for adolescents in the state of Indiana, a rationale for focusing on youth-serving CBOs, and a statement detailing the CBPR approach to be used (see Appendices A & B). Discussions of best

approaches to engage community leaders from across the state resulted in a recruitment strategy for a community advisory board. It was decided that members should represent a diverse range of youth-serving organizations, and as wide a geographic disbursement as possible. The research team and gatekeeper also decided to aim for a balanced mix of leaders and non-leaders.

The community advisory board held its first meeting in May 2008. The meeting consisted of two sessions of approximately 12 people each lasting about 90 minutes. Members of the board came from a diverse geographic background representing all major sections of the state and represented multiple organizations with varying foci (e.g., HIV, AIDS, lesbian, gay, bisexual, & transgender youth, after-school programs). All participants were paid staff of their organizations.

The advisory board meetings elicited from members what issues, challenges, barriers, and facilitating factors they experienced in their own work to provide some form of sexual health education to adolescents engaged in their programs (for agenda, see Appendix C). The goal of these conversations was to develop the driving research questions of the study, identify potential constructs underlying the issues discussed, and how such information would prove actionable for the community. The gatekeeper and research team facilitated the meetings, taking notes of various topics discussed during the meetings. An assistant to the gatekeeper also wrote various topics and keywords on large post-it paper which was displayed throughout each meeting for board members to refer to during discussion. Each meeting ended with a discussion of potential methods for conducting such a study, and an ideal timeline for conducting data collection given the seasonal nature of youth-serving CBOs.

The gatekeeper's organization, in conjunction with a local foundation, provided transportation reimbursements and incentives for members of the advisory board. Transportation covered standard mileage rates and incentives were distributed to advisory board members via a lottery drawing for one of ten $10 gift cards to a national retailer. The first group was provided a box lunch paid for by the gatekeeper's organization in conjunction with a local foundation. The second group received snacks.

Following the meetings, I analyzed three sets of notes taken by the gatekeeper, my advisor, and myself. Employing a thematic content analysis, I searched notes for common themes regarding issues, challenges, barriers, and facilitating factors to providing some form of sexual health education to adolescents engaged in advisory board members' programs. This grounded theory approach (Charmaz, 2004; Glaser & Strauss, 1967) resulted in themes which provided a laundry list of potential variables to be measured. The variables were consolidated into several constructs which in turn helped to articulate research questions which would address the needs of the community.

A meeting between the gatekeeper and research team occurred in June 2008. The resulting research questions and associated constructs and potential variables were discussed. Following the meeting, appropriate revisions to the research questions and constructs to be measured were made. The resulting study purposes were threefold: 1) to map the role of CBOs in providing sexuality-related information to youth, 2) to understand the current systems for providing sexuality-related in CBOs, and 3) identify facilitating factors and barriers to CBOs providing sexuality-related information. The research questions related to these purposes and constructs to be measured are detailed in Appendix D.

An advisory board meeting, consisting of a subset of the full advisory board, was convened in September 2008. Similar to the first meeting, the second meeting (for agenda, see Appendix E) used a focus group approach. At the meeting, the following topics were discussed: review of the research purposes, questions, and constructs to be measured, preferred type of instrument, inclusion criteria, recruitment strategies, incentives for participation in the study, data collection timing, time commitments from participants, preferred methods for advisory board approval of the final instrument, and desired reporting methods to the board upon completion of data analysis.

The advisory board did not modify the purposes or research questions. The constructs were also not significantly modified; rather, the advisory board provided critical feedback to help clarify and suggest ways of measuring the constructs. The methods that follow are a subset of the larger project described above.

Study purpose

The purpose of this study was to 1) assess the comfort and confidence of youth development professionals working in community-based organizations in the state of Indiana in providing sexuality-related information to young people and 2) describe the role and potential role of community-based organizations in providing sexuality-related information to youth.

Research questions

Research questions to assess comfort and confidence of youth development professionals (YDPs) in providing sexuality-related information to youth were 1) what types of sexuality-related topics do young people ask YDPs about, 2) what are YDPs comfort and confidence in answering those questions, 3) are there correlations and predictability among comfort, confidence, and the topics asked about by youth, and 4) do other variables such as work-related stigma, training, sexual attitudes, and demographics contribute to the prediction of comfort and confidence in answering sexuality-related questions posed by youth.

The following research questions helped to map the role community-based organizations (CBOs) play in providing young people with sexuality-related information: 1) what types of sexuality-related resources, referrals, and programming are currently offered by CBOs, 2) how do CBOs philosophically approach the provision of sexuality-related information to youth, 3) how do YDPs perceive the acceptance by youth of the sexuality-related information they provide, and 4) does the organizational profile of a CBO predict the types of sexuality-related resources, referrals, and programming it provides to youth it serves.

Participant recruitment

Persons invited to participate in the study included anyone, 18 years of age or older, who works or volunteers with an organization (excluding schools) which provides services to youth in the state of Indiana and whose role is related to the service of youth. Youth was defined as adolescents and young adults between the ages of 12 and 21.

The sampling strategy was purposive and convenient. The study purposively targeted YDPs in the state of Indiana. Recruitment strategies included four approaches. The first involved

youth-oriented non-profit organizations; many community-based organizations operate as non-profit organizations in the state of Indiana according to the advisory board. A comprehensive listing of non-profit organizations based on Internal Revenue Service (IRS) filings was utilized to develop a recruitment e-mail list. Filings were searched using the web-based services of GuideStar.com. A keyword search for the term “youth” limited to Indiana non-profits returned 1,517 unique organizations. Of these, 363 had e-mail addresses in the listings provided by GuideStar.com. These organizations received a recruitment message (see Appendix F). Undeliverable e-mails were 101, resulting in 252 e-mails successfully sent. The geographic representation as well as organizational diversity of the 252 organizations was sufficient for the purposes of the study. While purposeful and strategic, this first strategy was ultimately convenient as only organizations that had e-mail addresses were used.

The second strategy utilized a newsletter advertisement (see Appendix F). The organization targeted by the newsletter includes individuals from around the state who have engaged in training activities to further their skills as YDPs. The newsletter is received by 325 people. The third strategy involved use of professional networks. The recruitment e-mail message (see Appendix F) was initially sent to122 YDPs by the primary community contact. Finally, the fourth recruitment strategy involved snowball sampling. All recruitment messages as well as the introduction and thank you statements of the survey included a request that individuals pass along information regarding the study to others who may have qualified to participate. These last three strategies were purposeful but ultimately convenient as they were limited to the professional networks of the people and organizations which made up the sample. Recruitment via the GuideStar.com list was handled by the research team and primary community contact sent out the recruitment message to her personal networks and the 20 members of the advisory board (these 20 included in the 122 YDP e-mails indicated above). The newsletter advertisement was sent twice from the leaders of that organization.

Three rounds of e-mail recruitment were sent to 374 unique e-mail accounts. Each round was sent approximately 2 weeks apart. At 4 weeks into data collection, it was observed that response rates from Lake County (considered a suburb area of the Chicago metropolitan area)

were underrepresented compared to state population statistics. A special round of recruitment targeting organizations was employed yielding an additional 31 e-mail messages being sent during the third wave of recruitment.

For their participation, participants were able to choose a $5 gift card to Starbucks, Wal-Mart, or Target. Participants also had the opportunity to enter a drawing to win 1 of 10 $50 Visa gift cards. Two hundred sixteen people participated in the survey of which of which 169 completed the entire survey; these 169 were used for data analysis.

Data collection

An Internet-based survey was used to collect data. The advisory board, under advisement of the research team, agreed that due to the widely dispersed nature of the community of study, all organizations working with youth throughout the state of Indiana, an Internet-based survey instrument was ideal. Other considerations included cost and time. To employ an interview and/or observational protocol would have required significant amounts of money to cover travel expenses. These methodological options would have also required significant amounts of time, well beyond what the advisory board felt was reasonable given the sense of urgency in capturing actionable information. It was agreed by all members of the collaboration that based on survey results, a future study may be undertaken to gain a greater depth of understanding of the results.

The survey launched in March 2009 and was available for 5 weeks. The advisory board agreed this was an ideal start date due to the seasonal fluctuations of work load typically experienced by youth development professionals. The survey took approximately 20 minutes to complete and was anonymous with the exception that participants had the option of providing the name of the organization with which they work.

Measures

A full copy of the survey can be found in Appendix G. Below is a summary of measures to be included for this dissertation. The larger project contains other items not included here.

Demographics. Two general types of demographics were assessed, 1) individual and 2) organizational. Individual demographics included participant age, gender, race/ethnicity, and educational attainment. Other individual demographics described the role of the participant in the CBO with which they work or volunteer, length of service, and level of interaction with youth served by the CBO. Organizational characteristics included county of operation, type of organization, primary type of work done by the organization as defined by the community advisory board, operating budgets, number of workers/volunteers at the organization, faith-based status, perceived decision-making structure, organizational practices, and age, gender, sexual orientation, and educational attainment of the youth served by the organization.

Questions asked. Questions asked of YDPs may provide an indication of the actual role CBOs currently play in the provision of sexuality-related information to young people. Participants were asked to indicate how often (4-point Likert scale, 1=often, 4=never) they receive questions from youth on a broad range of sexuality-related topics. Topics were the six main categories comprising a comprehensive sexuality education as defined by SEICUS (citation). Table 1 lists these six categories and the definitions as they were presented to participants.

Table 1. *SIECUS topical categories for a comprehensive sexuality education*

Human Development*: Topics include reproductive and sexual anatomy and physiology, reproduction, sexual orientation, and body image and gender identity*
Relationships*: Topic include families and raising children, love, romantic relationships and dating, and marriage and lifetime commitment*
Personal Skills*: Topics include values, decision-making, communication, assertiveness and negotiation, and looking for help*
Sexual Behavior*: Topics include sexuality throughout the lifespan, masturbation, shared sexual behavior, sexual abstinence, human sexual response, sexual fantasy, and sexual dysfunction*
Sexual Health*: Topics include reproductive health, contraception, pregnancy and prenatal care, abortion, sexually transmitted infections and HIV/AIDS, and sexual abuse, assault, violence and harassment*
Society and Culture*: Topics include sexuality and society, gender roles, sexuality and the law, diversity, and sexuality and religion, the media, and the arts*

Comfort and confidence. The advisory board wanted to understand the comfort and confidence of YDPs in addressing sexuality-related questions asked by youth. It is believed comfort and confidence may be an indication of facilitating factors or barriers to CBOs being a provider of sexual health information. Following a similar format to Questions Asked, participants were asked to indicate their comfort (4-point Likert scale, 1=very comfortable, 4=very uncomfortable) in answering questions on the same list of topics. Three additional questions assessed confidence in ability, skills, and knowledge to answer questions on the same list of topics.

Training. All members of the advisory board believed firmly that training was a key component in a YDPs comfort and confidence to answer sexuality-related questions posed by youth. Five questions ascertained training of participants to address sexuality-related questions. Two questions asked about training received, both formal training and information-seeking, on the six topical categories assessed under comfort and confidence and questions asked; options were yes, no, or no response. Another question asked participants to indicate if they had certifications and/or licensures relevant to their position at the youth-serving organization and, if so, what those were. A question on participant interest in training on youth-related sexuality issues (yes/no/no response) was followed up for those indicating yes on what format they would prefer the training to be in and on which topics they were most interested in receiving additional training. Finally, one question sought to discover what sources the participants utilized in trying to stay current on sexuality-related information; items were generated from the community advisory board and participants could check all that applied to them.

Stigma. The advisory board indicated that job-related stigma may play a role in the level of comfort and confidence of YDPs in addressing sexuality-related issues for youth. A 9-item scale, modified from an HIV/AIDS care and prevention worker stigma scale (Reece, Tanner, Karpiak, & Coffey, 2007), looked at the level of stigma participants experience in three domains; working with youth, doing work related to adolescent sexuality, and working in a non-profit organization. Questions include items such as “I feel as though I have to justify to others why my work involves adolescent sexuality” and “I worry what others assume about me because of my

work with youth populations." Response options included always applies to me, sometimes applies to me, rarely applies to me, and never applies to me, as well as a no response option.

Sexual Attitude Scale (SOS). It is likely that sexual attitudes play a role in the comfort and confidence of YDPs to provide sexuality-related information to youth. Therefore, the 5-item short form Sexual Opinion Survey (W. A. Fisher, Byrne, White, & Kelley, 1988) was used to assess participant sexual attitudes. Participants rated their level of agreement (7-point Likert scale; 1=strongly agree, 7=strongly disagree) on statements such as, "Almost all pornographic material is nauseating."

Resources, referrals, and programming. Ascertaining the role of CBOs in providing sexuality-related information to young people necessarily involved mapping the types of resources, referrals, and programming offered by the organization. Participants were asked to indicate the types of resources, referrals, and programming offered by their organization by responding yes, no, unsure, or no response to a list of sexuality-related topics generated by the researchers and community advisory board. These questions were adapted from Tanner et al. (2007). A follow-up question on programming asked participants to indicate all the potential types of programming their organization uses. Options included items like "sessions run by staff/volunteer," "fieldtrips," "peer education," "support groups," and "lectures."

Approach. The philosophical approach of a CBO to sexuality-related information provision was something of great interest to the advisory board. This may help to better describe the varying roles CBOs play in addressing sexuality-related needs of adolescents. The item to measure the approach was drawn from Tanner et al. (2007). Options are derived from school-based options ranging from no sexuality information being provided to young people to a comprehensive approach similar to that delineated by SEICUS. Wording for options were developed by the community advisory board.

Data Management

Data was maintained on a secure server at Indiana University throughout collection. At the close of data collection, all responses were transferred to a file in the Statistical Package for the Social Sciences (SPSS) version 16.0. Server data was destroyed upon verification of a

successful transfer. The data file will be maintained on a restricted shared drive accessible only by the principal investigator, authorized research personnel, and the Institutional Review Board and appropriate federal officials. In accordance with Human Subjects requirements, the data file will be maintained for 3 years.

Adherence to CBPR

As part of the iterative process of CBPR (Israel et al., 1998), below is Table 2, taken from the work of Reece and Dodge (2004), identifying the principles of CBPR and their use across the various phases of this research project.

Table 2. *Application of CBPR Principles by Phase of Research*

Principles of community-based participatory research	Application of principles by research process				
	Research question development	Study design	Participant recruitment	Data analysis	Dissem-ination
CBPR facilitates collaborative, equitable partnerships in all phases of the research	X	X	X		X
CBPR integrates and achieves a balance between research and action for the mutual benefit of all partners	X				X
CBPR recognizes community as a unit of identity		X	X		X
CBPR builds on strengths and resources within the community	X	X	X		X
CBPR promotes co-learning and capacity building among all partners	X	X			X
CBPR involves a long-term process and commitment	X	X			X
CBPR emphasizes local relevance of public health problems and ecological perspectives that recognize and attend to the multiple determinants of health and disease	X	X		X	X
CBPR disseminates findings and knowledge gained to all partners and involves all partners in the dissemination process					X
CBPR involves systems development through a cyclical and iterative process	X	X	X	X	X

CHAPTER FOUR

MANUSCRIPT #1

COMMUNITY-BASED ORGANIZATIONS ROLE IN PROVIDING SEXUAL HEALTH AND SEXUALITY-RELATED INFORMATION TO YOUTH

Community-based organizations role in providing sexual health and sexuality-related information to youth

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Keywords: Adolescent sexuality; Sexual health; Community-based participatory research; community-based organizations; Programming; Youth services; Referrals; Resources

Abstract

Many scholars and practitioners have advocated for a more ecological approach to sexuality education for adolescents in the United States. This approach would include not only schools, but parents and community organizations. Extensive research has been conducted with schools and parents, but little information exists on the role community-based organizations (CBOs) may play in the provision of sexuality-related information to young people.

The purpose of this study was to 1) identify the types of sexual health and sexuality-related questions asked by youth and programming/services, resources, and referrals currently being provided by CBOs, 2) the approach CBOs take or would take in addressing adolescent sexuality, and 3) compare these findings with those from a similar study on school teachers, counselors, and nurses in the same state.

Data were collected from 169 people working in CBOs. The availability of programming/services, resources, and referrals were assessed across a variety of sexuality-related topics as well as perceived philosophical approach of the organization being reported on toward the provision of sexual health and sexuality-related information.

Results indicate a wide variety of topics were covered by CBOs through programming/services, resources, and/or referral protocols. Topics covered varied in frequency. Overall, participants indicated a relatively comprehensive and accessible approach to providing sexuality information to youth.

In considering an ecological approach to providing sexuality information to young people, the results of this study suggest CBOs should be included in the mix of sources. While CBOs should not be the only source of sexuality information, if organizations are supported with information, training, and resources, they could play a valuable role in the advancement of sexual literacy for adolescents.

Community-based organizations role in providing sexual health and sexuality-related information to youth

Introduction

The *Surgeon General's Call to Action to Promote Sexual Health and Responsible Sexual Behavior* (US Department of Health and Human Services, 2001) provided a general, community-wide notice that the sexual health of the nation needed tending. In particular, adolescent sexual health in the US was seeing, and continues to see, alarming rates of sexually transmitted infections (STIs) (CDC, 2007a, 2007b, 2008, 2009; Hall et al., 2008) and unintended pregnancy (Gold, 2006), especially compared to other industrialized nations (Panchaud, Singh, Feivelson, & Darroch, 2000; Singh & Darroch, 2000). Among many recommendations put forth, the call indicated a need for a more holistic, ecological approach to addressing sexual health. In addition to the traditional venues for the promotion of sexual health for adolescents (i.e., schools), the call included recommendations for the engagement of an array of groups including community-based organizations.

