The Need for Community-Responsive and Flexible Sex Ed for Historically Marginalized Youth

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Abstract
Introduction When it is offered, sexuality education in the USA is far from standardized. While studies have explored differences in delivery and type of sexuality education across the USA, sexual and reproductive health inequities persist among historically marginalized groups (Latino/a/x, Black, African American, LGBTQ +). There is a critical need to better understand the systemic barriers to receiving effective sexuality education in these communities.

Methods Participatory research methods were used in working with a community advisory board (CAB)—consisting of emerging adults and service providers from community-based organizations (CBOs) serving youth—to examine how structural barriers contribute to adolescent sexual and reproductive health (ASRH) inequities in Massachusetts. CAB meetings and semi-structured interviews were conducted in the cities of Springfield (n = 14) and Lynn (n = 9) between December 2020 and May 2021.

Results Inflexible funding guidelines, a related evidence-based curricular mandate, and a lack of community-responsive sexuality education fail to meet the sexual and reproductive health (SRH) needs of these youth.

Conclusions Current evidence-based mandates must be revisited to improve young people’s access to quality sexuality information in public schools. To guarantee sexuality education curricula is centered in the context of the community and population in which it is implemented, collaboration between youth-serving CBOs and school districts could improve students’ overall experience and social-emotional growth by providing comprehensive, positive, and community-responsive curricula.

Policy Implications Funders and programming should prioritize community responsiveness by financially supporting and developing and/or adapting evidence-based curricula to better match the community’s needs, which can be completed through culture-centered training and community-based partnership.

Keywords Public school system · Sexuality education · Systemic barriers · Marginalized youth · Evidence-based curricula

Introduction
There are a number of systemic barriers to implementing effective sexuality education in the USA. Sexuality education includes teaching about human sexuality, including intimate relationships, human sexual anatomy, sexual reproduction, sexually transmitted infections, sexual activity, sexual orientation, gender identity, abstinence, contraception, and reproductive rights and responsibilities (Breuner & Mattson, 2016). For the purposes of this research, formal
Sexuality education, “sex ed,” is delivered through curricula by public schools or community-based organizations. Regarding school-based sexuality education, only 30 states and the District of Columbia mandate that sexuality education be provided in the public education system (SIECUS, 2020; Guttmacher Institute, 2021). Of those states, only 18 require that content be medically accurate and nine require the program to be free of bias related to race, sex, and/or ethnicity (SIECUS, 2020). Furthermore, due to limited in-class time and resources in schools, sexuality education competes with academic subjects and other important socioemotional topics such as substance use, bullying, and suicide (SIECUS, 2020).

When it is offered, sexuality education is far from standardized, with differences in curricular content, perceived quality of information, comprehensiveness or scope/range of sexual and reproductive health content included in the program, as well as the physical and emotional environment in which the information is taught (Lindau et al., 2008). Without cohesive or consistent implementation processes, a highly diverse “patchwork” of sex education laws and practices exists (SIECUS, 2020).

Sexuality education in the public school system and the community can play a critical role in young people’s understanding of medically accurate and health-promoting information about sexuality-related topics (Lindau et al., 2008). Sexuality education can support young people in developing a healthy sexuality, which is a critical developmental milestone (Breuner & Mattson, 2016). Healthy sexuality encompasses more than the anatomy and physiology of sex and reproduction; it allows youth to learn and form thoughts and feelings about gender identity and sexual orientation and interpersonal relationships as well as intimacy (Breuner & Mattson, 2016). The inconsistent coverage of sexuality education limits youth’s ability to develop the needed skills and to access resources that enable them to engage in healthy sexual relationships (Breuner & Mattson, 2016; Goldfarb & Lieberman, 2021).

Differences in sexuality education have dramatic implications for adolescent sexual and reproductive health (ASRH) inequities. Quality sexuality education programming has been shown to decrease rates of pregnancy and sexually transmitted infection (STIs), as well as delay sexual intercourse, decrease the number of sexual partners, and increase the use of pregnancy and STI prevention measures (i.e., contraception) (Hall et al., 2016; Marseille et al., 2018). Furthermore, sexuality education can decrease homophobia and homophobic-related bullying, broaden understandings of gender and gender norms, increase knowledge and skills that support healthy relationships, build child sex abuse prevention skills, and reduce dating and intimate partner violence (Goldfarb & Lieberman, 2021). Youth who do not have access to adequate and inclusive sexuality education miss the opportunity to learn about SRH risks and outcomes, putting them at a disadvantage for negative health outcomes. Inclusive sex ed encompasses the beliefs, attitudes, and language for all identities and experiences, regardless of sex, sexual orientation, sexual behaviors, gender roles, gender identity, and gender expression (Cortes et al., 2016). Positive sexuality education or “sex-positive” approaches embrace sexuality and behavior and accepts sexuality as a natural human expression which can benefit adolescents’ experience (Kantor & Lindberg, 2020). Inclusive and positive sex ed provide students with a well-rounded curriculum that creates an open and safe environment for learning and discussion.