Traditional venues for the provision of sexual health and sexuality-related information for youth has primarily included schools (Fisher, 2009; Irvine, 2002; Luker, 2006; Moran, 2000). Research indicates a vast majority of adults want children to receive a comprehensive sexuality education in school (Bleakley, Hennessy, & Fishbein, 2006; Constantine, Jerman, & Huang, 2007; n.a., 2003). Yet not all schools offer it; 35% of schools required to teach sexuality education must teach abstinence as the only option with no conversation on contraception allowed (*Facts on sex education in the United States*, 2006). Additional research has shown schools are often not meeting statutory requirements for sex education (Bandiera, Jeffries, Dodge, Reece, & Herbenick, 2008; Dodge et al., 2008; Landry, Kaeser, & Richards, 1999; Landry, Singh, & Darroch, 2000; Tanner, Reece, Legocki, & Murray, 2007). While policymakers and communities continue to wrestle with how best to provide youth with sexual health and sexuality-related information through schools, consideration of the Surgeon General's call to include other institutions may be worth exploring.

Community-based organizations (CBOs) have a well-documented history of addressing the sexual health and sexuality-related information needs of the communities which they serve (Alstead et al., 1999; Hamdallah, Vargo, & Herrera, 2006; Itzhaky & York, 2001; Kramer et al., 2005; Okwumabua, Glover, Bolden, & Edwards, 2001; Oliva, Rienks, Udoh, & Smith, 2005; Smith & Bride, 2004). However, the focus has typically been on adult populations. To date, little known work has sought to understand the role of CBOs in providing sexual health and other sexuality-related information to youth.

Background

Recently, several community leaders and researchers in the state of Indiana have partnered up and systematically begun addressing various components of an ecologically driven adolescent sexual health campaign. Starting with more traditional venues of sex education, research has shown that, for the state of Indiana, parents overwhelmingly want their children to have accurate information about sexuality and sexual health (Yarber, Milhausen, Crosby, & Torabi, 2005). However, many parents indicate being unsure how to do this within their own parent-child interactions (n.a., 2003). Further research has pointed out that school teachers are engaged in a less than comprehensive approach to sexuality education (Tanner et al., 2007), perhaps due to political and job-security pressures. Yet, there is also an indication that school nurses and counselors may be potential resources for students with questions about sexuality and their sexual health (Tanner et al., 2007).

Community leaders have already begun the work of engaging policy-makers in schools and working with organizations to help parents talk with kids about sexuality. At the same time, many of these leaders have been involved in youth development work in community-based organizations for a number of years and have witnessed moments of sexuality education in their own work with youth. The perspective of these community members held that whether explicit or implicit, community-based organizations and the people in them who work with youth on a regular basis have interactions with young people that impact adolescent sexual health and literacy. From a research perspective, the idea of CBOs having a role in providing adolescents with sexuality-related information was intriguing. However, nothing is known empirically about what

these organizations do when it comes to youth and sex. Thus, a community-based participatory research project was developed to empirically explore the role of CBOs in providing youth with sexual health and sexuality-related information. Specifically, the purpose of this study was to 1) identify the types of sexual health and other sexuality-related questions asked by youth and programming/services, resources, and referrals currently being provided by CBOs, 2) the approach CBOs take or would take in addressing adolescent sexuality, and 3) compare these findings with those from a similar study on school teachers, counselors, and nurses in the same state.

Methods

Procedures

Using a community-based participatory research approach (Israel, Schulz, Parker, & Becker, 1998; Reece & Dodge, 2004; Wallerstein & Duran, 2003), a statewide group of community leaders, youth development professionals, and key stakeholders collaborated to conceptualize and design the study, decide on study constructs and measures, develop recruitment procedures, and interpret the preliminary findings of the study. All data were collected via an internet-based survey. All procedures were approved by the Institutional Review Board at Indiana University Bloomington.

Four strategic strategies were used by the community-academic coalition to recruit a purposive and convenient sample. First, GuideStar.com, a service providing a comprehensive searchable listing of Internal Revenue Service (IRS) registered non-profit organizations, provided a recruitment list of 252 unique e-mails representing a sufficient geographic representation of youth-oriented non-profit organizations. Second, a newsletter advertisement reaching up to 325 individuals was sent by an organization that provides training activities for people working with youth in CBOs. Third, 122 recruitment e-mail message were sent to professional contacts of individuals involved in the development of the study. Finally, a snowball message was included in all recruitment messages encouraging participants to share the study website with others.

Snowball sampling yielded 103 participants (60.9%) and 50 additional participants (29.6%) were recruited from the non-profit e-mail list. The inability to track who saw and/or read the recruitment message and not knowing how much overlap there was in the recruitment messages sent made calculating a response rate difficult; a conservative estimate based on website hits indicated a 40.8% response rate.

As an incentive for their participation, participants were able to choose a $5 gift card to a national retailer and also offered the opportunity to enter a drawing to win 1 of 10 $50 Visa gift cards. Of 216 individuals who participated in the study, 169 completed the entire survey; responses from these 169 participants were used for the analyses presented in this paper.

Measures

Participant characteristics. Characteristics assessed included age, race, gender, and educational attainment. Characteristics related to the individual's role within their CBO included employment status, role in the organization (i.e., executive director, front line worker), length of time at the organization, and level of interaction with youth.

Organizational characteristics. Organizational characteristics measured included non-profit status, annual budget, affiliation with faith-based organizations, age of youth served, name of organization, and county in which the organization operated.

Sexuality questions asked by youth. A 6-item scale assessed the perceived frequency with which participants received questions on sexual health and sexuality-related topics from youth in the course of their work in a CBO. The 6 domains of sexuality-related topical areas defined by SIECUS (2004) comprised the items in the scale and are shown in Table 1. Response options were on a 4-point Likert scale (1= often, 4= never). Participants indicating no interaction with youth in a separate item did not receive this question.

Resources, referrals, and programming/services. Ascertaining the role of CBOs in providing sexual health and sexuality-related information to young people necessarily involved mapping the types of resources, referrals, and programming/services offered by the organization. Resources were defined as informal information giving such as may be found in a pamphlet or poster. Programming/services were more formalized information giving as might be seen in a

workshop or discussion session. Referrals were described as protocols at the organizational level that tells who and where a young person should be referred for a particular issue (i.e., pregnancy testing). Participants were asked to indicate the types of resources, referrals, and programming offered by their organization by responding yes, no, unsure, or no response to a list of sexuality-related topics generated by the researchers and community members. These questions were adapted from Tanner et al. (2007). A follow-up question on programming asked participants to indicate all the potential types of programming their organization uses. Options included items like "sessions run by staff/volunteer," "fieldtrips," "peer education," "support groups," and "lectures."

Approach. The philosophical approach of a CBO to sexual health and sexuality-related information provision was something of great interest to the community. This may help to better describe the varying roles CBOs play in addressing sexual health and sexuality-related needs of adolescents. The item to measure the approach was drawn from Tanner et al. (2007). Options are derived from school-based options ranging from no sexuality information being provided to young people to a comprehensive approach similar to that delineated by SEICUS. Wording for options were developed by community collaborators.

Data Analyses

Data were analyzed utilizing the Statistical Package for the Social Sciences (SPSS) 16.0. Descriptive statistics were performed for all measures of interest. The majority of name-reporting organizations (n = 90, 93.8%) had 1 or 2 respondents each. Participants from the same organization did not always respond the same way to questions focused on the types and format of sexual health and sexuality-related information offered by the organization. While analysis could have been conducted at the organizational level, due to the aforementioned observed variance in responses at the organizational level, the unit of analysis was the individual participant.

Results

Participants

A total of 169 participants completed the survey. Participants mean age was 35.0 (SD = 12.7), were primarily female (n = 131, 77.5%), and white (non-Hispanic; n = 140, 82.8%). A majority were paid staff (n = 140, 82.8) and had a Bachelors degree or above (n = 132, 78.1%). Table 2 provides details of participant characteristics.

Organizations

Participants described the organizations with which they were affiliated as being primarily non-profit (n = 137, 81.1%).The operating budgets for the organization were not known by most (n = 119, 70.4%); for those indicating financial knowledge of the organization (n = 41), annual budgets ranged from $600 to $16.3 million with a median of $347,000 per year. Few organizations reported on by participants considered themselves to be faith-based (n = 34, 20.1%) and few believed religion played a role in the programs offered to youth by the organization (n = 30, 17.8%). However, nearly half (n = 81, 47.9%) had informal ties or affiliations with faith-based organizations. Most participants reported that the youth served by their organizations were primarily in middle or high school (n = 102, 66.2%) and heterosexual (n = 118, 69.8%).

Participants responding to the open-ended question asking for the name of the organization with which they worked or volunteered (n = 143, 84.6%) represented 96 distinct youth-serving organizations. Organizations were geographically distributed somewhat similar to IRS listings of youth-oriented non-profits in the state. The most populous regions of the state where a majority of CBOs operate were well represented; Marion county (Indianapolis) had 56 unique organizations represented (30.8%), Allen county (Fort Wayne) had 10 (10.4%), Tippecanoe county (Lafayette and West Lafayette) had 6 (6.2%), St. Joseph county (South Bend) had 5 (5.2%), Monroe county (Bloomington) had 5 (5.2%), Lake county (Gary) had 4 (4.2%), Clark, Floyd, and Harrison counties (Louisville Metropolitan Statistical Area) had 4 (4.2%), and Vanderburgh county (Evansville) had 3 (3.1%).

Questions asked by youth

Eight participants reported they did not work directly with youth and therefore did not receive this question. All sexual health and sexuality-related topics were reported as being a type of question asked by youth, though to varying degrees. Personal skills (n = 138, 85.7%) and relationships (n = 110, 68.3%) were the most frequently reported type of questions being asked. Conversely, sexual behavior (n = 53, 33.5%) and sexual health (n = 46, 29.1%) questions were never asked. Table 3 summarizes the results of the scale.

Programming/Services and Resources

All sexuality-related topics assessed were described by participants as being covered in the programs, services, or other resources offered by at least some organizations. Table 4 provides details on the frequency with which participants reported each topic being covered under programming/services and resources. Topics most frequently reported by participants as being covered in programming/services included relationship issues (n = 98, 58.0%), alcohol/drugs (n = 96, 56.8), and communication/refusal skills (n = 90, 53.3%). Similarly, participants indicated the same topics being most frequently offered as resources to youth. The format of more formal programming varied with sessions run by a staff or volunteer being the most frequently reported (n = 102, 60.4%). Table 5 details the frequency of formats reported by individual participants.

Referrals

As with programming/services and resources, participants indicated at least some referral protocols in place for all topics assessed. Table 6 details the topics and frequencies. Referral protocols most often reported by participants as being available through their organization included sexual abuse issues (n = 119, 70.4%), domestic violence (n = 106, 62.7%), and psychological distress (n = 99, 58.6). Least available were referrals for abortion (n = 57, 33.3%) and sexual orientation issues (n = 63, 37.3%).

Organizational Approach

Table 7 details frequencies for participants' descriptions of their perceptions of their organization's approach to providing youth with sexual health and sexuality-related information. Just over a quarter reported the belief that their organization would take an abstinence until

marriage approach (n = 43, 25.5%). A majority (n = 115, 68.1%) believed their organization would support access for youth to sexual health and sexuality-related information and accurate answers to any questions on the topic. A little less than a quarter (n = 41, 24.2%) chose not to respond to the question.

Chi-square analyses were conducted to compare programming/services, resources, and referrals across similar topics to assess the comprehensiveness of coverage on any one topic. For all topics, participants indicating their organization had programming/services on a given topic were more likely to also report resources on the same topic (see Table 8). Similarly, participants indicating their organization had referral protocols in place for a particular topic were more likely to also have indicated having programming/services and resources on the same topic (see Table 9).

Discussion

No known empirical information exists to describe the role community-based organizations may play in the provision of sexual health and sexuality-related information to youth. This study explored the role of Indiana CBOs in an attempt to begin to understand what these organizations may be doing around youth and sex. All possible sexual health and sexuality-related information topics available for participants to choose as being asked by youth or offered by their organization through programming/services, resources, and/or referrals were selected, though with varying frequencies. Personal skills and relationships were reported as the types of questions most frequently being asked by youth while more reported not receiving questions related to sexual health and sexual behavior. The most common topics covered in programming/services, resources, and referrals were relationships and sexual abuse. Least frequently covered topics included anatomy, puberty issues, self-exams, abortion and sexual orientation issues. It may be that CBOs are less focused on anatomy, puberty, and self-exams as these may be topics expected to be covered in school health classes. Abortion and sexual orientation issues have historically been more controversial topics and thus may be avoided even

in CBOs unless these topics are a part of their mission (i.e., Planned Parenthood, a gay youth group).

Overall approaches to providing sexuality-related information to young people were perceived to be accurate and accessible. Few organizations were believed by participants to support an abstinence until marriage approach. In fact, based on chi-square analyses, when an organization addressed a topic, they were likely to do so comprehensively by providing programming/services, resources, and referrals for that issue. It may be that not being part of a public school system up for scrutiny at all times allows CBOs to take a more comprehensive approach toward sexuality as they may not be as restricted by federal, state and local policy. It may also be that funders of these CBOs expect a more comprehensive approach when it comes to addressing sexuality concerns of youth.

A prior study conducted by Tanner et al. (2007) in Indiana schools found that teachers reported covering in class to varying degrees the topics covered in this study. Similar to the findings of this study, relationship issues were among the top topics covered, though in classrooms, it was covered by 43.3% of teachers versus 58% in formal programming/services among CBOs in this study. Relationship issues were covered further by resources at CBOs (68.6%). Sexual abuse, another frequently covered topic in this study, while measured, was not reported in the school study. Another topic covered more than others by teachers was HIV/AIDS (48.7%) and STIs (41.7%). In CBOs, reported formal programming for these topics was 32.5% and 30.2%, respectively. Least covered topics in both schools and CBOs, though much less in schools, included abortion (12.0% in schools, 16.6% in programming at CBOs) and sexual orientation (8.1% in schools, 29.0% in programming at CBOs).

Tanner et al. (2007) also asked school personnel to list the most common types of questions received from students related to sexual health and sexuality. Unlike the CBOs in this study, teachers, nurses, and counselors reported the most frequently asked questions were on topics such sexual behavior (26.2%) and pregnancy and contraception (22.3%). Participants of this study indicated they were more likely to get questions on personal skills and relationships.

In comparison to schools in Indiana, as a percentage, more CBOs appear to provide sexuality-related information to youth on several topics. It may be that schools are better equipped to address some topics such as HIV/AIDS with CBOs providing supplemental information through resources and referrals. Conversely, CBOs may be better positioned to provide programming to young people on more controversial topics such as sexual orientation and abortion. Data also seem to suggest that young people may be going to school personnel for some types of information and feel more comfortable going to people working in a community-based organization for other types of information. It may be that CBOs should be considered a vital and necessary component in an ecological approach to the provision of sexual health and sexuality-related information to youth.

There were several limitations to this study. The measurement of topics covered did not give an indication of the context in which the topic was covered. For example, a CBO may provide programming to youth on condoms; what is not known is what is being said about condoms (i.e., they are effective at preventing pregnancy). The study was conducted specifically for the state of Indiana. While findings may be indicative of what may be found in other states, it is also likely that other states with different CBOs will produce different results. For this reason, community-based participatory research methods may be ideal for studies of this nature. The unit of analysis for this paper was the individual participant. Most organizations were represented by only 1 or 2 participants making it difficult to provide a full picture of multiple organizations for comparison. Future studies should look to more systematically and strategically gather data from multiple individuals in a single organization with varying levels of responsibilities across multiple organizations to provide a more comprehensive assessment of CBO involvement in the provision of sexuality-related information to the young people they serve. Finally, while participants and the CBOs they worked for were relatively well distributed geographically, the sample was ultimately one of convenience. There may be characteristics of those choosing not to respond that may be indicative of the types of people and organizations that may not provide or be supportive of providing sexuality-related information to the youth they serve. Future studies should attempt to

ascertain the context of programming/services, resources, and referrals, explore other communities outside Indiana, and attempt to collect data from a wider array of organizations.

It should be noted the core beliefs of the community which helped to design this study professed a belief that CBOs should be engaged in the work of educating youth about sexual health. The aim of this study was to explore and map out the roles CBOs might play in this work. Ultimately, it is likely the questions asked of participants as well as those who chose to participate in the study held true to the assumption that CBOs could or should be explicit in their role in young peoples' development into healthy sexual adults.

In considering an ecological approach to providing sexuality information to young people, the results of this study suggest CBOs should be included in the mix of sources. This study shows that youth are asking questions in CBOs and people are delivering services via CBOs to youth. Sexual health advocates may need to consider CBOs a more essential component of our adolescent sexual health promotion initiatives; many of the sexual health topics parents want for their children (i.e., comprehensive sexuality education) are not or cannot be fully provided for by schools. While CBOs should not be the only source of sexuality information, if organizations are supported with information, training, and resources, they could play a valuable role in the advancement of sexual literacy for adolescents.

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Table 1.

Description of SEICUS Primary Sexuality Education Areas

Category	Definition
Human Development	Topics include reproductive and sexual anatomy and physiology, reproduction, sexual orientation, and body image and gender identity
Relationships	Topics include families and raising children, love, romantic relationships and dating, and marriage and lifetime commitment
Personal Skills	Topics include values, decision-making, communication, assertiveness and negotiation, and looking for help
Sexual Behavior	Topics include sexuality throughout the lifespan, masturbation, shared sexual behavior, sexual abstinence, human sexual response, sexual fantasy, and sexual dysfunction
Sexual Health	Topics include reproductive health, contraception, pregnancy and prenatal care, abortion, sexually transmitted infections and HIV/AIDS, and sexual abuse, assault, violence and harassment
Society and Culture	Topics include sexuality and society, gender roles, sexuality and the law, diversity, and sexuality and religion, the media, and the arts

Table 2.
Characteristics of Participants(N = 169)

Characteristic	n	%
Gender		
Female	131	77.5
Male	36	21.3
Other	2	1.2
Race/Ethnicity		
White, Non-Hispanic	140	82.8
African-American/Black	21	12.4
Asian/Pacific Islander	2	1.2
Other	5	3.0
No Response	1	0.6
Education		
High School or GED	1	0.6
Some College	23	13.6
Associates Degree	10	5.9
Bachelors Degree	93	55.0
Masters Degree	34	20.1
Professional (M.D., J.D., PhD)	4	2.4
Other	4	2.4
Length of Employment/Volunteering		
Less than 6 months	15	8.9
More than 6 months but less than 1 year	19	11.2
1-2 years	40	23.7
3-4 years	23	13.6
5+ years	71	42.0
No Response	1	0.6
Role in CBO		
Front-line service provider (e.g., programming coordinator)	89	52.7
Leadership capacity (e.g., Executive Director)	62	36.7
Other	12	7.1
Administrative capacity (e.g., administrative assistant)	5	3.0
No Response	1	0.6
Level of Youth Interaction		
Daily	68	40.2
2-3 times per week	51	30.2
Once a week	21	12.4
2-3 times a month	9	5.3
Once a month	7	4.1
Less than once a month	3	1.8
Does not interact directly with youth	8	4.7
No Response	2	1.2

Table 3.
Frequency reported by participants of questions asked by SEICUS topical categories (N = 161)

	Often		Sometimes		Occasionally		Never	
SEICUS Topical Categories	n	%	n	%	n	%	n	%
Human Development (n = 159)	39	24.6	29	18.2	55	34.6	36	22.6
Relationships (n = 159)	66	41.5	44	27.7	34	21.4	15	9.4
Personal Skills (n = 159)	93	58.5	45	28.3	18	11.3	3	1.9
Sexual Behavior (n = 158)	34	21.5	32	20.3	39	24.7	53	33.5
Sexual Health (n = 158)	38	24.1	28	17.7	46	29.1	46	29.1
Society & Culture (n = 158)	33	20.9	42	26.5	51	32.3	32	20.3

Table 4.
Frequency of programming/services and resources by topic (N = 169)

	Programming/Services		Resources	
Topic	n	%	n	%
Relationship Issues	98	58.0	116	68.6
Alcohol/Drugs	96	56.8	113	66.9
Communication/Refusal Skills	90	53.3	108	63.9
Body Image	75	44.4	94	55.6
Sexual Abuse	73	43.2	101	59.8
Sexual Decision Making	72	42.6	88	52.1
Abstinence	69	40.8	89	52.7
Pregnancy	56	33.1	77	45.6
HIV/AIDS	55	32.5	84	49.7
Gender issues	55	32.5	72	42.6
Condom Use/Safer Sex	53	31.4	64	37.9
Other STIs	51	30.2	79	46.7
Contraception	50	29.6	70	41.4
Sexual Orientation Issues	49	29.0	66	39.1
Puberty Issues	47	27.8	65	38.5
Reproductive Anatomy	37	21.9	58	34.3
Abortion	28	16.6	43	25.4
Breast/testicular self exams	25	14.8	46	27.2

Table 5.
Frequency of programming formats (N = 169)

Format of programming	n	%
Session run by staff/volunteer	102	60.4
Classes - several sessions	75	44.4
One time event	67	39.6
Panel/Guest speaker	62	36.7
Peer education	55	32.5
Discussion groups	54	32
Support groups	47	27.8
Leadership development	44	26
Lecture	38	22.5
Peer counseling	36	21.3
Fieldtrip	35	20.7
Homework/Parent Involvement	32	18.9
Online Resources	30	17.8

Table 6.
Frequency of referrals by topic (N = 169)

Topic	n	%
Sexual Abuse Issues	119	70.4
Domestic Violence	106	62.7
Psychological Distress	99	58.6
Relationship Counseling	91	53.8
Pregnancy Counseling	77	45.6
STIs	76	45.0
Pregnancy Testing	75	44.4
Spiritual Counseling	72	42.6
HIV Testing or Services	70	41.4
Financial Support for Teen Parents	70	41.4
Contraception	68	40.2
Sexual Orientation Issues	63	37.3
Abortion	57	33.7

Table 7.
Organizational approach to adolescent sexuality education

Description of approach	n	%
Young people should be ***discouraged from having sex until marriage*** and providing them with ***information about sexuality is a confusing mixed message*** that should be avoided	2	1.2
Young people should be discouraged from having sex until marriage and ***should not have easy access to information***. However, any ***questions they ask regarding sexuality should be answered accurately***	11	6.5
Young people should be discouraged from having sex until marriage. They ***should have access to information*** about sexuality and any ***questions they ask should be answered accurately***	30	17.8
Young people should be ***discouraged from having sex until adulthood***. They should have access to information about sexuality and any questions they ask should be answered accurately	37	21.9
Young people should be ***encouraged to reduce risks when they have sex***. They should have access to information about sexuality and any questions they ask should be answered accurately	48	28.4
No Response	41	24.2

Table 8.

Chi-square results of programming/services compared to resources by topic

Topic	df	n	χ^2	*p*
Relationship Issues	1	144	50.127	<0.01
Alcohol/Drugs	1	147	39.293	<0.01
Communication/Refusal Skills	1	141	46.171	<0.01
Body Image	1	139	36.596	<0.01
Sexual Abuse	1	140	38.897	<0.01
Sexual Decision Making	1	139	58.375	<0.01
Abstinence	1	139	49.784	<0.01
Pregnancy	1	137	32.331	<0.01
HIV/AIDS	1	135	48.191	<0.01
Gender issues	1	132	34.797	<0.01
Condom Use/Safer Sex	1	136	67.827	<0.01
Other STIs	1	134	57.322	<0.01
Contraception	1	138	43.365	<0.01
Sexual Orientation Issues	1	134	45.339	<0.01
Puberty Issues	1	133	30.770	<0.01
Reproductive Anatomy	1	132	42.802	<0.01
Abortion	1	133	29.713	<0.01
Breast/testicular self exams	1	131	47.927	<0.01

Table 9.
Chi-square results of referral topics compared to similar programming/services and resources by topic

Topic	df	n	Programming/Services X^2	Programming/Services *p*	Resources X^2	Resources *p*
Relationship Counseling	1	130	7.958	<0.01	26.425	<0.01
Sexual Abuse Issues	1	126	18.078	<0.01	35.834	<0.01
Pregnancy Counseling*	1	116	22.817	<0.01	34.706	<0.01
Pregnancy Testing*	1	119	21.092	<0.01	42.128	<0.01
HIV Testing or Services	1	117	12.282	<0.01	33.436	<0.01
STIs	1	116	26.636	<0.01	41.455	<0.01
Contraception	1	123	23.268	<0.01	32.315	<0.01
Sexual Orientation Issues	1	114	24.542	<0.01	35.584	<0.01
Abortion	1	117	12.571	<0.01	25.596	<0.01

CHAPTER FIVE

MANUSCRIPT #2

EXPANDING OUR REACH: THE POTENTIAL FOR YOUTH DEVELOPMENT PROFESSIONALS IN COMMUNITY-BASED ORGANIZATIONS TO PROVIDE SEXUALITY INFORMATION

Expanding our reach: The potential for youth development professionals in community-based organizations to provide sexuality information

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Keywords: Adolescent sexuality; Sexual health; Community-based participatory research; community-based organizations; Comfort; Confidence; Skills; Knowledge; Training

Abstract

Adolescents in the United States continue to face sexual health issues. While community-based organizations (CBOs) have a long history of addressing the sexual health needs of those they serve, little attention has been given to CBOs focused on adolescent populations and the role youth development professionals (YDPs) may play in the advancement of sexual health.

The purpose of this study was to assess the potential of YDPs to provide sexuality information to youth by 1) determining the frequency and type of questions YDPs receive from youth on sexuality, and 2) ascertaining the perceived comfort, confidence, skills, and knowledge of YDPs in answering questions from youth and characteristics that might be predictive of increased levels of comfort, confidence, skills, and knowledge.

Utilizing a community-based participatory research process that engaged the researchers with leaders, key stakeholders, and youth development professionals from community-based organizations throughout the state, data were collected from 169 YDP in Indiana.

YDPs received questions from youth on a broad array of sexuality-related topics with personal skills and relationships being the most frequent topics. YDPs had high levels of comfort, confidence, skills, and knowledge (CCSK) in addressing questions from youth about sexuality. Training, both formal classroom-type training and more informal practices such as advice-seeking from a professional, was the only factor predictive of higher levels of CCSK.

Results indicate that YDPs may play an important role in providing sexuality information to youth. Communities interested in ameliorating disparities among youth may want to consider including CBOs and YDPs in an ecological approach to sexual health education.

Expanding our reach: The potential for youth development professionals in community-based organizations to provide sexuality information to youth

Introduction

Adolescents in the United States continue to confront a range of issues related to sexual health. The Centers for Disease Control and Prevention (CDC) continues to report that youth face challenges with sexually transmitted infections such as chlamydia (CDC, 2007b) and gonorrhea (CDC, 2007a), genital warts (CDC, 2007a), and Human Immunodeficiency Virus (HIV) (CDC, 2008, 2009; Hall et al., 2008). US adolescents also continue to experience high rates of unintended pregnancy (Gold, 2006). Beyond the typical sexual health issues of pregnancy and STIs seen among adolescent populations, research indicates a broad array of issues related to sexuality and health. For example, lesbian, gay, bisexual, and transgender (LGBT) youth continue to experience high rates of verbal and physical harassment as well as physical assault both in and out of school (Kosciw & Diaz, 2005).

Few would deny there is much work to be done to improve the sexual health of US adolescents. More contentious a debate is where to address these issues (Fisher, 2009; Irvine, 2002; Luker, 2006; Moran, 2000). Historically, a majority of the debate has focused on the role of schools and teachers (Irvine, 2002; Luker, 2006) with a minor discourse on the function of the medical community, such as pediatricians and nurses (Moran, 2000). The last 20 years has seen an increase in community-based organizations (CBOs), and the professionals working in them, who work with sexual health issues, primarily in adult populations. CBOs have done sexual health work around HIV and AIDS (Hamdallah, Vargo, & Herrera, 2006; Oliva, Rienks, Udoh, & Smith, 2005; Smith & Bride, 2004), unintended pregnancy (Kramer et al., 2005; Simkin, Radosh, Nelsesteun, Silverstein, & Academy for Educational Development, 2003), STDs (Alstead et al., 1999; Okwumabua, Glover, Bolden, & Edwards, 2001), and sexual violence (Itzhaky & York, 2001; Specktor, Stafford, & Minnesota State Dept. of Corrections St Paul, 1988). A few researchers have looked at CBOs working with the sexual health needs of specific adolescent populations such as lesbian, gay and bisexual youth (see for example Wright, Gonzalez, Werner,

Laughner, & Wallace, 1998). However, little is known about youth development professionals (YDPs), individuals whose primary job is working with youth in some capacity that impacts their physical, mental, and/or psycho-social development, and their roles in addressing adolescent sexual health issues. More specifically, little empirical information exists regarding the qualifications and abilities of youth development professionals (YDPs) to talk to youth about their sexual health.

In considering the qualifications and abilities of professionals who work with a diverse array of issues related to sexual health (i.e., not just STDs or pregnancy), many have written about the importance of comfort, confidence, skills, and the knowledge to do so. In the field of nursing, it has been suggested that educational programming focused on increasing nurse's comfort and confidence would improve their ability to deal with issues related to their patients' sexuality (Higgins, Barker, & Begley, 2008; Magnan, Reynolds, & Galvin, 2006). Similarly, studies looking at the role of physicians indicated a need to increase the skills (Boekeloo et al., 1991), comfort (Figueroa et al., 1991; Torkko, Gershman, Crane, Hamman, & Baron, 2000; Yudkowsky, Downing, & Ommert, 2006), and confidence (Figueroa et al., 1991) for physicians to properly address the sexual health needs of their patients. In the classroom, it has been suggested that the comfort and confidence of a teacher to discuss sexual health topics is paramount to successfully educating students on such issues (Ahmed et al., 2006; Haignere, Culhane, Balsley, & Legos, 1996; Hamilton & Gingiss, 1993). Finally, studies examining parent-child communications on sexuality topics have found that comfort (Ballard & Gross, 2009; Jordan, Price, & Fitzgerald, 2000; Miller & Whitaker, 2001; Pluhar, DiIorio, & McCarty, 2008; Thomas, Flaherty, & Binns, 2004), confidence (Ballard & Gross, 2009), skills (Miller & Whitaker, 2001; Pluhar et al., 2008), and knowledge (Jordan et al., 2000; Miller & Whitaker, 2001) are all important components for assessing the success of these interactions. However, information on these issues in youth-serving CBO's is lacking.

Background

Recent research into the provision of sexual health information for Indiana youth has demonstrated public schools may not be adequately addressing their needs (Tanner, Reece,

Legocki, & Murray, 2007) despite parents wanting their children to have information on sexual health (Santelli et al., 2006). Further, little to no information exchange between Indiana parents and their children appears to be occurring (n.a., 2003). The politically treacherous terrain of sex education in the schools (C. M. Fisher, 2009; Irvine, 2002; Luker, 2006; Moran, 2000) and the difficulty of reaching out to parents has left many community leaders to ponder the role of YDPs in CBOs, given their history of providing services in other areas, to provide sexual health information to adolescents in Indiana. However, little is known about how YDPs and CBOs can and/or do interface with parents and schools. Leaders in the community came together to design a study to assess whether there might be a role for CBOs to be a part of an ecological approach that provides sexuality information to adolescents

This study was part of a larger community-based participatory project conducted by and for CBOs in the state of Indiana. The purpose of this study was to assess the potential of YDPs to provide sexuality information to youth by 1) determining the frequency and type of questions YDPs receive from youth on sexuality, and 2) ascertaining the perceived comfort, confidence, skills, and knowledge of YDPs in answering questions from youth and characteristics that might be predictive of increased levels of comfort, confidence, skills, and knowledge.

Methods

Procedures

A group of community leaders, youth development professionals, and key stakeholders from around the state of Indiana met several times to conceptualize the study, design it, collectively decide on study constructs and measures, and develop recruitment protocols. This group also pilot-tested the 20 minute Internet-based survey. All procedures were approved by the Institutional Review Board at Indiana University Bloomington.

The sampling strategy was purposive. Recruitment strategies included four approaches. A comprehensive listing of Indiana youth-serving non-profit organizations based on Internal Revenue Service (IRS) filings from GuideStar.com was utilized to develop a recruitment list of 252 unique e-mails. The geographic representation as well as organizational diversity of the 252

organizations was sufficient for the purposes of the study. The second strategy utilized a newsletter advertisement which reaches 325 individuals from around the state who have engaged in training activities to further their skills as YDPs. The third strategy involved use of the professional networks of the community advisory board; the recruitment e-mail message was sent to122 YDPs. Finally, the fourth recruitment strategy involved snowball sampling. Three rounds of e-mail recruitment were sent to both the non-profit e-mail list and professional networks while two newsletters contained the recruitment advertisement. Snowball sampling yielded the largest number of participants (n = 103, 60.9%) followed by the non-profit e-mail list (n = 50, 29.6%). Response rates were difficult to estimate due to the large number of snowball participants, the inability to track who saw and/or read the recruitment message, and not knowing how much overlap there was in the recruitment messages sent; a conservative estimate based on website hits indicated a 40.8% response rate.

For compensation, participants were able to choose to receive a $5 gift card to a national retailer. Participants also had the opportunity to enter a drawing to win 1 of 10 $50 Visa gift cards. Of 216 individuals who participated in the study, 169 completed the entire survey; responses from these 169 participants were used for the analyses presented in this paper.

Measures

Participant characteristics. Characteristics of participants measured included age, race, gender, and educational attainment. Characteristics related to the individual's role with the CBO being reported on in the survey included employment status, role in the organization (i.e., executive director, front line worker), length of time at the organization, and level of interaction with youth.

Sexuality questions asked of YDPs. A 6-item scale assessed the perceived frequency with which participants received questions on sexuality-related topics from youth in the course of their work in a CBO. Each item represented 1 of the 6 domains of sexuality-related topical areas defined by SIECUS (2004) as shown in Table 1. Response options were on a 4-point Likert scale (1= often, 4= never). Participants indicating no interaction with youth in a separate item did not receive these questions.

Comfort, confidence, skills, and knowledge. The research team and community advisory board developed measures based on the work of Tanner et al. (2007) to assess the constructs of perceived comfort, confidence, skills and knowledge of YDPs in answering sexuality-related questions from youth. The 24-item scale included items to assess each of the four constructs of interest (comfort, confidence, skills, and knowledge); within each construct items were mapped to the 6 domains of sexuality-related topical areas defined by SIECUS (2004) and shown in Table 1 (Dodge et al., 2008). Each subscale had a potential of 6 to 24 points, with 24 being high comfort, confidence, skills, or knowledge. Participants were asked to rate themselves on each topical area for each construct (4-point Likert scale, 1= very uncomfortable / not confident / not skilled / no knowledge, 4= very comfortable / confident / skilled / knowledgeable about). All four sub-scales had good internal consistency (comfort $\alpha = 0.89$, confidence $\alpha = 0.91$, skills $\alpha = 0.89$, and knowledge $\alpha = 0.84$). The scale on comfort, confidence, skills, and knowledge, called the CCSK scale, had very good internal consistency ($\alpha = 0.95$).