While studies have explored differences in delivery and type of sexuality education across the USA (Hall et al., 2016; Leung et al., 2019; Marseille et al., 2018), ASRH inequities persist among historically marginalized groups (Latino/a/x, Black, African American, LGBTQ +) (Centers for Disease Control and Prevention [CDC] WONDER, 2019). Although inequities in ASRH are often interpreted along racial lines, this simplification of data can advance a narrative that perpetuates racialized stereotypes (Cox, 2020). Instead, ASRH inequities should be understood as the result of a broad set of inter-related social determinants of health, including socioeconomic status and community environment (Garrido et al., 2018), and as the consequence of structural violence (Galtung, 1969 in Herrick & Bell, 2020). In a forthcoming manuscript, we document the structural barriers contributing to ASRH inequities among historically marginalized youth during the COVID-19 pandemic era.

There is a critical need to better understand the systemic barriers to receiving effective sexuality education in these communities. We present findings from a 4-year, community-based participatory research (CBPR) study begun in early 2020 by two researchers from a state university in Massachusetts and funded by the Massachusetts Department of Public Health (MDPH), Office of Sexual Health and Youth Development in the Bureau of Community Health and Prevention. The study aims to conduct formative research using participatory research methods in partnership with two diverse communities in Massachusetts (Valdez & Gubrium, 2020).

Specifically, we sought to understand ASRH service providers’ and emerging adults’ personal experiences with and perspectives on systemic issues that affect young people in Springfield and Lynn, MA, and their sexual and reproductive health, including racism, hetero/sexism, poverty, housing, food insecurity, policing, and education/schooling. Here, we present key findings focused on the systemic barriers to receiving effective sexuality education for historically marginalized youth.
Methods

Approach

Community-based participatory research is an effective qualitative research approach to engage in collaborative partnership with community members, organizational representatives, and academic researchers (Wallerstein & Duran, 2006). This research approach ensures a systematic effort to incorporate community participation and decision making, local theories of etiology and change, and community practices into the overall research effort (Wallerstein & Duran, 2006). CBPR may include community members across the research process, including in problem definition, data collection, the interpretation of data, and community application of the data (Israel et al., 1998). This is a viable approach to work with marginalized communities to understand social, structural, and physical environmental inequities (Israel et al., 1998).

Campus-Community Partnerships

The academic researchers partnered with two community-based organizations to conduct this study. The two partners are community-based organizations that serve Latino/a/x, Black, African American, and other culturally diverse populations in Springfield and Lynn, MA. Together, the academic researchers and community organizations recruited emerging adults and youth service providers, including those from outside organizations, to engage in a community advisory board (CAB) in each community (Valdez & Gubrium, 2020).

Study Setting

The study setting is located in the Springfield Metropolitan Area, including Springfield and Holyoke; and Lynn, MA; with both sites having large Black, Indigenous, and people of color (BIPOC) communities and exhibiting inequitable social indicators. Of Springfield residents, 44.7% are Hispanic or Latino/a/x and 20.9% are Black or African American (United States Census, 2020c). Nearly 20% of the overall Springfield population speaks a language other than English (United States Census, 2020a). Lynn, MA, is home to approximately 94,299 residents, as of 2019 (US State Census, 2020b). Lynn’s community is 43% Latino/a/x, 49% White, 14% Black, 7% Asian, less than 1% Native or Indigenous, and 7% multiracial (United States Census, 2020b). Lynn also has a substantial percentage of immigrants from several different nations; approximately 38.9% of the city reports being foreign-born and 51.5% of residents speak a language other than English at home (Spanish 33.8%, Asian languages 6.1%) (Beth Israel Lahey Health, 2019).

In 2019–2020, Springfield had an unemployment rate of about 6.2%, which is double the state’s unemployment rate of 3.1% (Gleckel, 2019). Lynn has a similar unemployment rate of 6.3% (Beth Israel Lahey Health, 2019). These statistics were published prior to the COVID-19 pandemic, which caused enormous job loss, and has subsequently impacted income and socioeconomic levels. The median household income for Springfield is $37.1 K, while the median household income in Lynn is much higher at $56 K. However, both cities are much lower than the MA state average of $74.2 K (United States Census, 2020c; US State Census, 2020b; Gleckel, 2019).

Approximately, 28.6% of the Springfield population live below the poverty line, with the majority identifying as Latino/a/x. Of the entire Springfield population, 76.7% are economically disadvantaged (Gleckel, 2019; Baystate Medical Center, 2019). In Lynn, 16.6% of residents live in poverty (US State Census, 2020b). More than one in four Lynn households have an income of less than $25,000, including about 10% of Lynn households with an income of less than $10,000 (Metropolitan Area Planning Council, 2021).

The teen birth rate (births per 1000 females aged 15 to 19 years) remains low in MA at about 6.9 per 1000, compared to the national average of 16.7, in 2019 (Martin et al., 2018; CDC WONDER, 2019). Although MA has the lowest teen birth rate in the country, it has some of the largest disparities between White and Latino/a/x teen birth rates, seen in Western MA (PHI Health Equity Report, 2019; CDC WONDER, 2019). Teen birth rates in Western MA are higher than the state average (PHI Health Equity Report, 2019; Massachusetts Births, 2017). Springfield, which is located in Hampden County, had an overall teen birth rate of 28.5 per 1000 in 2017; this increased from 25.2 in 2016, which was approximately four times the state average (Massachusetts Births, 2017, 2019; PHI Health Equity Report, 2019). The high teen birth rate in Springfield belies extreme ethnic and racial inequality.