Training. Four questions ascertained the construct of training on sexuality-related topics. These included 1) training received, both formal training and information-seeking, on the six topical categories in Table 1 (yes / no), 2) certifications and/or licensures relevant to their position at the youth-serving organization (yes / no), 3) interest in training on youth-related sexuality issues (yes / no), and 4) sources utilized in trying to stay current on sexuality-related information (check all that apply from a list of items generated by the community advisory board).

Stigma. A 9-item scale, modified from an HIV/AIDS care and prevention worker stigma scale (Reece, Tanner, Karpiak, & Coffey, 2007) measured levels of stigma participants experienced in three domains, including: feeling the need to justify their work, embarrassment felt in their work, and worry about perceptions of others . Questions include items such as “I feel as though I have to justify to others why my work involves adolescent sexuality” and “I worry what others assume about me because of my work with youth populations.” Response options included always applies to me, sometimes applies to me, rarely applies to me, and never applies to me, as well as a no response option. Internal consistency was acceptable ($\alpha = 0.77$).

Sexual Attitude Scale. The 5-item short form Sexual Opinion Survey (Fisher, Byrne, White, & Kelley, 1988) was used to assess participant sexual attitudes. Participants rated their level of agreement (7-point Likert scale; 1=strongly agree, 7=strongly disagree) on statements such as, "Almost all pornographic material is nauseating." Scoring for the SOS results in a range from 0 being the most erotophobic to 30 being the most erotophilic, which is typically associated with more sex-positive attitudes. Internal consistency was good (α = 0.80).

Data Analyses

Data were analyzed utilizing the Statistical Package for the Social Sciences (SPSS) 16.0. Descriptive statistics were performed for all measures of interest. CCSK scores were analyzed against several variables using t-tests, ANOVA, bivariate correlational analysis, and a multiple regression analysis.

Results

Participants

A total of 169 participants completed the survey. The mean age of participants was 34.96 (SD = 12.71). They were paid staff (n = 140, 82.8%) and came from across the state of Indiana in relative proportion to the distribution of youth-serving community based organizations according to IRS non-profit listings. Participants were predominately female (n = 131, 77.5%), white (non-Hispanic; n = 140, 82.8%), and had at least a Bachelors degree (n = 132, 78.1%). Table 2 provides details of participant characteristics.

Questions asked

Eight participants indicated they did not interact with youth as part of their work with a CBO. Topical areas in which participants most often or sometimes received questions from youth included personal skills (n = 138, 85.7%) and relationships (n = 110, 68.3%). Sexual behavior and sexual health questions received the lowest endorsement with never being selected 33.5% (n = 53) and 29.1% (n = 46), respectively. Table 3 summarizes the results of the scale.

Comfort, confidence, skills, and knowledge (CCSK)

Table 4 shows CCSK mean scores and sub-scale mean scores for each of the six SIECUS topical categories. Overall, participants indicated high levels of perceived comfort (M = 20.87, range 10 to 24), confidence (M = 19.79, range 7 to 24), skills (M = 20.87, range 8 to 24), and knowledge (M = 20.63, range 11 to 24). Standard deviations, as seen in Table 3, indicate the majority of participants scored high on all subscales. Participants were most comfortable, confident, skilled, and knowledgeable in talking with youth about relationships and personal skills while scoring lowest on doing the same for the topics of sexual behavior and sexual health. Overall, participants were lowest in confidence in talking with youth about sexuality. Bivariate correlational analysis revealed that all four sub-scales were significantly correlated (r = 0.596 to 0.825, $p < 0.01$).

Training

Many participants indicated they had received some type of training on each of the six sexuality topics in the past 5 years. Table 5 provides an overview of the extent to which participants had received training on each topic. A majority also indicated an interest in receiving more training on how to deal with youth-related sexuality issues (n = 118, 68.8%). For those interested in more training, the most preferred format for training indicated was a ½-day workshop (n = 80, 67.8%), followed by self-guided online classes and full-day workshops (n = 61, 51.7% for each), continuing education classes for CE credit (n = 51, 43.2%), and instructor-led online classes (n = 42, 35.6%). Least preferred formats were weekend retreats (n = 29, 24.6%) and college degree or certificate programs (n = 30, 25.4%). Sources used by participants to stay current on sexuality-related information included the Internet (n = 111, 65.7%), seminars, workshops, and/or in-services (n = 88, 52.1%), popular media such as newspapers or magazines (n = 79, 46.7%), and academic journals (n = 73, 43.2%).

Analysis of variance with Tukey's honestly significantly different (HSD) post-hoc analyses were conducted to assess variation among scores for each CCSK sub-scale across types of training received (formal training, information-seeking, both formal training and information-seeking, or no training) for the each topic. For example, ANOVA was conducted on CCSK scores

for human development against types of training received in human development. No significant variations were found. However, as reported in Table 6, some significant variations were found for total CCSK scores across each SIECUS domain. In particular, for each domain, total CCSK scores varied significantly between those reporting both formal training and information-seeking on the topic and those who indicated no training. Tukey's HSD post-hoc testing revealed CCSK scores were significantly higher for those with both types of training.

Stigma and sexual attitudes

The majority of participants did not indicate perceived or felt stigma in regards to feelings of embarrassment or worrying about perceptions of others. There were greater levels of perceived stigma in having to justify the work they do in non-profits (mean = 1.86, SD = 0.94), with youth (mean = 1.92, SD = 0.96), and with adolescent sexuality (mean = 1.84, SD = 0.93). With regards to sexual attitudes (SOS scores), participants, overall, leaned slightly towards being more erotophobic (mean = 13.80, SD = 6.65). Bivarate correlational analyses revealed no significant relationship between the CCSK scores and stigma scores. Conversely, a small significant correlation with SOS scores was found ($r = 0.248$, $p < 0.01$) indicating more sex-positive attitudes correlated to higher CCSK.

Predicting CCSK

Age, race, gender, educational attainment, frequency of interaction with youth, employment status with the youth-serving organization participants were reporting on, and sexual attitudes were entered into a multiple regression model. While the total model was non-significant for predicting CCSK, employment status emerged from the model as mildly correlated with higher CCSK ($r = 0.164$, $p < 0.05$).

Discussion

The purpose of this study was to assess the potential of YDPs to provide sexuality information to youth by 1) determining the frequency and type of questions YDPs receive from youth on sexuality, and 2) ascertaining the perceived comfort, confidence, skills, and knowledge of YDPs in answering questions from youth and characteristics that might be predictive of

increased levels of comfort, confidence, skills, and knowledge. YDPs indicated that all SIECUS categories were covered in questions asked of them by youth with relationships and personal skills being the most frequently asked. While sexual behavior and sexual health were the least frequently asked topics, there was still a substantial number of participants indicating that, at least occasionally, these were topics of inquiry from youth. It is likely that, based on questions asked, YDPs may be able to play an important role in an ecological approach to sexuality information provision to youth. It is also likely that the work YDPs do has an impact on the sexual literacy of the young people they serve, even if they do not necessarily consider the work they do to be sexuality-related. Many of the topics labeled by SIECUS as sexuality-related have to do with issues that many others would not necessarily considered (i.e., relationships, communication skills).

Overall, YDPs in the community-based organizations surveyed had high levels of CCSK. As indicated by other research, these four constructs are important for the provision of sexual health information. It is likely that YDPs would be good providers of sexual health information to adolescents based on their high levels of CCSK. No characteristics appeared to be predictive of higher levels of CCSK.

Areas where there may be room for further training and development include the categories of sexual behaviors and sexual health. These areas had lower rates of comfort, confidence, skills, and knowledge. Concepts described in the SIECUS guidelines (SIECUS, 2004) for these categories include HIV/AIDS, sexually transmitted infections, abortion, contraception, and pregnancy. The public health community may want to consider additional training efforts for YDPs in these areas as a method of ameliorating sexual health disparities among youth. Based on results, it may be the case that training on any sexuality-related topic for YDPs would provide an increase in overall CCSK, thus improving their potential to address sexuality-related information needs of the youth they serve.

Participants indicated that their preferred methods for receiving such training include half- to full-day workshops and internet courses. The higher number of participants seeking information via informal sources indicates that the internet may be a good vehicle for delivering training.

Overall, participants were relatively moderate in their sexual attitudes. While there were trends to suggest that sexual attitudes and being a paid YDP were correlated with CCSK, they were weak trends. Stigma was not significantly correlated with CCSK score. This may be due to the fact that participants in this study did not indicate high levels of perceived stigma. In fact, of the three main areas of stigma measured, participants only indicated a perceived need to justify their work with youth, in non-profits, and around adolescent sexuality. There was almost no perceived stigma related to embarrassment or concern over what others might think of someone working in this field. It may be that those responding to the survey were in fact very proud of the work they did and did not mind explaining their job to others.

While it would stand to reason that an individual whose career is to work with youth may have higher CCSK than a volunteer, the correlation in this study was weak. It is possible this was due to the large number of paid YDPs participating in the study. Likely, there were characteristics not measured in this study which may be predictive of CCSK among YDPs. The findings of this study suggest that perhaps the most effective strategy for improving CCSK, and subsequently the potential for YDPs to be a sexual health resource for adolescents, lies in additional and on-going training.

There were several limitations to the current study. The potential for bias existed in the recruitment and data collection methods. Recruitment occurring through e-mail necessarily excluded YDPs without e-mail. Likewise, YDPs without any Internet access or even access to a computer with Internet in a sufficiently private environment may have left some without the ability to participate. This “e-limitation” was deemed acceptable by the community members who helped to develop the study; it was their belief that most YDPs would have access to e-mail and the Internet.

The survey identified information-seeking as informal training which was broadly defined as looking up information on one’s own, such as using the Internet or consulting an expert. In retrospect, this nomenclature may have been a potential bias based on the wording of the question, though a thorough definition was provided. Additionally, the survey was not able to assess what type of information was being accessed during training. There were much higher

levels of information-seeking than formal training which may lead to concerns about the accuracy of information being found, particularly on the Internet. This could in turn lead to a false sense of high CCSK that leaves YDPs providing youth inaccurate information on sexuality.

A strength of the study was its community-based participatory nature. The focus on Indiana YDPs was appropriate as this was the community of interest defined by the community itself (Israel, Schulz, Parker, & Becker, 1998; Reece & Dodge, 2004). The specific results may be limited to Indiana; however, the concept of CCSK and its measurement may be useful in studies of other communities.

An interesting finding in this study was that a majority of YDPs were female (n = 131, 77.5%). This number was not surprising to the researchers or the community leaders involved in the study. It has been suggested elsewhere that when it comes to discussions about sexuality-related information, boys are often muted in the conversations (see for example Tolman, Striepe, & Harmon, 2003). As CBOs and YDPs become more engaged in an ecological approach to sexuality information provision, development of more programs specifically focused on boys may be needed. Accordingly, the workforce may need to expand in order to increase the extent to which more men are actively involved in the development and implementation of programs for boys.

Future research should look to expand the geographic scope of study. Indiana may be a unique site due to its location in the mid-western United States and relatively large number of rural communities. It is likely that a CBPR project conducted in a different community would look different in order to meet the needs of the community of study. Due to the varied nature of values surrounding youth and sexuality, it may be essential for studies of this nature to use CBPR methods. Additionally, based on the high level of inter-item correlation for the CCSK sub-scales, validation of the total scale should be conducted with other populations. More in-depth research may also be warranted to better understand details of the training in sexuality-related topics received by YDPs; it is likely that different types of training, both pedagogically and contextually, may contribute to CCSK as well as provide differing messages to youth.

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Table 1.

Description of SIECUS Primary Sexuality Education Areas

Category	Definition
Human Development	Topics include reproductive and sexual anatomy and physiology, reproduction, sexual orientation, and body image and gender identity
Relationships	Topics include families and raising children, love, romantic relationships and dating, and marriage and lifetime commitment
Personal Skills	Topics include values, decision-making, communication, assertiveness and negotiation, and looking for help
Sexual Behavior	Topics include sexuality throughout the lifespan, masturbation, shared sexual behavior, sexual abstinence, human sexual response, sexual fantasy, and sexual dysfunction
Sexual Health	Topics include reproductive health, contraception, pregnancy and prenatal care, abortion, sexually transmitted infections and HIV/AIDS, and sexual abuse, assault, violence and harassment
Society and Culture	Topics include sexuality and society, gender roles, sexuality and the law, diversity, and sexuality and religion, the media, and the arts

Table 2.

Characteristics of Participants

Demographics	n	%
N = 169		
Gender		
Female	131	77.5
Male	36	21.3
Other	2	1.2
Race/Ethnicity		
White, Non-Hispanic	140	82.8
African-American/Black	21	12.4
Asian/Pacific Islander	2	1.2
Other	5	3.0
No Response	1	0.6
Education		
High School or GED	1	0.6
Some College	23	13.6
Associates Degree	10	5.9
Bachelors Degree	93	55.0
Masters Degree	34	20.1
Professional (M.D., J.D., PhD)	4	2.4
Other	4	2.4
Length of Employment/Volunteering		
Less than 6 months	15	8.9
More than 6 months but less than 1 year	19	11.2
1-2 years	40	23.7
3-4 years	23	13.6
5+ years	71	42.0
No Response	1	0.6
Role in CBO		
Front-line service provider (e.g., programming coordinator)	89	52.7
Leadership capacity (e.g., Executive Director)	62	36.7
Other	12	7.1
Administrative capacity (e.g., administrative assistant)	5	3.0
No Response	1	0.6
Level of Youth Interaction		
Daily	68	40.2
2-3 times per week	51	30.2
Once a week	21	12.4
2-3 times a month	9	5.3
Once a month	7	4.1
Less than once a month	3	1.8
Does not interact directly with youth	8	4.7
No Response	2	1.2

Table 3.
Frequency of questions asked by SEICUS topical categories (N = 161)

	Often		Sometimes		Occasionally		Never	
SEICUS Topical Categories	n	%	n	%	n	%	n	%
Human Development (n = 159)	39	24.6	29	18.2	55	34.6	36	22.6
Relationships (n = 159)	66	41.5	44	27.7	34	21.4	15	9.4
Personal Skills (n = 159)	93	58.5	45	28.3	18	11.3	3	1.9
Sexual Behavior (n = 158)	34	21.5	32	20.3	39	24.7	53	33.5
Sexual Health (n = 158)	38	24.1	28	17.7	46	29.1	46	29.1
Society & Culture (n = 158)	33	20.9	42	26.5	51	32.3	32	20.3

Table 4.
Comfort, confidence, skills, and knowledge by SEICUS topical categories (N = 166)

	Comfort		Confidence		Skills		Knowledge		Total CCSK	
SEICUS Topical Categories	M	SD	M	SD	M	SD	M	SD	M	SD
Human Development	3.35	0.66	3.22	0.82	3.28	0.67	3.36	0.56	13.20	2.28
Relationships	3.68	0.53	3.49	0.69	3.56	0.60	3.63	0.53	14.36	1.97
Personal Skills	3.77	0.44	3.61	0.58	3.63	0.51	3.73	0.44	14.75	1.58
Sexual Behavior	3.16	0.83	3.07	0.92	3.13	0.79	3.23	0.66	12.58	2.80
Sexual Health	3.43	0.67	3.20	0.86	3.27	0.73	3.37	0.66	13.27	2.47
Society & Culture	3.48	0.66	3.20	0.88	3.24	0.75	3.30	0.67	13.23	2.59
Total	20.87	3.11	19.79	3.94	20.10	3.28	20.63	2.66	81.39	11.53

Table 5.

Frequencies of participants with training in the past 5 years by SIECUS category

SIECUS	Formal Training		Information-seeking	
Categories	n	%	n	%
Human Development	98	58.0	130	76.9
Relationships	109	64.5	139	82.2
Personal Skills	112	66.3	142	84.0
Sexual Behavior	76	45.0	113	66.9
Sexual Health	77	45.6	112	66.3
Society and Culture	99	58.6	129	76.3

* Formal training was defined as degree-granting programs, workshops, or continuing education. Information-seeking was defined as looking up information, talking to an expert, or reading a book.

Table 6.

Comfort, confidence, skills, & knowledge total scores by training type and topical category

SEICUS Categories	Training type					
	Formal training	Information-seeking	Both	None	F	p
Human Development	82.8_{a}	$79.7_{b,c}$	$85.3_{d,b}$	$71.7_{a,d,c}$	9.84	< 0.000
Relationships	80.3	80.9_{a}	83.9_{d}	$71.3_{a,d}$	6.07	0.001
Personal Skills	80.0	80.4	83.5_{a}	73.3_{a}	3.24	0.024
Sexual Behavior	84.9_{d}	$81_{a,e}$	$87.2_{a,f}$	$73.1_{d,e,f}$	16.31	< 0.000
Sexual Health	83.6_{d}	$80.9_{e,f}$	87.3_{e}	$73_{d,e,f}$	15.67	< 0.000
Society and Culture	80.7	81.5_{a}	84.2_{d}	$73.9_{a,d}$	5.32	0.002

$_{a,b,c}$ Means in the same row that share these subscripts differ at $p < 0.05$ in the Tukey honestly significantly different (HSD) comparison

$_{d,e,f}$ Means in the same row that share these subscripts differ at $p < 0.01$ in the Tukey honestly significantly different (HSD) comparison

CHAPTER SIX

REFLECTIONS ON A CBPR PROJECT

Project reflections

Throughout this dissertation project, I have kept notes, e-mails, and other related materials for the purpose of reflecting on the project, what I have learned from various events, and how this has and will impact my professional development and future research directions. This, the final chapter in my dissertation, is the collection and processing of these reflections. It is my hope that not only I gain from writing this but that others who may read this can gain insights from my experiences which may serve them well in their endeavors.