Among all teen births in Springfield during 2017, 76.3% of mothers identified as Latino/a/x or Hispanic, compared to the state average of 53.7% (Massachusetts Births, 2017). Mothers who identified as Black non-Hispanic made up 13.9% of the teen births in Springfield, compared to the state average of 12.8% (Massachusetts Births, 2017, 2019). STIs are also high in Springfield compared to the state rate (Baystate Medical Center, 2019). In 2019, Springfield had the fourth highest chlamydia incidence rate in Massachusetts (1064.9 per 100,000 compared to the statewide rate of 444.1) and one of the highest gonorrhea incidence rates in Massachusetts (382.5 per 100,000 compared to the statewide rate of 109.1) (Massachusetts Department of Public Health, 2020). The city of Lynn also experiences SRH inequities. In 2017, teen birth rates in Lynn were 28.2 per 1000, which is four times the state rate and double the country’s average
Individual CAB Member and Coalition Member Interviews

We organized a CAB in each community to better understand the community experiences with and perspectives on ASRH inequities. CAB meetings took place quarterly by Zoom for 60 min/meeting in both Springfield and Lynn. We focused on discussing the study process and findings, with CAB members either providing services to youth (n = 10) or emerging adults (ages 18–24) who have received services from youth-serving organizations in the Springfield metro area or in Lynn, MA (n = 7). Some service providers have grown up in the local community. Inclusion criteria for CAB members are the following: (1) age 18 and older; (2) recipient of services by a youth-serving organization OR key stakeholder in a community-based organization serving youth; (3) agree to Zoom recording of participation in CAB meetings and one individual interview. We did not explicitly ask CAB members to indicate their race/ethnicity, but all CAB members identify as being from a historically marginalized populations (e.g., Black, African American, Latino/a/x, LGBTQ+). With assistance from our community partners, we also recruited seven members of a local coalition of key stakeholders focused on promoting adolescent health and positive youth development. The coalition includes volunteers from a variety of partnering organizations in the community: school-based health instructors or clinical staff, policymakers focused on the expansion or implementation of sexuality education for adolescents, family planning providers, and emerging adult community members. Coalition members participated in group-based interviews about ASRH service provision and inequity in the Springfield Metropolitan Area.

Sample and Recruitment

To inform the study process and for data collection purposes, the academic researchers and CBOs recruited key stakeholders to join a CAB in each community to better understand the community experiences with and perspectives on ASRH inequities. We engaged eight key stakeholders in the Springfield metro area and nine in Lynn (17 total) to participate in the respective CABs. CAB members either provide services to youth (n = 10) or emerging adults (ages 18–24) who have received services from youth-serving organizations in the Springfield metro area or in Lynn, MA (n = 7). Some service providers have grown up in the local community. Inclusion criteria for CAB members are the following: (1) age 18 and older; (2) recipient of services by a youth-serving organization OR key stakeholder in a community-based organization serving youth; (3) agree to Zoom recording of participation in CAB meetings and one individual interview. We did not explicitly ask CAB members to indicate their race/ethnicity, but all CAB members identify as being from a historically marginalized populations (e.g., Black, African American, Latino/a/x, LGBTQ+). With assistance from our community partners, we also recruited seven members of a local coalition of key stakeholders focused on promoting adolescent health and positive youth development. The coalition includes volunteers from a variety of partnering organizations in the community: school-based health instructors or clinical staff, policymakers focused on the expansion or implementation of sexuality education for adolescents, family planning providers, and emerging adult community members. Coalition members participated in group-based interviews about ASRH service provision and inequity in the Springfield Metropolitan Area.

Data Collection and Management

CAB Meetings CAB meetings took place quarterly by Zoom for 60 min/meeting in both Springfield and Lynn. We focused on discussing the study process and findings, with CAB members asked to provide their feedback and perspective on the study proceedings. One research assistant also took notes during CAB meetings to provide reflections and capture meeting dynamics not reliably documented by a Zoom recording. CAB members were compensated with $25 online gift cards for their participation in each meeting.

CAB Member and Coalition Member Interviews Individual interviews with all CAB members and group interviews (i.e., 2–3 participants) with Coalition members occurred via Zoom. The 1-h, semi-structured interviews sought to understand (1) systemic issues that affect young people in Springfield and Lynn and their sexual and reproductive health (racism, hetero/sexism, poverty, housing and food insecurity, policing, education/schooling, COVID, and others); (2) personal experiences with these issues; (3) resources for young people in the community and additional resources needed; (4) experiences with ASRH curricula/programming; and (5) whose voices or perspectives are missing? CAB members were compensated with $25 online gift cards for their participation in the interviews. Coalition members were not compensated for interviews due to funding restrictions.