In considering the many ways in which I could write this chapter, it felt most appropriate to engage my reflections through a community-based participatory research (CBPR) lens. As noted earlier in this document, the 9 principles of CPBR articulated by Israel et al. (1998; 2003) have come to greatly influence the way in which I understand and practice CBPR. Therefore, as opposed to a chronological accounting of the significant events experienced during my work on this project, I will recount events as they have become meaningful to me within a given principle of CBPR. For the sake of avoiding repetition, some principles have been brought together into a single section as the event described crossed multiple principles. As noted by Israel et al., the principles of CBPR "are presented with the recognition that the extent to which any research endeavor can achieve any one or a combination of these principles will vary depending on the context, purpose, and participants involved in the process." (1998, p. 177) In line with this caveat, I only detail below the principles which surfaced for me during significant points of the project. Others involved may have different interpretations or understandings of the events and their relevance to CBPR.

Recognizes community as a unit of identity. Early in the project, I wrestled with the concept of what constituted a community. My previous research experience typically engaged "communities" as groups of individuals with a very concrete, shared identity within a confined geographic region. For example, a study on men who have sex with men (MSM) in Indianapolis involved a community which, for the most part, had a shared identity (gay and bisexual men) and

a shared cultural reference (a large Midwest city). This is what I often thought of as a community. To study a more loosely defined group, in this case, people from across a diverse state working in different fields (e.g., social work, public health, faith-based) potentially providing very different types of services to youth, to me, felt like a weakening of the principle and maybe not really a CBPR project. In essence, I believed the people being brought together for this project would not have enough common ground to come together as unit of identity.

The first set of community meetings to discuss the role that community-based organizations (CBOs) might play in young people's sexual health occurred over a morning and afternoon session; each session was comprised of a different set of individuals at varying levels of youth-serving CBOs. As each session unfolded, I was surprised to hear the level of common issues articulated by executive directors and front line youth workers for their respective organizations. Perhaps the most salient of these similarities involved conversations around stigma felt as a youth development professional, particularly when addressing sexual health-related topics with young people. Without prompting, the afternoon group embarked on a conversation on stigma very similar to the morning group. Through these conversations, and others like it, as well as the generally familiarity among participants from all parts of the state, it became clear to me there was a shared identity self-defined by this community.

Methodologically, the initial community meetings also brought to the fore of my mind the mixed methods nature of CBPR. As the sessions progressed, I was reminded of my experiences as a research assistant at San Francisco State University. I was fortunate to lead a group of youth in a semi-structured focus group session on being peer sex educators. The flow of dialogue during this project's early meetings was very reminiscent of the more formalized focus group. I learned that while no official protocols were in place, I was indeed part of a team leading a qualitative focus group.

Facilitates collaborative partnerships in all phases of the research, involves a cyclical and iterative process, & involves a long-term process and commitment. Not long after the initiation of the project, my calendar quickly filled up with meetings and my e-mail inbox become flooded with conversations about the study. The primary community contact for the project, Kathleen Baldwin,

my advisor, Dr. Michael Reece, and I had several conversations both in person and via e-mail to conceptualize, develop, re-design, and ultimately implement the study. There was not a single decision made about the project, be it the meaning-making of initial community meeting notes, research questions, survey questions, or data interpretation, that wasn't done in a collaborative way. Some researchers may find this collaborative process through all phases of the research tedious; I, however, relished the partnership. It provided me with a sense of accomplishment in that not only did I make every attempt to stay true to this CBPR principle, but that I was achieving a personal goal of mine – to provide timely, relevant, and ultimately useful research to address an issue identified by the community. The litany of e-mails and meetings were well worth the time and disk space.

The multitude of meetings and e-mails were also indicative of the cyclical and iterative process of CBPR. The meetings, in particular, provided proof of the team being attendant to this principle. After the first set of community meetings, I was tasked with compiling and analyzing for common themes the notes from all parties charged with note-taking. The initial list of themes, soon to become constructs to be measured in the study, were only the first iteration. In a subsequent meeting between Kathleen, Dr. Reece, and me, we fleshed out meanings for each potential theme; afterwards, a second iteration of the themes emerged. A second cycle involved a second community meeting comprised of individuals who had attended the first round of meetings. Here again, the themes were discussed and a third iteration of meanings were made. It was at this point that being cyclical and iterative might have felt tiring to others; for me, it was yet again another sense of accomplishment that we were truly getting at what was needed to best inform the community to help address the needs of the young people they served. A fourth iteration involved the proposal meeting for this dissertation in which other academic experts helped to further refine not only the constructs to be assessed, but the questions used to get at the constructs. An added bonus that I have come to appreciate in retrospect is the increased level of validity offered by a cyclic and iterative process.

The multiple meetings and e-mail conversations that constituted the collaborative and cyclic and iterative nature of the study may appear to have taken a great deal of time and

commitment. And indeed they did! But perhaps more telling of this principle, for this study, was something I came to appreciate in my interactions with Dr. Reece and Kathleen. The beginnings of this study predated my arrival to Indiana University, and in some ways, they even predated Dr. Reece's relationship with Kathleen. Many years ago, Kathleen was involved with researchers at Ball State University in conducting a study of Indiana parents' desires for their children's sex education (n.a., 2003). Soon after, she engaged Dr. Reece in a statewide study of teachers, counselors, and nurses in schools on their interactions with youth around sexuality-related topics. It was through this and other partnerships that Dr. Reece and Kathleen (and others in the community through other projects) that laid the groundwork for the current study. I have come to have a deep appreciation for what it means to have a long-term commitment to the communities in which I will work. To be an agent of change through my research, and to realize this principle, requires me to not only engage communities for a given project, but become a part of the community in order to foster and grow meaningful relationships. These relationships will allow for the building of trust and mutual respect as well as a track record of producing results. I recall a former advisor of mine telling me research was hard work. I have come to see it as fulfilling work that can foster long-term, meaningful, and rewarding relationships.

Builds on strengths and resources within the community. A unique experience from this study provides, perhaps, a cautionary tale of building on the strengths and resources within the community, particularly studies on sexuality and youth. During the first round of community meetings, a prominent member of a statewide organization dedicated to youth-serving organizations offered a valuable resource to be used in the recruitment of participants for the study – a comprehensive list of organizations and contact information for each one. This would have provided the strength of representativeness to the study. As we approached the launch of the study, this individual was contacted on several occasions to acquire the list. Finally, a response indicated the statewide organization was unwilling to provide access to the information due to a concern that the study was about youth and sex. This turn of events was particularly disconcerting as the head of the organization was involved in the initial conversations about the study and had expressed a great deal of support. Ironically, while the study was about youth and

sex, it was targeted to adults and what they did or did not do to educate youth about sexuality-related topics.

It was through the fortitude of the research team that this obstacle was overcome. Through academic channels, a non-profit database compiled from IRS listings was identified as an ideal alternative source for recruitment. The database provided searchable listings that yielded a large set of potential organizations from which to recruit. The added challenge was for most of the organizations, e-mail contact information was not provided and thus additional time was needed to collect the information needed. Ultimately, an alternate recruitment strategy was developed and implemented.

Reflections on these events have led me to consider the unique challenge to building on the strengths and resources of communities, particularly when conducting sexual health research. This is perhaps a reflection of what many sex researchers over the years have and continue to experience; a general concern for the legitimacy and need for sex research. The overall response of community partners involved in this study indicated to me an overwhelming level of support and need for such a study on youth and sexuality. Yet there are, and will continue to be, those who do not support such research. As the researcher in CBPR projects, I will need to continue to be cognizant of such issues and plan appropriate contingencies when engaging community strengths and resources in the event those strengths and/or resources ultimately fail to materialize.

Integrates knowledge and action for mutual benefit of all partners & disseminates findings and knowledge gained to all partners. From the early beginnings of this project, it has been a clearly articulated goal to ensure the information gained from the study benefitted all partners and that findings were openly shared. The primary benefit to the researchers has materialized in this dissertation. It has also professionally benefitted me as a study that has provided invaluable experiences in conducting a CBPR project. However, the dissertation and experience, for me, is in some ways anti-climatic. More germane to me was the recent community summit where the preliminary results of the survey were shared with the community.

The summit occurred in two parts; the morning session involved my presentation of the preliminary study findings and the afternoon session had 8 smaller groups discuss the findings and potential next steps. The morning presentation was very well received. Participants of the summit indicated the information was enlightening and useful. Due to the exploratory nature of the study, several questions indicated a need for more follow-up work. In particular, the need for future research on what CBOs could do to improve the provision of sexual health information to youth was articulated. During the afternoon session, I came to the realization that this need was already being addressed in the small groups. Fortunately, Kathleen, who organized the summit, had the foresight to have a "documentarian" in each group who recorded the conversations. Thus, the mutual benefit for all partners was renewed in yet another iteration of the project. Summit participants gained knowledge from the current study, began engaging in action through small group discussions, and provided new data for analysis which can be used to strengthen current findings and provide future direction for more action.

Lessons learned

My experiences throughout this project have provided me with several key lessons for conducting community-based participatory research. These include being surprised, relationship-building, and contingency planning. Not that long ago, a former advisor told me when doing research, "always try to be surprised." I know now what she meant. It is difficult to go into any research endeavor without ones' own presuppositions. Our experiences shape our expectations. While I may not be able to set aside all of my expectations, if I look for that which surprises me, I will have allowed myself to adjust my expectations. I saw this early on in this study when I was surprised at the coalescence of identity of the community. Reflecting on what came before me (and will continue after I have left) has shown me the importance of building relationships. Already, plans are being laid whereby I will continue my relationships with Kathleen and others in the community; and these relationships are beginning to lead to new relationships in my future community of Omaha, Nebraska. Finally, due to the nature of my focus, sexual health, I will consider the possibility that community support may not always materialize in the research I do. I

will be mindful of this and always be on the lookout for potential pitfalls and have contingencies planned whenever possible.

These reflections and lessons learned have, to now, focused on experiences directly related to the project that makes up this dissertation. However, it also seems appropriate to include a short reflection on my doctoral training as a whole. In particular, I wish to reflect on the conceptual and methodological growth I have experienced. Conceptually, I came to Indiana University with a distinctly post-modernist view of research. While exposed to quantitative research during my Masters work, I came to IU with a distrust of statistics. As Mark Twain famously quipped, “There are lies, damned lies, and then there are statistics.” After four semesters of statistics classes, and even co-teaching a statistics class this past year, I have grown to appreciate statistics. Specifically, I have come to believe that statistics, much like qualitative analysis, depends very much on what the researcher puts into them. The decisions made on types of statistics to run, assumptions made, and adjustments deemed necessary all impact the results. And like qualitative research, conclusions, particularly in behavioral research, are always partial. It is the limitations which help qualify findings and thus, are an integral part of any study involving quantitative approaches.

I have also found a conceptual grounding of sorts during my time at IU. Arriving with a “high theory” background firmly rooted in my mind, many of my early conversations revolved around meaning, discourse, and power; I was a child of Foucault and Butler, though I didn’t and still don’t fully understand all that these great philosophers have to offer. Missing from my conceptual framework was a sense of action. It was an amazing thing to theorize about why social inequalities existed, how they operated at a macro level, and what fueled their continued existence. But I often felt powerless to enact change. During my time at IU, and I feel in particular due to my exposure to CBPR, I have evolved my conceptual framework to include actionable, realistic, and yes, somewhat positivistic components. I feel these revolutions have helped round me out as a researcher and academician. And I feel prepared to continue my evolution as I grow and change in my new career in Omaha.

My methodological growth at IU has been necessitated by my conceptual growth. I have grown by leaps and bounds when it comes to conducting statistical analyses (arguably, I came with almost no ability in this realm). Perhaps more relevant than developing quantitative analytic skills has been honing my ability to develop questions that provide the data to analyze. I was fortunate to have a course prescription committee that saw this hole in my skill set and pushed me to engage in coursework which helped me to develop basic skills in item generation. These and other skills comprised the nuts and bolts of my methodological growth. The more abstract component was mixed methods.

The methodological experiences I brought to IU were decidedly qualitative. I ran focus groups as a research assistant, did ethnographic work for classes, and conducted semi-structured interviews for my thesis. As my conceptual world evolved to be more actionable and with a new-found love of CBPR, I realized a mixed methods route was desirable. I found to be a true collaborator in a CBPR project, a well-rounded methodological approach was needed to better serve the community of interest. This stems from a methodological approach that I learned and embraced early in my career here at IU: the research question should always drive the methods. To be an expert in only one methodology would limit me as a community-based participatory researcher. This “truth” solidified for me during this dissertation project; I realized the need for qualitative skills both in the beginning of the project and during the summit. As a matter of need, I also needed quantitative skills to guide the development of the survey and analyze the results. Consequently, I have grown to believe in a mixed methods approach to my research.

Future directions

Future papers to be written (beyond those presented in this dissertation) are many. The first paper already in development is a psychometric assessment of the CCSK scale. I will be engaging the expertise of my friend and colleague, Dr. Ariane Hollub, to co-author this paper. During the development of the study and subsequent writing of this dissertation, I discovered while there is a great amount of consensus that comfort, confidence, skills, and knowledge are important components for professionals dealing with sexuality, there is little consensus on how

best to measure them. The proposed psychometric paper will provide the opportunity to publish a scale that can be used for future research.

A second paper will be a methodological presentation of the use of CBPR in the study of sexual health and youth. It may be that CBPR is ideally suited as a methodological approach to the study of communities and their role in providing sex education to adolescents. The successes of this study can provide evidence to support such an approach and offer guidance to other researchers who may wish to consider using CBPR in their studies of youth and sexuality. This paper will be modeled after a similar paper on using CBPR in sexuality research (Reece & Dodge, 2004) authored by members of my dissertation committee.

A third paper may be possible based on data collected at the summit. While tentative until the focus group style data has been seen, this paper would put this data in conversation with the quantitative results from the survey or it may be a stand-alone paper on the summit itself. In addition to these two to three papers, a community report will be written. The report will include preliminary findings presented at the summit, copies of the papers included in this dissertation, results from the summit small group discussions, and additional analyses requested by participants of the summit. The report will be a collaborative process with Kathleen Baldwin.

Future research projects will undoubtedly utilize the skills and lessons learned from both my experiences at IU and this project. A foreseeable project stemming from this research will be a study to validate the CCSK scale in other populations. In my new position at University of Nebraska Medical Center, it will be possible to expand the scale to encompass physicians, nurses, and other clinicians. I would also like to explore the possibility of replicating, to the extent possible with a CBPR project, this study in Omaha. Most likely the study will and should look different as the types of organizations will vary from those in Indiana as well as the sexual health issues facing youth in Omaha. Beyond the scope of this study, it is difficult to predict the types of research projects I will conduct over the coming years. As a CBPR researcher, my projects will be determined by the needs of the communities with which I will work. One known issue is the dramatic incidence of chlamydia and gonorrhea, particularly among Black and Hispanic populations. This will be the focus of some of my initial research efforts in Nebraska. I look

forward to using the lessons learned and skills I have acquired during my time at IU to continue advancing sexual health through community-based participatory research.

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Appendix A: Initial Community Rationale, Focus, & Plan for the Study

Assessing Indiana Youth Workers' Capacity to Promote Adolescent Sexual Health

Rationale

Children and youth need access to information about their bodies, boundaries, decision-making, growth and development, and healthy relationships at all ages. Further, youth need access to caring adults who have skills and information, as well as the comfort and confidence to address sexuality issues and sexual development.

Research shows that public middle and high schools in Indiana are not adequately addressing vital sexuality topics which are key in promoting healthy adolescent sexuality. Additionally, research from Indiana indicates parents and families rarely or never discuss thirteen of the same important sexuality topics at home. This is a dangerous reality, since we know that a comprehensive sexuality education experience and access to caring adults can lay the foundation for lifelong health and wellbeing.

Clearly a holistic lifespan approach to human sexuality is best advised. We know that the complexity of the topics involved and the sensitive political nature of this dimension of life make this aspect of healthy youth development especially challenging for youth workers. Few other aspects of adolescent development and experience bring the same level of concern about language, values and content among practitioners in the field. Additionally, training or coursework in human sexuality is not required for pre-service training of social workers or others who interact directly with young people. Too many on the frontline as youth workers are left to deal with these issues without the benefit of agency or administrative guidance, or even a generalist's basic knowledge of sexuality and sexual development.

Identifying the barriers and challenges youth workers in Indiana face in regards to providing information, services and support related to sexuality issues necessary for healthy youth development will be an important step towards addressing the barriers and building their capacity to be effective in this area.

Focus

Using a community-based participatory approach, youth workers and young people from across Indiana will join with researchers from Indiana University, in partnership with Planned Parenthood of Indiana, to develop a research plan designed to assess the current capacity, as well as the challenges and barriers youth workers face in their efforts to promote healthy adolescent sexuality and sexual development. Once barriers are identified, those who support youth workers, youth and healthy sexuality, will be positioned to more effectively address those issues, with the guidance of those most affected.

We believe a community-based participatory research approach is ideal for this application, as it will provide the format and opportunity for those who are directly involved to define and guide the process.

Plan

Planned Parenthood of Indiana, in partnership with Indiana University's Center to Promote Sexual Health will convene a meeting of key stakeholders from Indiana community-based organizations and government departments to invite input from youth workers. Additionally, a separate meeting for groups of adolescents will be convened. The focus of these sessions will be to solicit input about what to assess, who to solicit for participation,

and how to best access the targeted groups. The goal of this project is to identify what would help the youth workers in the state acquire the skills, information and practice to build their confidence and comfort in working with the sexuality issues of the young people in their programs and communities.

Tentative Timeline

January - March, 2008	Design research plan. Involve partners, including IYI, and identify youth workers, and young people to invite to stakeholder forums. Design standardized agenda for forums.
April - May, 2008	Convene forums
May- June, 2008	Design assessment tool and research method.
June – September, 2008	Conduct research/collect data.
September – Dec., 2008	Analyze data.
January –March, 2009	Report findings to community.
March – April 2009	Design collaborative response.
May – June 2009	Initiate multi-year response to address findings.