All interviews and meetings were conducted and recorded on Zoom and transcribed verbatim by a research assistant. Zoom is a secure and reliable video platform used for virtual meetings and webinars (www.zoom.com). The data was kept in an encrypted OneDrive folder and only accessible to the research team. OneDrive is a file-sharing service for businesses and individuals and has stringent measures for data security (www.onedrive.live.com). Throughout all steps of the research process, confidentiality of data remained a high priority. All participant information is deidentified. The [University] IRB office approved this study.

Data Analysis

The two study co-principal investigators (co-PIs) and four research assistants independently reviewed and generated themes from the transcripts. The research team then conducted a second level of data analysis via weekly Zoom meetings. We explored and identified emerging themes within individual cases, and then across the data sources to consider how identified themes played out across the corpus of data to develop a preliminary list of codes. The research team members reached a consensus to finalize a codebook with a detailed description; inclusion and exclusion criteria; and typical, atypical, and close-but-no exemplars for each code to guide data coding (Bernard & Ryan, 2010). Collectively, we reviewed the codebook to guide further analysis and interpretation of the data. We used a content analysis approach to examine key themes emerging in the data and a context analysis approach to examine structural contexts (i.e., historical, political, economic) surrounding these themes.

CAB Member Check We presented an overview of key themes to Springfield and Lynn CAB members during separate quarterly meetings via Zoom, which were also audio-recorded and transcribed verbatim. The presentations were structured using a Socratic method, in which the academic research team posed a research question on a PowerPoint...
slide related to one emergent theme, after which the research team presented a brief review of the theme on a second slide, and then presented a third slide with empirical materials (i.e., interview extracts) that serve as evidence to support the finding. The research question, review of theme, and empirical material guided discussion with CAB members to clarify, expand, and check the validity of findings (Syvertsen, 2020). Results include content from these sessions.

**Results**

Interviews with youth service providers and emerging adults indicate that inflexible funding guidelines and a related evidence-based curricular mandate and a lack of community-responsive sexuality education fail to meet the SRH needs of historically marginalized—including Black, Latino/a/x, and or LGBTQ+ youth.

1. **Inflexible Funding Guidelines and Evidence-Based Curricular Mandate**

   Service providers shared their frustration with the strict and rigid guidelines outlined by funding agencies to work in ASRH, which they perceived to limit the effectiveness of sexuality education programs and services in the community. One service provider described how community organizations struggle to engage young people where they are at, given these inflexible funding guidelines.

   We don’t have a lot of flexibility from the funder about what we can do and if there’s emerging needs… We do run into youth who are trading sex for a place to live, or you know, various other things. And they’re people we would like to just engage them on the spot… But if we had a little more built-in flexibility, we might be able to meet the young adults where they’re at in a more effective way.

   Participants commented on the myopic focus of state funders (the most common source of funding available to support sexuality education programming) on narrow evidence-based approaches that must be offered with fidelity, rather than allowing them the flexibility to think more broadly and holistically to address co-occurring needs in the community that impact ASRH (e.g., housing and food insecurity). They emphasized the limitations of using evidence-based curricula, which are pre-approved and expected to be used as the “gold standard” in line with funding mandates. Given the process to establish a program as “evidence-based,” which requires lengthy randomized control trial testing and evaluation, approved curricula are often out-of-date and not responsive to pressing community needs. One service provider commented on the need for flexibility in this respect:

   I’m so torn with evidence-based curriculum. Because I understand why the funder wants us to use them, because they’re proven to be effective. And so, you want high-quality for the folks you’re working with. Especially since our…programming is supposed to be with kids who may be from families who were under-resourced, or more at risk of being pregnant… So, we wouldn’t want a disadvantage of them by giving something subpar.

   But if you don’t have a certain amount of flexibility, you can’t engage always in all the conversations that need to be engaged in. You don’t have the flexibility to do something shorter. Like we have multiple hours of curriculum, and we only have certain places where we can do that. But we have homeless young adults…that really could use some of the birth control, STI information in a shorter format… We’re not funded to do that and not that we never just do it anyway.

   Another service provider commented on the challenging expectation that each and every element of an evidence-based sexuality curriculum be imparted with fidelity to students. This means that curricula are long and onerous to implement, which dovetails with a lack of flexibility in their offering and, thus, an inability to meet participants’ needs:

   Sometimes it would just be really useful to be able to do a shorter version, a one time or whatever, just to jump in there where we have the opportunity…. The [Department of Public Health] is our funder, and they are not as flexible on those kinda points… I’m sure it’s because of where their funding comes from too and what’s required. I get it, but that piece would…allow us to be more responsive to sort of like emerging community needs and where we see these potentials for partnership… And then we have to say, “Oh, well, we could do that, but not very often because we’re locked into this other thing.”

   Participants discussed challenges with evidence-based curricula and their effectiveness for use in specific communities. One service provider described having to implement an evidence-based curriculum to fidelity, and their desire to use a curriculum better suited to the needs of their community.

   We also do an evidence-based curriculum. And I don’t think there is this perfect curriculum. And when…we have funding, that we have to do evidence-based and follow fidelity it gets really complicated… I wish, you know, that we could do a curriculum that really is effective for the population that we’re serving and not have to use this evi-
dence-based-to-fidelity [curriculum just] because somebody else is doing research that you’re going to screw up if you modify that curriculum.