1/22/08

Appendix B: Initial Community Purpose & Assumptions for the Study

Assessing the Capacity of Indiana Youth Development Professionals To Effectively Address Adolescent Sexuality

Blue Ribbon Stakeholders Meeting

Purpose

Convene a group of youth development professionals and key administrators of youth-serving organizations to invite input about designing and conducting a study of youth development professionals in Indiana. The study will seek to assess current capacity of youth development professionals, at community-based organizations in Indiana to promote healthy sexual development among the youth with whom they work. Further, we will convene groups of adolescents to assess their needs and interests in utilizing CBO youth workers to assist with their information, skill-building and referral needs related to their sexual health.

The discussion will be co-facilitated by Christopher Fisher, lead project researcher, Indiana University Center for Sexual Health Promotion and Kathleen Baldwin, Vice President of Education and Training, Planned Parenthood of Indiana.

Assumptions

Given recent data indicates that neither families or middle and high schools in Indiana are adequately addressing the need for medically accurate information about sexuality, and since both school personnel and parents report discomfort and low confidence in addressing this information, it is essential to understand the ability of other important adults to address this gap.

It is beneficial for young people to have access to knowledgeable and helpful adults who are able to be both proactive in promoting healthy sexual development and to respond in positive ways to questions and situations that arise. If schools and parents are unable to provide such information, it may be possible to provide it through community-based organizations.

Access to age and developmentally appropriate information that is medically accurate on all topics is an essential component of promoting healthy adolescent sexual development.

Appendix C: 1st Advisory Board Meeting Agenda

Assessing the Capacity of Indiana Youth Workers To Effectively Address Adolescent Sexuality

Blue Ribbon Stakeholders Meeting Agenda

I. Introductions

II. Study Origins
   a. Purpose
   b. Assumptions

III. Research Plan
   a. CBPR - an overview
   b. Intended use of findings
   c. Identifying things to be measured
   d. Methods

IV. Wrap-up
   a. Identify stakeholders to follow-up for feedback on study design
   b. Q&A

May13, 2008

Appendix D: Community Study Purpose, Research Questions, and Constructs

Purpose & Research Questions

- Map role of CBO
  - What are the expectations of CBO youth development professionals in providing sexual health information?
  - How do CBOs vary in their roles to provide sexual health information to youth?
  - To what extent are youth development professionals confronted with requests for sexual health information? Where are the questions coming from?
- What is CBO doing?
  - What types of sexual health resources are CBOs providing youth?
  - How is sexual health information provided to youth?
  - How are CBO youth development professionals trained in providing sexual health information to youth? What are they trained on?
- Identify facilitating factors & challenges
  - How does stigma impact youth development professionals' ability to provide sexual health information?
  - What are the characteristics of youth development professionals and CBOs who provide sexual health information?
  - What role(s) does the community play in a CBO providing sexual health information to youth?
  - What macro-level factors (e.g., legal, policy) impact provision of sexual health information and how?

Constructs to be measured to address research questions

- Organization Characteristics – an overall picture of the organization which may include mission/values statements, types of funding (and if that funding specifically includes sex education), who is served by the organization, what types of services are provided (e.g.,

expectation to provide sexual health information), overall culture of the organization, and context in which org works with youth (context is key in categorizing responses for comparison)

- Community served Characteristics – an overall picture of the community in which the organization operates; specifically, how involved is the community with the CBO or what level of collaboration exists and perceived support of the CBO and what it does
- Ecological Curriculum
  - Referrals/Resources – what types of resources are available for youth development professionals in addressing sexuality needs of youth (e.g., pamphlets from health department, palm cards with websites and/or hotline numbers, posters, designated person to talk to)
  - Patterns of info seeking – how do youth go about seeking sexuality information; what types of questions do they ask, resources do they consume; are there questions that are asked but not answered and if so what are they or what types of questions are answered
  - Programming – different from referrals/resources in that these are scheduled events that involve some form of "teaching" or "dialoguing"; what are these events like (e.g., guest speakers, peer education events) and what types of materials are used (e.g., a specific curriculum, workbooks)
    - Where does the programming effort fall on a continuum of sex information (comprehensive to abstinence-only); may ask what is taught based off of SIECUS guidelines; what are the values messages communicated to youth in the provision of sex information
  - Training – what type(s) of training do youth development professionals receive on sexuality (e.g., college course work, Journey Fellows, self-directed training)
  - Competency – how competent/confident do youth development professionals feel they are in being able to answer youth questions about sexuality; are youth workers perceive themselves as approachable/askable (how often do they receive questions); do they believe the information they provide is accepted and utilized by youth (e.g., do they

witness youth regurgitating the messages and information given); how is information provided to youth by workers (e.g., a one-on-one discussion, a group discussion, handing a resource to youth)

- Cultural Perceptions
  - Stigma – how do youth development professionals experience stigma related to being seen (or not seen) as a provider of sexuality information to youth; may be similar to stigma of HIV and AIDS workers or sex toy party consultants
  - Agency Perceptions – what are the perceptions of internal and external support for providing sexuality information to youth; what policy or legal issues support or hinder efforts to provide sexuality information to youth
  - Sexual Attitudes – what are the sexual attitudes and values of youth development professionals (e.g., attitudes towards sexual orientation, premarital sex, condom provision) (this will provide additional point of comparison to other questions)

Appendix E: 2nd Advisory Board Meeting Agenda

Assessing the Capacity of Indiana Youth Workers To Effectively Address Adolescent Sexuality

Blue Ribbon Stakeholders Meeting Agenda

I. Introductions
II. Recap from previous meeting
III. Present/Discuss research questions
IV. Present/Discuss survey shell
V. Discuss recruitment/incentives
VI. Present timeline for project
VII. Summary

Sept 22, 2008

Appendix F: Recruitment Script

Recruitment scripts for Indiana Youth Worker Survey

E-mail to non-profit organizations identified in GuideStar.com database:

Dear Youth-Serving Organization/Youth Development Professional,

Below is a message requesting participation in a study being conducted by researchers at Indiana University. This e-mail address was identified through governmental non-profit listings as an organization that may work with youth in Indiana. It is greatly appreciate if you could share this e-mail with all who work or volunteer with your organization. Feel free to forward this e-mail to those individuals or print and post in an area accessible to those who work or volunteer for the organization.

If you are 18 years of age or older and work or volunteer with an Indiana youth-serving organization you are invited to participate in a collaborative survey being conducted by Indiana and several community youth leaders in Indiana. The purpose of the study is to better understand the role of community-based organizations, such as the one you work or volunteer with, in providing sexual health-related information to the young people you and your group serve. We are interested in participation from all youth development professionals at all levels of an organization (e.g., front line youth workers, executive directors) in the state of Indiana, regardless of whether or not your organization deals specifically with sexual health issues.

The confidential survey is approximately 20 minutes in length. You will be able to provide contact information at the end of the survey to receive a $5 gift card for your participation as well as enter for a chance to win 1 of 10 $50 gift cards. To learn more about the study and to take the survey, please visit https://www.indiana.edu/~youth. (If you type in the web address, the "~" before "youth" is typically found by holding the shift key and pressing the key to the left of the number 1).

If you have questions, please contact the project lead, Christopher Fisher, at 812-856-0791 or via e-mail at fishercm@indiana.edu.

Thank you for your time and please feel free to share this information with others you believe may qualify to participate. We hope that multiple individuals from any single organization will respond. As such, if you are willing, it is greatly appreciated if you could share this information with your colleagues.

E-mail to individuals identified as colleagues of the community advisory board:

Dear Youth Development Professional,

If you are 18 years of age or older and work or volunteer with an Indiana youth-serving organization you are invited to participate in a collaborative survey being conducted by Indiana and several community youth leaders in Indiana. The purpose of the study is to better understand the role of community-based organizations, such as the one you work or volunteer with, in providing sexual health-related information to the young people you and your group serve. We are interested in participation from all youth development professionals at all levels of an organization (e.g., front line youth workers, executive directors) in the state of Indiana, regardless of whether or not your organization deals specifically with sexual health issues.

The confidential survey is approximately 20 minutes in length. You will be able to provide contact information at the end of the survey to receive a $5 gift card for your participation as well as enter for a chance to win 1 of 10 $50 gift cards. To learn more about the study and to take the survey,

please visit https://www.indiana.edu/~youth. (If you type in the web address, the "~" before "youth" is typically found by holding the shift key and pressing the key to the left of the number 1).

If you have questions, please contact the project lead, Christopher Fisher, at 812-856-0791 or via e-mail at fishercm@indiana.edu.

Thank you for your time and please feel free to share this information with others you believe may qualify to participate. We hope that multiple individuals from any single organization will respond. As such, if you are willing, it is greatly appreciated if you could share this information with your colleagues.

Journey Fellows recruitment ad for future newsletter:

Indiana Youth Worker Survey

Individuals (18 and up) working with youth through community-based organizations at all levels (e.g., front line workers, executive directors) are invited to participate in a collaborative study between Indiana University and community youth leaders in Indiana. The study seeks to understand to role non-school oriented youth-serving organizations play in providing Indiana youth with sexual health information, resources, and referrals.

Participants will be able to provide contact information at the end of the ~~anonymous~~ confidential survey to receive a $5 gift card and enter into a drawing for 1 of 10 $50 Visa gift cards (approximately 1 in 40 chance of winning).

To learn more and/or participate, visit the study website at: https://www.indiana.edu/~youth

(If you type in the web address, the "~" before "youth" is typically found by holding the shift key and pressing the key to the left of the number 1)

If you have questions, please contact the project lead, Christopher Fisher, at 812-856-0791 or via e-mail at fishercm@indiana.edu.

Appendix G: Survey Instrument

Indiana Youth Worker Survey

Thank you for your interest in the Indiana Youth Worker Survey. Researchers at Indiana University's Center for Sexual Health Promotion have partnered with various youth-serving organizational leaders in Indiana to develop this study. The aim is to assess the role of youth-serving community organizations and the adults who work in them in providing sexual health information, resources, and referrals to the young people of Indiana. Findings will help guide this group of leaders in developing appropriate youth worker trainings as well as make needed resources available to address the sexual health needs of young people in Indiana.

For your participation in this 20 minute survey, you will be able to provide your contact information to eceive a $5 gift card to a national retailer (Wal-mart, Target, or Starbucks) and enter into a drawing to win 1 of 10 $50 Visa gift cards.

If you are interested in learning more about the study, please click here. [continue to Study Information Sheet]

If you do not wish to learn more about the study, please click here. [redirect to www.google.com]

Study # 09-13788

INDIANA UNIVERSITY – BLOOMINGTON
STUDY INFORMATION SHEET

Indiana Youth Worker Survey

You are invited to participate in a research study. Please read this form before agreeing to be in the study. Should you have questions, contact information for the researchers is found below.

STUDY INFORMATION

The purpose of this study is to explore the provision of sexual health information and resources to Indiana youth through non-profit organizations. If you agree to participate, you will be one of 400 individuals who will be participating in the study. If you agree to be in the study, please indicate so by clicking the "Continue to Survey" button below. The survey will take approximately 20 minutes to complete. You will be asked questions about you, your organization, the types of sexual health information and resources you and your organization provide or do not provide to the youth you work with, and the facilitating factors and barriers you experience in your work.

To be eligible to participate, you should be at least 18 years of age and work or volunteer with a non-profit organization which serves Indiana youth, 12-21 years of age.

BENEFITS

Data collected from this study will contribute to researchers' and community organizations' understanding of the role groups such as yours play in the provision of sexual health information, resources, and referrals to young people in Indiana. Information may be used to develop training programs for youth workers and help funders of non-profit groups to make appropriate decisions on priorities for funding

ALTERNATIVES TO TAKING PART IN THE STUDY:
Instead of being in the study, you can choose not to participate.

COMPENSATION

For your participation in this study, you will be able to provide your contact information at the end of the survey to receive a $5 gift card to a national retailer which will be mailed to you. You will also have the opportunity to enter into a drawing for a chance to win 1 of 10 $50 Visa gift cards. Winners will be selected randomly from all who enter and only 10 winners will be selected. The odds of winning a $50 Visa gift card are approximately 1 in 40.

CONFIDENTIALITY

Efforts will be made to keep your personal information confidential. We cannot guarantee absolute confidentiality. Your personal information may be disclosed if required by law. The data you provide in the questionnaire will be confidential. All contact information that you provide will be kept separately from other study data. Your contact information will not be linked with any of your responses and will be destroyed or deleted by February 2010.

Organizations that may inspect and/or copy your research records for quality assurance and data analysis include groups such as the study investigator and his/her research associates, the IUB Institutional Review Board or its designees, and (as allowed by law) state or federal agencies, specifically the Office for Human Research Protections (OHRP), etc., who may need to access your research records.

RISKS

The risks associated with completing the survey may include some embarrassment when responding to the questions. If you have concerns or would like a referral for information related to sexual matters, please speak with or contact the researcher. There is also a potential risk of loss of confidentiality. This is safeguarded by the investigator as outlined above in the "Confidentiality" section.

CONTACT INFORMATION

If you have questions at any time related to the study, you may contact the researcher, Christopher Fisher at HPER 116, Indiana University, Bloomington, IN 47405, (812) 856-0791, fishercm@indiana.edu.

If you feel that you have not been treated according to the descriptions in this form, or your rights as a participant in research have not been honored during the course of this project, you may contact the office for the Indiana University Bloomington Human Subjects Committee, Carmichael Center L03, 530 E. Kirkwood Avenue, Bloomington, IN 47408, (812) 855-3067, by email at iub_hsc@indiana.edu.

VOLUNTARY NATURE OF STUDY

Taking part in this study is voluntary. You may choose not to take part or may leave the study at any time. Leaving the study will not result in any penalty or loss of benefits to which you are entitled. After you submit your survey it will not be possible to return it and your data will remain in the study.

SUBJECT'S CONSENT

In consideration of all of the above, if you agree to participate in this research study please complete the survey that follows. You may keep this information sheet for your records; to do so, please print this page now. You may also receive a copy of this information sheet by contacting the researchers.

Date: January 30, 2009

Indiana Youth Worker Survey

A. I am at least 18 years of age.

Yes
No

B. I work/volunteer, either paid or unpaid, with an organization or group (not a school) within the state of Indiana that provides services to adolescents aged 12 to 21.

Yes
No

C. How did you hear about this survey?

I received an e-mail directly from the researchers
From my boss
From a co-worker/fellow volunteer at my organization
From the Journey Fellows newsletter
From a colleague/friend at another organization
Other: _____
No Response

[If yes to A & B, continue to survey. If no to either one, then direct to do not qualify page below]

Do not qualify page

Thank you for your interest in participating in our study. Based on your responses, you do not qualify for participation because you indicated you are not over the age of 18 and/or you do not work or volunteer with an organization which serves Indiana youth between the ages of 12 and 21.

If you know someone who might qualify for the study, please feel free to pass along the web address, https://www.indiana.edu/~youth , to those individuals.

Indiana Youth Worker Survey

The questions below will ask you about yourself and the youth-serving organization with which you work or volunteer. If you work or volunteer for more than one youth-serving organization, please respond to questions for the organization with which you have done the most work in the past year.

1. What age are you? _____

   No Response

2. What is your gender?

   Female
   Male
   Other: _____
   No Response

3. What is your race/ethnicity?

   African-American/Black
   White, Non-Hispanic
   Hispanic/Latino
   Asian/Pacific Islander
   Other: _____
   No Response

4. What is the highest level of education you have completed?

   High School or GED
   Some College
   Associates Degree
   Bachelors Degree
   Masters Degree
   Professional (M.D., J.D., PhD)
   Other: _____
   No Response

5. Do you hold any professional credentials, licenses, or certifications relevant to your current position?

   Yes
   No
   No Response

   [If yes,]

   5a. Please list the professional credentials, licenses, and/or certifications relevant to your current position in the box below. [text box, 250 characters]

6. In which Indiana county do you work/volunteer?

   [Drop-down list of counties]
   No Response

7. Please tell us the name of the youth-serving organization with which you work/volunteer. This information is held in the strictest of confidence and will only be used to group respondents by organization for analytic purposes. No organizational names will be directly tied to specific results.

   [Text Box, 100 characters]
   I prefer not to provide the name of my organization
   No Response

8. Is your organization non-profit, for-profit, or a government agency?

   ❒ Non-profit ❒ For-profit

   Government: ❒ Federal ❒ State ❒ City ❒ County

   ❒ No Response

   8a. If Non-profit OR For-Profit, is your organization formally incorporated?

   ❒ Yes ❒ No ❒ Don't know ❒ No Response

9. Which of the following best describes your role in the youth-serving organization for which you work/volunteer?

   I work/volunteer primarily for the organization in a leadership capacity (e.g., Executive Director, Associate/Assistant Director, Program/Department Manager)
   I work/volunteer primarily as a front-ling service provider who implements programs for the youth served by the organization (e.g. mentor, programming coordinator, activities coordinator, educator)
   I work/volunteer primarily for the organization in an administrative capacity (e.g. accountant, administrative assistant)
   Other: _____
   No Response

10. In what year was your organization founded (if part of a larger organization (i.e., national), please indicate for your specific chapter)?

    [Drop-down of years 1900-2009]
    I am unsure
    No Response

11. What were your organization's total annual revenues for the most recent fiscal year?

$	Don't Know	No Response

12. What percent of your total annual revenues are used to provide youth services?

%	Don't Know	No Response

13. What is the total number of adult (21 and over) paid employees in your organization?

	Don't Know	No Response

14. What percent of those adult employees provide direct services to youth?

%	Don't Know	No Response

15. What is your total number of adult (21 and over) non-paid volunteers (not on the board of directors)?

	Don't Know	No Response

16. What percent of those adult volunteers (not on the board of directors) provide direct services to youth?

%	Don't Know	No Response

17. Religious organizations are increasingly becoming involved in service delivery for youth. We'd like to ask some questions regarding your organization's involvement with faith-based organizations.

	Yes	No	Don't Know	No Response
Our organization is faith-based or is formally tied to or affiliated with faith-based organization (s).				
Our organization has informal ties with or affiliations to faith-based organization(s).				
Religion or religious themes play an important role in the programs offered to juveniles by this organization.				
Our program is co-located at a faith-based organization.				

18. How long have you been working/volunteering for this organization?

    Less than 6 months
    More than 6 months but less than 1 year
    1-2 years
    3-4 years
    5+ years
    No Response

19. The youth-serving organization or group with which I work considers me to be

    A paid staff member
    An unpaid volunteer
    No Response

20. Which of the following best describes the frequency of your interactions with youth served by your organization?

    Daily
    2-3 times per week
    Once a week
    2-3 times a month
    Once a month
    Less than once a month
    I do not interact directly with the youth served by the organization
    No Response

21. What is the approximate age range of the youth served by your organization?

    [numeric text box] years of age to [numeric text box] years of age
    No Response

22. Which of these statements best describes the gender of the youth served by your organization?

    Mostly female or all female
    More females than males
    About equal numbers of males and females
    More males than females
    Mostly male or all male
    Unsure
    No Response

23. We have observed a full range of diversity among youth served by organizations. Which of these statements best describes the sexual orientation of the youth served by your organization?

    Mostly heterosexual/straight
    About equal numbers of heterosexual/straight and gay/lesbian/bisexual/transgender
    Mostly gay/lesbian/bisexual/transgender
    Unsure
    No Response

24. Which of these statements best describes the educational status of the youth served by your organization?

    Most are in middle school
    Most are in high school
    Most have dropped out of school
    Most are in college
    Unsure
    No Response

The following questions are about your organization's general characteristics.

25. Our organization is characterized by:

	Strongly Agree	Agree	Neither **Agree** nor Disagree	Disagree	Strongly Disagree	No Response
A high rate of new program and service introduction, compared to our competitors (including new program or service features and improvements)						
An emphasis on continuous improvement in methods of operation or service delivery						
Risk taking by key managers or administrators in seizing and exploring chancy growth opportunities						
A "live and let live" philosophy in dealing with competitors or funding or clients						
Seeking of unusual, novel solutions by senior managers to problems via the use of "idea people", brainstorming, etc						
A top management philosophy that emphasizes proven services, programs, and approaches and the avoidance of heavy new development costs						

26. In our organization, top-level decision making is characterized by:

	Strongly Agree	Agree	Neither **Agree** nor Disagree	Disagree	Strongly Disagree	No Response
Cautious, pragmatic, step-at-a-time adjustments to problems						
Active search for new opportunities						
Rapid growth or major social change as the dominant goal						
Large, bold decisions despite uncertainties of the outcomes						
Compromises among the conflicting demands of stakeholders (board members, management, employees, clients, suppliers, government, etc.)						
Adherence to the status quo, steady growth, and stability as primary concerns						

The next set of questions will ask you to think about your work with youth and issues of sexuality. We are defining sexuality in it's broadest terms. For example, youth often ask adults in their life about dating; we consider dating an important component of a young person's sexual development. For each set of questions, you will see several categories, like relationships, with examples of topics, such as dating, that might be included in the category.

[If answered "don't work with youth" to question 20, skip to 28]

27. How often are you asked questions about the following topics by the youth you work with?	**Often**	**Sometimes**	**Occasionally**	**Never**	**No Response**
Human Development*: Topics include reproductive and sexual anatomy and physiology, reproduction, sexual orientation, and body image and gender identity*					
Relationships*: Topic include families and raising children, love, romantic relationships and dating, and marriage and lifetime commitment*					
Personal Skills*: Topics include values, decision-making, communication, assertiveness and negotiation, and looking for help*					
Sexual Behavior*: Topics include sexuality throughout the lifespan, masturbation, shared sexual behavior, sexual abstinence, human sexual response, sexual fantasy, and sexual dysfunction*					
Sexual Health*: Topics include reproductive health, contraception, pregnancy and prenatal care, abortion, sexually transmitted infections and HIV/AIDS, and sexual abuse, assault, violence and harassment*					
Society and Culture*: Topics include sexuality and society, gender roles, sexuality and the law, diversity, and sexuality and religion, the media, and the arts*					

28. How *comfortable* are you (or would you be) answering questions from youth on the following topics?	**Very Comfortable**	**Comfortable**	**Uncomfortable**	**Very Uncomfortable**	**No Response**
Human Development*: Topics include reproductive and sexual anatomy and physiology, reproduction, sexual orientation, and body image and gender identity*					
Relationships*: Topic include families and raising children, love, romantic relationships and dating, and marriage and lifetime commitment*					
Personal Skills*: Topics include values, decision-making, communication, assertiveness and negotiation, and looking for help*					
Sexual Behavior*: Topics include sexuality throughout the lifespan, masturbation, shared sexual behavior, sexual abstinence, human sexual response, sexual fantasy, and sexual dysfunction*					
Sexual Health*: Topics include reproductive health, contraception, pregnancy and prenatal care, abortion, sexually transmitted infections and HIV/AIDS, and sexual abuse, assault, violence and harassment*					
Society and Culture*: Topics include sexuality and society, gender roles, sexuality and the law, diversity, and sexuality and religion, the media, and the arts*					

29. How *confident* are you (or would you be) in your ability to answer questions from youth on the following topics?	**Very Confident**	**Confident**	**Somewhat confident**	**Not confident**	**No Response**
Human Development*: Topics include reproductive and sexual anatomy and physiology, reproduction, sexual orientation, and body image and gender identity*					
Relationships*: Topic include families and raising children, love, romantic relationships and dating, and marriage and lifetime commitment*					
Personal Skills*: Topics include values, decision-making, communication, assertiveness and negotiation, and looking for help*					
Sexual Behavior*: Topics include sexuality throughout the lifespan, masturbation, shared sexual behavior, sexual abstinence, human sexual response, sexual fantasy, and sexual dysfunction*					
Sexual Health*: Topics include reproductive health, contraception, pregnancy and prenatal care, abortion, sexually transmitted infections and HIV/AIDS, and sexual abuse, assault, violence and harassment*					
Society and Culture*: Topics include sexuality and society, gender roles, sexuality and the law, diversity, and sexuality and religion, the media, and the arts*					

30. Please indicate which option best describes your *level of knowledge* on each topic.	**Very Knowledgeable**	**Somewhat Knowledgeable**	**Not Very Knowledgeable**	**No knowledge on this topic**	**No Response**
Human Development*: Topics include reproductive and sexual anatomy and physiology, reproduction, sexual orientation, and body image and gender identity*					
Relationships*: Topic include families and raising children, love, romantic relationships and dating, and marriage and lifetime commitment*					
Personal Skills*: Topics include values, decision-making, communication, assertiveness and negotiation, and looking for help*					
Sexual Behavior*: Topics include sexuality throughout the lifespan, masturbation, shared sexual behavior, sexual abstinence, human sexual response, sexual fantasy, and sexual dysfunction*					
Sexual Health*: Topics include reproductive health, contraception, pregnancy and prenatal care, abortion, sexually transmitted infections and HIV/AIDS, and sexual abuse, assault, violence and harassment*					
Society and Culture*: Topics include sexuality and society, gender roles, sexuality and the law, diversity, and sexuality and religion, the media, and the arts*					

31. Please indicate which option best describes your ***skill or ability* to answer questions from youth on each of the following topics.**	**Very Skilled/Able**	**Somewhat Skilled/Able**	**Not Very Skilled/Able**	**No Skill /Ability Discussing This Topic**	**No Response**
Human Development*: Topics include reproductive and sexual anatomy and physiology, reproduction, sexual orientation, and body image and gender identity*					
Relationships*: Topic include families and raising children, love, romantic relationships and dating, and marriage and lifetime commitment*					
Personal Skills*: Topics include values, decision-making, communication, assertiveness and negotiation, and looking for help*					
Sexual Behavior*: Topics include sexuality throughout the lifespan, masturbation, shared sexual behavior, sexual abstinence, human sexual response, sexual fantasy, and sexual dysfunction*					
Sexual Health*: Topics include reproductive health, contraception, pregnancy and prenatal care, abortion, sexually transmitted infections and HIV/AIDS, and sexual abuse, assault, violence and harassment*					
Society and Culture*: Topics include sexuality and society, gender roles, sexuality and the law, diversity, and sexuality and religion, the media, and the arts*					

Many professionals who work with youth receive training, both formal and informal. Formal training may include degree-granting programs, workshops, or continuing education credits. Informal training may consist of looking up information, talking with an expert, or reading a book.

32. Please indicate below whether, in the last **5 years**, you have received training, both formal and/or informal, on the following categories, which were described in the previous questions.

	Formal Training		Informal Training		
	Yes	No	Yes	No	No Response
Human Development					
Relationships					
Personal Skills					
Sexual Behavior					
Sexual Health					
Society and Culture					

33. I would be interested in training on how to deal with youth-related sexuality issues.

Yes
No
No Response

[If yes]

33a. Which of the following methods of training would you prefer? (check all that apply)

Instructor-led online classes
Self-guided online classes
Continuing education classes for CE credit
½ day workshops
Full-day workshops
Weekend retreats
College degree or certificate program
Other: _____
No Response

33b. If time and cost were not barriers, in rank order, what are the 3 sexuality-related topics you most want additional training/education on?

[text boxes, 50 words]

1 _____
2 _____
3 _____

34. In staying current on sexuality-related information, which source(s) do you use the most? [check all that apply]

    Academic journals
    Newsletters
    Internet/Websites
    Popular media (e.g., newspapers, magazines)
    Seminars/Workshops/In-services
    Other: _____
    I do not need to stay current on sexuality-related information
    No Response

Many youth-serving organizations provide resources and/or programming/services to youth on a variety of topics. Resources are typically informal and may include things like a pamphlet, brochure, or a card with a phone number or website on it. Programming is more formal and may include workshops, rap (discussion) sessions, or leadership development. Services would be considered a normal part of what the organization provides youth such as HIV testing.

35. Does your organization provide resources and/or programming to the youth served for any of the following topics/issues?

	Resources			Programming/Services			
	Yes	No	Unsure	Yes	No	Unsure	No Response
Alcohol/Drugs							
HIV/AIDS							
Other STIs (e.g., syphilis, gonorrhea)							
Contraception							
Pregnancy							
Puberty Issues: Menstruation, Breast Development, Voice Changes, etc .							
Reproductive Anatomy							
Gender issues							
Breast/testicular self exams							
Body Image							
Sexual Abuse							
Abortion							
Sexual Decision Making							
Communication/Refusal Skills							
Abstinence							
Condom Use/Safer Sex							
Sexual Orientation Issues							
Relationship Issues							

[If yes to any of the above under programming]

35a. What types of programming does your organization offer? (Check all that apply)

Session run by staff/volunteer
Classes that meet over several sessions (curriculum-based)
One time event (e.g., health fairs)
Lecture
Leadership development
Panel/Guest speaker
Peer education
Fieldtrip
Homework/Parent Involvement
Online Resources
Peer counseling
Support groups
Discussion groups
Other: _____
No Response

Many youth-serving organizations have protocols in place to handle referrals for youth. These protocols typically include a source(s) to which youth are directed to address a specific issue and a plan for how to refer to that organization (i.e., give the contact information to the youth, make an appointment for the youth). For example, an organization may have a list of other organizations that deal specifically with counseling youth of recently divorced parents which can either be given to the youth or called to set up an appointment for the youth.

36. Are there protocols in place at your organization for referrals for:	**Yes**	**No**	**Unsure**	**No Response**
Pregnancy Counseling				
Sexual Abuse Issues				
STIs (e.g., syphilis, gonorrhea)				
Contraception				
HIV Testing or Services				
Pregnancy Testing				
Domestic Violence				
Relationship Counseling				
Sexual Orientation Issues				
Abortion				
Psychological Distress				
Spiritual Counseling				
Financial Support for Teen Parents (WIC)				
Other: _____				

37. Which of the following descriptions best describes (or would describe) your organization's approach to providing sexual health and/or sexuality-related information to the youth they serve?

    a) Young people should be discouraged from having sex until marriage and providing them with information about sexuality is a confusing mixed message that should be avoided.
    b) Young people should be discouraged from having sex until marriage and should not have easy access to information. However, any questions they ask regarding sexuality should be answered accurately.
    c) Young people should be discouraged from having sex until marriage. They should have access to information about sexuality and any questions they ask should be answered accurately.
    d) Young people should be discouraged from having sex until adulthood. They should have access to information about sexuality and any questions they ask should be answered accurately.
    e) Young people should be encouraged to reduce risks when they have sex. They should have access to information about sexuality and any questions they ask should be answered accurately.
    f) No Response

38. How supportive do you perceive that the following are (or would be) to your organization for the dissemination of sexuality-related information?

	Very Supportive	Supportive	Neutral	Obstacle	Very Much An Obstacle	No Response
The leaders of your organization						
Your organization's policy/mission/values						
The community served by your organization						
Other staff/volunteers of your organization						
Youth served by your organization						
Parents of youth served by your organization						
Those who fund your organization						
Local policy						
State policy						
Federal policy						

The next questions concern a possible organization addressing sexuality-related needs for youth-serving agencies in Indiana. Please indicate your level of agreement with the following statements.

39. Youth serving agencies in Indiana could benefit from an organization that could provide sexuality-related research, evaluation, training, referral information, resource information and programming.

    ❒ Strongly Agree
    ❒ Agree
    ❒ Neither Agree nor Disagree
    ❒ Disagree
    ❒ Strongly Disagree
    ❒ No Response

40. There is an existing organization that could fill this role.

    ❒ Strongly Agree
    ❒ Agree
    ❒ Neither Agree nor Disagree
    ❒ Disagree
    ❒ Strongly Disagree
    ❒ No Response

    40a. If you agree, what is the name of that organization?

    _____

    40b. If you disagree, do you think a new organization should be created?

    ❒ Yes ❒ No ❒ Not sure ❒ No Response

41. Thinking about the work you do with the youth-serving organization you work/volunteer for, please indicate how often each of the following statements apply to you.

	Always applies to me	Sometimes applies to me	Rarely applies to me	Never applies to me	No Response
I feel as though I have to justify to others why I work with youth populations					
I feel as though I have to justify to others why my work involves adolescent sexuality					
I feel as though I have to justify to others why I work in a non-profit organization					
I am embarrassed about working with youth populations					
I am embarrassed that my job deals with adolescent sexuality					
I am embarrassed that my job is in the non-profit sector					
I worry what others assume about me because of my work with youth populations					
I worry what others assume about me because of my work around adolescent sexuality					
I worry what others assume about me because of my work in the non-profit sector					

42. Please indicate the extent to which you agree or disagree with the following statements:

	Strongly Agree	Agree	Somewhat Agree	Neutral	Somewhat Disagree	Disagree	Strongly Disagree	Unsure	No Response
Almost all pornographic material is nauseating.									
Masturbation can be an exciting experience.									
It would be emotionally upsetting to me to see someone expose themselves publicly.									
The thought of engaging in unusual sex practices is highly arousing.									
The thought of having long-term sexual relations with more than one partner is not disgusting to me.									

43. Over the course of this survey, we have asked you many questions about providing sexuality-related information to the young people served by your organization. Below is an open text box. Please feel free to provide any additional comments regarding the provision of sexuality-related information to youth through organizations such as yours. Are there things that would make it easier or more difficult for your organization to do this type of work? What role, if any, would you like your group to take in giving sexuality-related information to youth?

[text box, 5000 characters]

Thank you for your time completing this survey. If you know of anyone who may qualify to participate in the study, please feel free to pass along the web address to them (https://www.indiana.edu/~youth).

If you wish to receive a $5 gift card for participating and enter the drawing for 1 of 10 $50 Visa gift cards, please click the “I’d like a gift card” button below. You will be directed to a separate webpage not connected with the survey to provide a name and mailing address. If you do not wish to receive a $5 gift card for participating and do not wish to enter the drawing, please click the “Thank you, I do not want a gift card” button.

I’d like a gift card [continue to separate page not linked to survey database]

Thank you, I do not want a gift card [redirect to www.google.com]

Indiana Youth Worker Survey

You have indicated you would like to receive a $5 gift card and enter into the drawing for 1 of 10 $50 Visa gift cards for your participation in the Indiana Youth Worker Study. $5 gift cards are mailed every few days as mailing information is collected. Cards are mailed in an Indiana University envelop and contain no information indicating participation in the study. If you choose to enter the drawing and are selected as one of the winners, the card will be mailed to the same address. The drawing will occur on or before April 15th, 2009.

Thank you again for your participation. If you know of anyone who might qualify to participate in this survey, please feel free to provide them with the web address to take the survey (https://www.indiana.edu/~youth).