2. Lack of Culturally Responsive Sexuality Education Curricula

Participants reported that much evidence-based sexuality education curricula used in Massachusetts are not sensitive to the needs of the youth with whom they work. They identified strong racially and culturally stereotyped messaging in sexuality education curricula that they perceived to negatively impact youth’s ability to relate to and engage with the material. In particular, they spoke of the hyper-sexualization of minoritized youth in the curricula and the ways these depictions can negatively impact recipients’ willingness to listen and learn, as well as their sense of self-esteem and health behaviors. One youth service provider explained how her students reacted to White educators teaching an evidence-based curriculum focused on Black youth:

The curriculum I had when I first started was Making Proud Choices and it was designed by Black people; Black, you know, public health people and sex ed teachers and stuff. And they designed it with Black youth in the videos because they wanted the youth that they were working [with] to see their own images, you know like, reflected. But yeah, I mean now it’s, like, thinking of, you know, a White woman coming in and showing these videos of Black youth. Like, sometimes youth would be like, “Why is it all Black people? Like, that makes it look like we’re the ones that are having all the problem?” You know, so it’s like, it just has different connotations based on who’s seeing it, and then it just like trying different things and seeing what’s working.

Telescoped depictions like these impart messages that may influence attitudes, beliefs, and behavior among historically marginalized youth. One service provider reasoned:

I mean, if you’re expected as a young person of color that you’re probably going to get pregnant, then why not fulfill the expectation that society has for you? It’s too hard to do the opposite.

Stereotypes may also impact young people’s ability to learn and engage with curricular material, as well as their sense of comfort in the sexuality education classroom. One emerging adult commented on the distress incurred from the trafficking of incendiary statistics:

Just from my experience, [educators] don’t, like, they don’t, per se, marginalize anybody when they’re talking about [sex]… Or sometimes they do. I guess you could say that ‘cause, like, for example, like, statistics…they always say like, “Black people…are more likely to get, like for example, a sexually transmitted disease than a White person is or a Hispanic girl or a Hispanic male is over any other kind of race, or that, like, Hispanics and Black people have, uhm, more health conditions, like, that are bad than other people.” Like, maybe that is true but it’s, like, I don’t know. Like, in high school, like, I was, like, the only Puerto Rican girl in my class. So, for you to say that, like, that, that just puts a target on my back.

Participants also commented on the narrow purview of sexuality education programs regarding gender identification and sexual orientation. Most curricula selected for implementation take a heteronormative and cisgendered perspective. One emerging adult commented that sexuality education curricula fail to account for differences in gender identity and sexual orientation:

If [sexuality education] didn’t really talk about gender identity and sexual orientation and like different sex, like, risks for them, so that’s also missing. Like, you shouldn’t only have, like, “okay, well put on a condom” and stuff. Not everybody you know has a penis that’s having sex, you know. Like…not everyone is having like heteronormative sex, so there could definitely be some variation.

One service provider spoke of attempting to adjust sexuality education curricula to be more inclusive of the experiences of a range of youth to avoid perpetuating stigma and shame:

One of the things we’ve done in this curriculum is make some of those adjustments… I noticed that even some of the curriculum that are intended to be more culturally responsive still have this sort of bit about, you know, being a young parent is not a good thing kinda, it’s something we really should avoid at all costs… It’s just definitely a rework of how the curriculum is set up. You know, they’re just more, like, you know, these are the things you should do to avoid… and you’re just, like, “ugh.” I don’t know. And I think that most of the curricula I’ve looked at have a lot of that in it so.

Discussion

We interviewed ASRH providers and emerging adult service recipients to explore perspectives on systemic barriers to receiving quality sexuality education in two underserved communities in Massachusetts. Youth service providers in our study reported that they struggle to meet the needs of local youth due to rigid and inflexible guidelines set by
their funders, including the duration and timing of approved evidence-based curricula. Towns, cities, and communities alike are increasingly required to implement evidence-based curricula by state and federal funders; however, educators are often not provided the essential guidance or tools to teach the material and promote behavior change in the youth (Chinman et al., 2008; Dickson et al., 2019). When districts select a curriculum, they should consider evidence to select and adapt programs that best match student needs and school capacity (Sedivy et al., 2017).

Additionally, studies show that instructors often struggle to retain fidelity and, as a result, adapt the evidence-based curriculum to suit the particular needs of their students, especially in school settings (Arons et al., 2016; Sedivy et al., 2017). Even when evidence-based curricula are selected for a particular population, instructors are faced with the challenge to ensure that all curricula content is taught in line with the school and funder’s standards and policies (Sedivy et al., 2017). Experts agree that the mandate for evidence-based sexuality education is almost always doomed to failure because the “gold standard” does not allow for flexibility in approach and the process to claim evidence-based is lengthy, meaning that curricula are almost assured to be outdated by the time they are implemented (Arons et al., 2016; Chinman et al., 2008). There is a growing need for funding entities, like departments of public health, to offer flexibility within their grant awards to address constraints (i.e., time, money, teaching staff, and other resources) faced by youth service providers in serving their communities (Chinman et al., 2008). Research suggests that flexibility is needed to allow facilitators to adapt the delivery of content of evidence-based practices to participant needs (Parekh et al., 2019). In the future, evidence-based program developers should include trainings with the instructors to discuss potential adaptations and understand where and when this is allowed, in order to improve the outcomes (Parekh et al., 2019).

Given the limited time and resources allocated to sexuality education in schools (SIECUS, 2020), research points to the benefits of partnering with local youth-serving organizations with SRH expertise and resources, approaches, and necessary personnel to deliver sexuality education (Butler et al., 2018). By teaming up with local sexual health organizations, schools may be able to offer CEBPs that can include contemporary workshops or activities tailored to the community (Secor-Turner et al., 2017).

We argue that curriculum centering on negotiating lived experiences—such as socioemotional and sexuality education programs—will rarely be adequate if they must hew to an evidence-based standard. Our local worlds are always changing—politically, socially, economically, and culturally, they are dynamic. The evidence-based mandate works against acknowledging dynamic considerations and is best conducted in a lab-based scenario.

Evidence-based programs heavily focus on pregnancy and STI prevention, rather than the broader inclusion of comprehensive sexuality education topics. Specifically, by having a narrow focus on reproduction and disease, the success measures of these evidence-based programs can only report on these limited areas of concern. This inhibits schools from focusing on other important components of sexuality health (e.g., sexual identity, sexual orientation, consent, healthy relationships) where relevance can vary between communities. The current curriculum deprive adolescents of the potential educational opportunities with these topics.

We acknowledge the rationale for evidence-based mandates—which arose out of the need to shift medicine and education toward science rather than folk practices (Guyatt et al., 1992; Slavin, 2002). In the context of sexuality education, evidence-based approaches have also served as correctives to abstinence-based approaches that spread shame, stigma, and misinformation (Stanger-Hall & Hall, 2011).

This means moving beyond the evidence-based mandate to develop culture-centered sexuality education programs for historically marginalized groups (Black, Latino/a/x, LGBTQ+, immigrant youth), ones that consider local cultural understandings, beliefs, values, and practices; structural dynamics; and that center the bodies and voices of the very youth engaged (Dutta, 2008; Kosciw, 2020). Indeed, evidence illustrates that many existing sexuality education curricula do not consider local social, cultural, or racial/ethnic dynamics, nor do they acknowledge the everyday reality of youth sexual practices (Kantor & Lindberg, 2020; Williams et al., 2013). Dialogic and participatory approaches to ASRH program development and implementation, including youth participatory action research (YPAR) (Fakoya et al., 2021), CBPR (McCuistian et al., 2021), and arts-based methods like digital storytelling (Botfield et al., 2018), body mapping and story circles (Brody et al., 2021; Gubrium & Shafer, 2014), and poetic inquiry (Dill et al., 2018), are shown to be successful at engaging historically marginalized youth. These approaches and techniques engage youth by increasing their sense of autonomy and self-expression, and by valuing and amplifying their voices (McCuistian et al., 2021).

Finally, scholars have documented problems not only in formal curricula, but also in the informal or hidden curricula—the implicit messages embedded in sexuality education—through which educators may inadvertently promote class, gender, and race stereotypes (Fields, 2008; Morris, 2007). Future research and practice should prioritize efforts to hire SRH educators and service providers from local communities with diverse linguistic and sociocultural backgrounds and skillsets, as well as support training based on the tenets of cultural humility (Greene-Moton & Minkler, 2020).
Conclusion

These findings highlight important systemic barriers to receiving effective sexuality education for historically marginalized youth, as perceived by emerging adult service recipients and youth service providers. Sexuality education curricula must be centered in the context of the community and population in which it is implemented, both in terms of inclusivity and representation, as well as in terms of recognizing the everyday lived experiences of youth recipients. Collaboration between youth-serving CBOs and school districts could greatly improve students’ overall experience and social-emotional growth, by providing comprehensive, positive, and community-responsive curricula backed by committed stakeholders.

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Author Contribution Elizabeth Valdez, Aline Gubrium, and Elizabeth Beatriz contributed to the study conception and design. Material preparation, data collection, and analysis were performed by Isabella Caruso, Elizabeth Valdez, Camille Collins Lovell, Jazmine Chan, and Aline Gubrium. The first draft of the manuscript was written by Isabella Caruso and all authors commented on previous versions of the manuscript. All authors read and approved the final manuscript.

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Declarations

Ethics Approval This study was performed in line with the principles of the Declaration of Helsinki. This study was declared exempt by the University of Massachusetts—Amherst Human Subject’s Protection Program—Institutional Review Board.

Consent to Participate Informed consent was obtained from all individual participants included in the study.

The opinions and views in this manuscript are the author(s)’ own and do not necessarily reflect the official policy or position of the Massachusetts Department of Public Health.

Conflict of Interest The authors declare no competing interests.

References

Arons, A., Decker, M., Yarger, J., Malvin, J., & Brindis, C. D. (2016). Implementation in practice: Adaptations to sexuality education curricula in California. The Journal of School Health, 86(9), 669–676. https://doi.org/10.1111/josh.12423

Baystate Medical Center. (2019). Community health needs assessment on Hampden County. Retrieved from https://www.baystatehealth.org/.