Please indicate the retailer of choice and provide a mailing address.
__ Wal-mart
__ Target
__ Starbucks

Name:
Address:
Address:
City: State: Zip Code:

[submit] – redirect to www.google.com

CURRICULA VITA

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EDUCATION

Indiana University
Doctorate of Philosophy in Health Behavior **2009**
Minor: Curriculum Studies and Educational Policy
Dissertation: "Assessing sexual health information and resource provision in Indiana youth-serving community-based organizations utilizing community-based participatory research (CBPR) method"

San Francisco State University
Master of Arts in Human Sexuality Studies **2008**
Thesis: "Same-sex attracted male youth experiences with abstinence-only until marriage sexuality education"

City College of San Francisco
Associate of Arts in Lesbian, Gay, Bisexual, and Transgender Studies **2003**

Indiana University
Bachelor of Science in Business Administration **1995**
Area of Concentration: Marketing

ACADEMIC APPOINTMENTS

Assistant Professor **2009-Present**
Department of Health Promotion, Social & Behavioral Health
College of Public Health
University of Nebraska Medical Center

Associate Instructor **2006-2009**
Department of Applied Health Science
School of Health, Physical Education and Recreation
Indiana University

Research Coordinator **2006-2009**
Center for Sexual Health Promotion
Department of Applied Health Science
School of Health, Physical Education and Recreation
Indiana University

Lecturer **2005-2006**
Biology Department
College of Science and Engineering
San Francisco State University

Lecturer/Consultant **2005-2006**
Academic Technology
Department of Academic Support
San Francisco State University

Research Assistant **2004-2005**
Center for Research in Gender and Sexuality
San Francisco State University

Graduate Teaching Assistant/Teaching Assistant **2003-2005**
Biology Department
College of Science and Engineering
San Francisco State University

RESEARCH

RESEARCH PROJECTS

Principal Investigator
Assessing sexual health information & resource provision in Indiana youth-serving community-based organizations utilizing community-based participatory research (CBPR) methods
Co-investigators: Michael Reece, PhD, MPH, Eric Wright, PhD, Brian Dodge, PhD, Catherine Sherwood, HSD
Funding: School of HPER Research Grant-In-Aid, $400

Co-Principal Investigator
Growing up LGBT in Indiana
Co-Principal Investigator: Eric Wright, PhD Co-investigators: Harold Kooreman, MA, Indiana Youth Group
Funding: School of HPER Research Grant-In-Aid, $1000; Graduate & Professional Student Organization Research Grant, $500; Friends of the Kinsey Institute Collaborative Student Research Grant, $500

Project Lead
Qualitative study of questions asked of in-home sex toy party consultants
Co-Investigators: Debby Herbenick, PhD, MPH, Michael Reece, PhD, MPH, Brian Dodge, PhD, Sonya Satinsky, MPH, Dayna Fischtein, MA

Project Lead
Indianapolis Men's Sex Survey
Co-Investigators: Michael Reece, PhD, MPH, Sonya Satinsky, MPH, Andreia Alexander, MPH, The Stamp Out Syphilis Community Coalition, MSM Subcommittee

Principal Investigator
Gay and Bisexual male experiences with abstinence-only until marriage sexuality education
Co-Investigators: Deborah Tolman, EdD, Jessica Fields, PhD
Funding: College of Behavioral & Social Sciences Research Grant, SFSU, $500

INTERNAL FUNDING FOR RESEARCH ACTIVITIES

School of Health Physical Education & Recreation Travel Grant-In-Aid **2009**
Presentation at Annual Meeting of the Society for the Scientific Study of Sexuality, Indiana University, $200.00

School of Health Physical Education & Recreation Travel Grant-In-Aid **2008**
Presentation at Annual Meeting of the Society for the Scientific Study of Sexuality, Indiana University, $200.00

Graduate & Professional Student Organization Travel Grant **2007**
Presentations at Annual Meeting of the American Public Health Association, Indiana University, $250.00

REFEREED RESEARCH ARTICLES

Fisher, C.M., Herbenick, D., Reece, M., Dodge, B., Satinsky, S., & Fischtein, D. (in press). Exploring sexuality education opportunities at in-home sex toy parties in the United States. *Sex Education*.

Fisher, C.M. (2009). Queer youth experiences with abstinence-only until marriage sexuality education: "I can't get married so where does that leave me?" *Journal of LGBT Youth*, 6(1), 61-79.

Dodge, B., Reece, M., Herbenick, D., **Fisher, C.M.**, Satinsky, S., & Stupiansky, N. (2008). Relations between sexual compulsivity and sexually transmitted infection diagnosis among a community-based sample of men who have sex with men (MSM). *Sexually Transmitted Infections*, 84, 324-327.

Satinsky, S., **Fisher, C.M.**, Stupiansky, N., Dodge, B., Alexander, A., & Reece, M. (2008). Sexual compulsivity among men in a decentralized gay community. *AIDS Patient Care and STDs,* 22(7), 553-560.

Reece, M., Dodge, B., Herbenick, D., **Fisher, C.M**., Alexander, A., & Satinsky, S. (2007). Experiences of condom fit and feel among African-American men who have sex with men (MSM). *Sexually Transmitted Infections*, 83, 454-457.

Fisher, C. M. (2006). Automated classroom response systems: Implications for sexuality education and research. *American Journal of Sexuality Education*, 1(4), 23-31.

BOOK REVIEWS

Fisher, C. M. (2007). Readings for the sexual literacy warrior. *Journal of Sex Research*, 44(4), 398-401.

BOOK CHAPTERS

Fisher, C. M. (2004). SB71 - The state of sexuality education in California. In A. Auleb (Ed.), *Human sexuality: Biology 330 lecture guide and workbook* (pp. 416-417). San Francisco: Edan Programs.

Fisher, C. M. (2004). A brief history of same-sex marriage. In A. Auleb (Ed.), *Human sexuality: Biology 330 lecture guide and workbook* (pp. 424-426). San Francisco: Edan Programs.

Fisher, C. M. (2004). The anus: The taboo erogenous zone. In A. Auleb (Ed.), *Human sexuality: Biology 330 lecture guide and workbook* (pp. 427-429). San Francisco: Edan Programs.

MANUSCRIPTS IN PREPARATION

Fisher, C.M., Reece, M., Wright, E., Dodge, B., Sherwood-Laughlin, C., and Baldwin, K. Expanding our reach: The potential for youth development professionals in community-based organizations to provide sexuality information.

Fisher, C.M., Reece, M., Dodge, B., Wright, E., Sherwood-Laughlin, C., and Baldwin, K. Expanding our reach: The role of community-based organizations in providing sexual health and sexuality-related information to youth.

Fisher, C.M. and Rosenberger, J. A queer pedagogy for sexuality education.

Fisher, C.M., Wright, E., Kooreman, H., and Reece, M. Long-term sexual health outcome associations with LGBT youth group participation.

RESEARCH PRESENTATIONS

Fisher, C.M., Herbenick, D., and Reece, M. (2009). *Exploring opportunities for increasing sexual literacy among women at in-home sex toy parties*. Transcending Boundaries in Sexuality Research: Bridging Disciplines & Communities, Campus Coalition for Sexual Literacy Regional Student Conference, Bloomington, IN.

Fisher, C. M., Wright, E., Kooreman, H., & Reece, M. (2008). *Results of a community-based participatory study assessing long-term impacts of LGBT youth groups.* Annual Meeting of the Society for the Scientific Study of Sexuality, San Juan, PR.

Fischtein, D., Satinsky, S., Herbenick, D., Reece, M., & **Fisher, C. M.** (2008). *Women's questions at in-home sex toy parties: Examining the heterosexual script.* Annual Meeting of the Society for the Scientific Study of Sexuality, San Juan, PR.

Fisher, C. M. (2008). *Development and deployment of a theory-based pedagogy for sexual health education.* Annual Meeting of the American Public Health Association, San Diego, CA.

Fisher, C. M., Wright, E., & Kooreman, H. (2008). *LGBT youth service organizations: Is there a relationship between participating in them and HIV/AIDS knowledge, testing behaviors, and serostatus?* Annual Meeting of the American Public Health Association, San Diego, CA.

Fisher, C. M., Koceja, D., Reece, M., Dodge, B., & Satinsky, S. (2008). *Assessing risk in men who have sex with men (MSM) based on number of sexual partners.* Annual Meeting of the American Public Health Association, San Diego, CA.

Dodge, B., Reece, M., Herbenick, D., **Fisher, C.M.**, Satinsky, S., & Stupiansky, N. (2008). *Relations between sexually transmitted infection diagnosis and sexual compulsivity in a community-based sample of men who have sex with men (MSM)*. Annual Meeting of the American Public Health Association, San Diego, CA.

Fisher, C. M., Alexander, A., Hollub, A., Satinsky, S., Stupiansky, N., Jozkowski, K, et al. (2008). *Sexual health in Indiana: A research update from the IU Center for Sexual Health Promotion*. Annual Meeting of the Indiana Public Health Association, West Lafayette, IN.

Fisher, C. M. (2007). *Narrative exploration of gay/bi male experiences of abstinence-only sex education*. Annual Meeting of the Society of the Scientific Study of Sexuality, Indianapolis, IN.

Fisher, C. M., Eggleston, B., Reece, M., & Satinsky, S. (2007). *Barebacking and MSM: Does assessing behavior alone really tell us much about risk?* Annual Meeting of the Society of the Scientific Study of Sexuality, Indianapolis, IN.

Satinsky, S., **Fisher, C.M**., Reece, M., & Eggleston, B. (2007). *Sexual compulsivity and venue-related sexual activity among men who have sex with men in Indiana*. Annual Meeting of the Society of the Scientific Study of Sexuality, Indianapolis, IN.

Fisher, C. M. (2007). *Sexual health of same-sex attracted male youth: Impacts of abstinence-only sexuality education*. Annual Meeting of the American Public Health Association, Washington, D.C.

Fisher, C. M., Reece, M., & Herbenick, D. (2007). *Perceptions of condom fit and feel and condom access among African-American men who have sex with men*. Annual Meeting of the American Public Health Association, Washington, D.C.

Fisher, C. M. (2007). *Abstinence-only sexuality education: Implications for sexual health and identity for same-sex attracted male youth*. Annual Meeting of the Rural Center for AIDS and STD Prevention, Bloomington, IN.

Fisher, C. M., Satinsky, S., & Reece, M. (2007). *Innovative sexual health research methods: Community recruitment of hidden populations*. Annual Meeting of the Rural Center for AIDS and STD Prevention, Bloomington, IN.

Satinsky, S., **Fisher, C. M.**, Eggleston, B., & Reece, M. (2007). *Loneliness and sexual disclosure to friends by MSM in a predominantly rural state*. Annual Meeting of the Rural Center for AIDS and STD Prevention, Bloomington, IN.

Fisher, C. M. (2006). *Navigating gay identities in an abstinence-only sex education environment.* The SF State of Sexuality: Graduate Conference, San Francisco, CA.

INVITED PRESENTATIONS

Fisher, C.M. (2009). *Panel: Community focused research*. Transcending Boundaries in Sexuality Research: Bridging Disciplines & Communities, Campus Coalition for Sexual Literacy Regional Student Conference, Bloomington, IN.

Fisher, C.M. (2008). *Growing up LGBT in Indiana.* Friends of the Kinsey Institute Student Seminar, Bloomington, IN.

TEACHING

COURSES TAUGHT

Course	*Semesters Taught*	*Average Enrollment*
Graduate		
HPER T590: Intro to Research in Health, Kines, & Rec (Online) Department of Applied Health Science, Indiana University (Co-taught)	1	10
HPER H540: Practicum in Teaching College Human Sexuality Department of Applied Health Science, Indiana University	1	1
HPER C591: Public Health Statistics Department of Applied Health Science, Indiana University (Co-taught)	1	50
Undergraduate		
HPER F255: Human Sexuality Department of Applied Health Science, Indiana University	3	100
HPER H340: Practicum in Teaching College Human Sexuality Department of Applied Health Science, Indiana University	1	5
HPER H315: Consumer Health Department of Applied Health Science, Indiana University	2	15
HPER H494: Research & Evaluation Methods in Health & Safety Department of Applied Health Science, Indiana University	4	34
BIOL 330: Human Sexuality Biology Department, San Francisco State University	4	225
BIOL 330: Human Sexuality (Online) Biology Department, San Francisco State University	2	150
BIOL 322: Human Sexuality, Integrative Science Biology Department, San Francisco State University	3	100
Faculty Seminars		
iLearn for Instructors Department of Academic Support, San Francisco State University	3	10

STUDENT RESEARCH MENTORING

Master's Thesis Mentor
Tun Aung Kyaw
Thesis: "HIV related knowledge and behaviors of Burmese refugees in the United States"

SERVICE

RESEARCH-RELATED SERVICE TO THE PROFESSION

Treasurer, HIV/AIDS Section **2008-Present**
American Public Health Association

Co-Chair, Programming Committee **2008-Present**
American Public Health Association, Student Assembly

Reviewer, HIV/AIDS Section Conference Abstracts **2008-Present**
American Public Health Association

Reviewer, Annual Conference Abstracts **2008-Present**
Society for the Scientific Study of Sexuality

SERVICE AS RESEARCH CONFERENCE MODERATOR

Discussant **2009**
'Challenges to change' papers: A panel discussion.
New Voices in Academia, A Graduate Student Conference, Bloomington, IN

Moderator **2008**
Comprehensive Approaches to Reducing HIV Among Adolescents
Annual Meeting of the American Public Health Association, San Diego, CA

Moderator **2008**
Emerging Scholars in HIV-Related Research
Annual Meeting of the American Public Health Association, San Diego, CA

Moderator **2007**
Policy Issues, HIV Intervention Programs, and Educational Strategies
Targeting Underserved Populations
Annual Meeting of the American Public Health Association, Washington, D.C.

Facilitator **2007**
Indiana Sexual Health Summit, Bloomington, IN

SERVICE TO UNIVERSITY, SCHOOL, AND DEPARTMENT

Treasurer **2007-2009**
Graduate & Professional Student Organization, Indiana University

Event Coordinator **2006-2007**
Indiana University Annual Latexhibition, World AIDS Day
An artistic display of latex-barrier devices to promote safer-sex practices

Coordinator **2007**
School of HPER, Dept. of Applied Health Science Exposition Booth
Annual Meeting of the American Public Health Association, Washington, D.C.

Invited Guest Lectures

HPER H263: Personal Health
Presentation: Being a good consumer of health
Department of Applied Health Science, Indiana University
HPER F255: Human Sexuality
Presentation: Anal sex 101: Myths and fact
Department of Applied Health Science, Indiana University
HPER F255: Human Sexuality
Presentation: Sexual differentiation & the intersex community
Department of Applied Health Science, Indiana University
HPER F255: Human Sexuality
Presentation: Reproductive anatomy and physiology
Department of Applied Health Science, Indiana University
HPER T590 Intro to Research in Health
Presentation: Qualitative research methods: The semi-structured interview
Department of Applied Health Science, Indiana University
HPER F255: Human Sexuality
Presentation: Gender roles and the intersex community
Department of Applied Health Science, Indiana University

HPER F255: Human Sexuality
Presentation: Theories of sexual identity and gender role development
Department of Applied Health Science, Indiana University
HPER H263: Personal Health
Presentation: Sexual health and you
Department of Applied Health Science, Indiana University

PEDAGOGICAL AND SERVICE PRESENTATIONS

Indiana Summit to Promote Adolescent Sexual Health (Apr 2009)
Health Care and Education Training, Inc., Indianapolis, IN.

Sex and the Mind-Body-Spirit Connection (Nov 2008)
Spirit & Place Festival, Indianapolis, IN.

Sexual health 101 (Sept 2007 & 2008)
Alpha Kappa Psi Event. Indiana University, Bloomington, IN.

Ask the "Sexpert" (Aug 2007)
IYG, Inc., Indianapolis, IN.

LGBT dating 101(July 2007)
IYG, Inc., Indianapolis, IN.

Focus group training (April 2007)
Positive Impact, Inc., Atlanta, GA.

COMMUNITY SERVICE

Mentor **2007-2008**
Indiana Youth Group

Certified Sex Educator **2004**
San Francisco Sex Information

Certified Peer Counselor **1990-1992**
Indiana Youth Group

ACADEMIC AND PROFESSIONAL HONORS

Exemplary Diversity Scholar **2009**
National Center for Institutional Diversity, University of Michigan

Indiana University School of HPER Graduate Fellowship, $3000 **2008-2009**

Best Student Abstract Award **2007**
School Health Education and Services Section
American Public Health Association

Indiana University School of HPER Graduate Fellowship, $1000 **2006-2007**

Grant A. Larson Fellowship in Gay and Lesbian Studies, $1000 **2006**
Human Sexuality Studies Department
College of Behavioral & Social Sciences
San Francisco State University

Dean's List **2003**
City College of San Francisco

Presidential Scholarship **1990-1991**
Ball State University

MEMBERSHIPS

American Public Health Association (APHA)
Indiana Public Health Association (IPHA)
Society for the Scientific Study of Sexuality (SSSS)

OTHER PROFESSIONAL EXPERIENCE

Editor **2004-2006**
EDAN
San Francisco, CA

Director of Marketing **2002-2003**
Resident Manager **2002**
Pacific Investment Properties
San Francisco, CA

- Responsible for marketing of company and available rentals; utilized research to enact actionable business plans
- Interacted with diverse groups of people during rental process
- Hired, trained and managed 8 assistant managers, promotion of 2 to resident manager

Senior Business Analyst **2001-2002**
Buyer **2000-2001**
Mervyn's
Hayward, CA

- Managed $40 & $50 million businesses
- Utilized market research in the development of new product offerings and advertising

Assistant Buyer **1999-2000**
Garden Ridge
Houston, TX

- Partnered with team to research, develop and implement new assortments
- Member of diverse task group that implemented new company policies and procedures

Allocation Analyst **1998-1999**
Merchandise Assistant **1997-1998**
Wilson's Leather
Brooklyn Park, MN

- Managed $250 million merchandise assortment
- Utilized store profiles and statistical sales analysis to define store clusters and assortments
- Primary communication link with international manufacturing offices

Assistant Buyer **1996-1997**
Target Corporation, Department Store Division
Minneapolis, MN

- Negotiated cost-savings programs with vendors
- Trained successful Merchant Trainee and managed two Merchant Technicians