Bernard, H. R., & Ryan, G. W. (2010). Analyzing qualitative data: Systematic approaches. SAGE.

Beth Israel Lahey Health. (2019). Community health needs assessment. Northeast Hospital Corporation.

Botfield, J. R., Newman, C. E., Lenette, C., Albury, K., & Zwi, A. B. (2018). Using digital storytelling to promote the sexual health and well-being of migrant and refugee young people: A scoping review. Health Education Journal, 77(7), 735–748.

Breuner, C. C., & Matsson, G. (2016). Sexuality education for children and adolescents. Pediatrics, 138(2), e1–e11.

Brody, A., Lee, S. Y., Futrell, E., Bennett, I., Bouris, A., Jagoda, P., & Gilliam, M. (2021). Body mapping and story circles in sexual health research with youth of color: Methodological insights and study findings from adolescent X, an art-based research project. Health Promotion Practice, 1.

Butler, S., Sorange, D., & Hentz Beach, K. (2018). Institutionalizing sex education in diverse U.S. School Districts. Journal of Adolescent Health, 62(2), 149–156.

CDC WONDER. America’s Health Rankings analysis of CDC Wonder. (2019). Natality public use files, united health foundation. AmeriHealthRankings.org.

Chimman, M., Hunter, S. B., Ebener, P., Paddock, S. M., Stillman, L., Imm, P., & Wandersman, A. (2008). The getting to outcomes demonstration and evaluation: An illustration of the prevention support system. American Journal of Community Psychology, 41(3–4), 206–224.

Cortes, N., Eisler, A., & Desiderio, G. (2016). Tip sheet: Gender, sexuality, and inclusive sex education. Baltimore: Healthy Teen Network.

Cox, J. E. (2020). Understanding the differences in pregnancy and birth rates for Black and White teens. Journal of Adolescent Health, 67(3), 313–314. https://doi.org/10.1016/j.jadohealth.2020.06.010

Dickson, E., Parshall, M., & Brindis, C. D. (2019). Isolated voices: Perspectives of teachers, school nurses, and administrators regarding implementation of sexual health education policy. Journal of School Health, 90(2), 88–98.

Dill, L. J., Rivera, B. P., & Sutton, S. (2018). Don’t let nobody bring you down. The Ethnographic Edge.

Dutta, M. J. (2008). Communicating health: A culture-centered approach. Polity.

Fakoya, I., Cole, C., Larkin, C., Punton, M., Brown, E., & Ballonoff Suleiman, A. (2021). Enhancing human-centered design with youth-led participatory action research approaches for adolescent sexual and reproductive health programming. Health Promotion Practice, 15248399211003544.

Fields, J. (2008). Risky lessons. [Electronic resource]: sex education and social inequality. Rutgers University Press.

Galtung, J. (1969). Violence, peace, and peace research. Journal of Peace Research, 6(3), 167–191.

Garrido, M., Sufrinko, N., Max, J., & Cortes, N. (2018). Where youth live, learn, and play matters: Tackling the social determinants of health in adolescent sexual and reproductive health. American Journal of Sexuality Education, 13(3), 269–282.

Gleckel, J. (2019). Status of women and girls in Western Massachusetts. Springfield, MA: Public Health Institute of Western Massachusetts. Retrieved from https://www.publichealthwm.org/application/files/5816/0383/3804/FINAL_Status-of-Women-and-Girls-in-Western-Massachusetts-2019.pdf.

Goldfarb, E. S., & Lieberman, L. D. (2021). Three decades of research: The case for comprehensive sex education. Journal of Adolescent Health, 68(1), 13–27.

Greene-Moton, E., & Minkler, M. (2020). Cultural competence or cultural humility? Moving beyond the debate. Health Promotion Practice, 21(1), 142–145.
Guttmacher Institute. (2021). Federal policy snapshot: Federally funded

Gubrium, A., & Shafer, M. (2014). Sensual sexuality education with young parenting women. *Health Education Research, 29*(4), 649–661.

Guttmacher Institute. (2021). Federal policy snapshot: Federally funded

Guyatt, G., Cairns, J., Churchill, D., et al. (1992). Evidence-based medicine: A new approach to teaching the practice of medicine. *JAMA, 268*(17), 2420–2425. https://doi.org/10.1001/jama.1992.03490170092032

Hall, K. S., McDermott Sales, J., Konro, K. A., & Santelli, J. (2016). The state of sex education in the United States. *The Journal of Adolescent Health: Official Publication of the Society for Adolescent Medicine, 58*(6), 595–597.

Herrick, C., & Bell, K. (2020). Concepts, disciplines, and politics: on “structural violence” and the “social determinants of health.” *Critical Public Health*.

Israel, B., Schulz, A. J., Parker, E., & Becker, A. B. (1998). Review of community-based research: Assessing partnership approaches to improve public health. *Annual Review of Public Health, 19*(1), 173. https://doi.org/10.1146/annurev.publhealth.19.1.173

Kantor, L. M., & Lindberg, L. (2020). Pleasure and sex education: The need for broadening both content and measurement. *American Journal of Public Health, 110*(2), 145–148.

Kosciw, J. G., Clark, C. M., Truong, N. L., & Zongrone, A. D. (2020). *The 2019 National School Climate Survey: The experiences of lesbian, gay, bisexual, transgender, and queer youth in our nation’s schools*, New York: GLSEN.

Leung, H., Shek, D., Leung, E., & Shek, E. (2019). Development of contextually relevant sexuality education: Lessons from a comprehensive review of adolescent sexuality Education Across Cultures. *International Journal of Environmental Research and Public Health, 16*(4), 621.

Lindau, S. T., Tetteh, A. S., Kasza, K., & Gilliam, M. (2008). What schools teach our patients about sex: Content, quality, and influence on sex education. *Obstetrics & Gynecology, 111*, 256–266.

Marseille, E., Mirzazadeh, A., Biggs, M. A., Miller, A. P., Horvath, H., Lightfoot, M., & Kahn, J. G. (2018). Effectiveness of school-based teen pregnancy prevention programs in the USA: A systematic review and meta-analysis. *Prevention Science, 19*(4), 468–489.

Martin, J., Hamilton, B., Osterman, M., & Driscoll, A. (2018). Births: Final data for 2018. *National Vital Statistics: CDC, 68*(13).

Massachusetts Births. (2019). Boston, MA: Registry of Vital Records and Statistics. https://www.mass.gov/doc/2019-birth-report/download

Massachusetts Births. (2017). Boston, MA: Registry of Vital Records and Statistics. https://www.mass.gov/doc/2017-birth-report-updated-0/download

Massachusetts Department of Public Health, Bureau of Infectious Disease and Laboratory Sciences. (2019). Integrated HIV/AIDS, STD and viral hepatitis surveillance report. https://www.mass.gov/doc/2019-integrated-hiv-aids-std-and-viral-hepatitis-report/download. Published December 2020

McCustian, C., Wootton, A. R., Legnito-Packard, D., et al. (2021). Addressing HIV care, mental health and substance use among youth and young adults in the Bay Area: description of an intervention to improve information, motivation and behavioural skills. *BMJ open, 11*(4), e042713. https://doi.org/10.1136/bmjopen-2020-042713

Metropolitan Area Planning Council. (2021). Housing Lynn: A plan for inclusive growth. http://mapc.org/housing-lynn

Morris, E. W. (2007). Ladies or loudies? Perceptions and experiences of Black girls in classrooms. *Youth & Society, 38*(4), 490–515.

Parekh, J., Stuart, E., Blum, R., Caldas, V., Whitfield, B., & Jennings, J. M. (2019). Addressing the adherence-adaptation debate: Lessons from the replication of an evidence-based sexual health program in school settings. *Prevention Science, 20*(7), 1074–1088.

Public Health Institute of Western Massachusetts. (2019). *Springfield Health Equity Report*. Public Health Institute of Western Massachusetts.

Slavin, R. E. (2002). Evidence-based education policies: Transforming educational practice and research. *Educational Researcher, 31*(7), 15–21.

Secor-Turner, M., Randall, B. A., Christensen, K., Jacobson, A., & Loyola Meléndez, M. (2017). Implementing community-based comprehensive sexuality education with high-risk youth in a conservative environment: Lessons learned. *Sex Education, 17*(5), 544–554

Sedyvi, V., Rollerli, L., & Lesesne, C. (2017). Making evidence-based sexual health education work in schools: A companion to the promoting science-based approaches to teen pregnancy prevention using the getting to outcomes (PSBA-GTO manual) (MESH-EWS). Baltimore, MD: Healthy Teen Network.

SIECUS. Sex Ed for Social Change. (2020). SIECUS State Profiles: Updated May 2020. https://siecus.org/wp-content/uploads/2020/05/SIECUS-2020-Sex-Ed-State-Law-and-Policy-Chart_May-2020-3.pdf

Stanger-Hall, K. F., & Hall, D. W. (2011). Abstinence-only education and teen pregnancy rates: Why we need comprehensive sex education in the U.S. *PLoS ONE, 6*(10), 1–11. https://doi.org/10.1371/journal.pone.0024658

Syvertsen, J. L. (2020). Sharing research, building possibility: Reflecting on research with men who have sex with men in Kenya. *Human Organization, 79*(2), 83–94. https://doi.org/10.17730/1938-3525.79.2.83

United States Census. (2020a). Hampden county, massachusetts. U.S. Department of Commerce.

United States Census. (2020b). Lynn City, Massachusetts. U.S. Department of Commerce.

United States Census. (2020c). Springfield City, Massachusetts. U.S. Department of Commerce.

Valdez, E. S., & Gubrium, A. (2020). Shifting to virtual CBPR protocols in the time of Corona Virus/COVID-19. *International Journal of Qualitative Methods, 19*, 1609406920977315.

Williams, D. J., Prior, E., & Wegner, J. (2013). Resolving social problems associated with sexuality: Can a sex-positive approach help? *Social Work, 58*(3), 273.

Wallerstein, N. B., & Duran, B. (2006). Using community-based participatory research to address health disparities. *Health Promotion Practice, 7*(3), 312–323.

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