JOURNAL OF SCHOOL HEALTH

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Research Article

Facilitators and Barriers to Implementing a Comprehensive Sexual Health Education Policy in Chicago Public Schools

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ABSTRACT

BACKGROUND: In 2013, the Chicago Public Schools (CPS) district passed a policy requiring schools to deliver comprehensive sexual health education (SHE) to all K-12th grade students. A performance improvement case study was conducted in the 2019-2020 school year to evaluate the implementation of the policy and identify lessons learned to support implementation in schools.

METHODS: Key informant interviews were conducted with 11 school principals and 29 teachers to discuss SHE implementation at their school. Interviews were recorded, transcribed, and analyzed to assess school and classroom factors that affect implementation. Themes that cut across these factors were then identified and summarized by 2 evaluators.

RESULTS: The following themes were identified across key informant interviews: (a) principal prioritization of SHE helps ensure SHE is implemented, (b) the expansion of school and teacher capacity facilitates SHE implementation, and (c) the creation of accountability mechanisms in classrooms and schools fosters adherence to SHE policy.

CONCLUSIONS: Principals play a crucial role in building capacity to deliver SHE and ensuring SHE accountability mechanisms are implemented in their school. CPS is using these findings to adjust technical assistance and resources provided to principals and SHE instructors.

Keywords: policy implementation; school; sexual health education; evaluation.

Citation: Belcher K, Fishman E, Ramirez-Mercado K, Marshall B, DiPaolo M, Jarpe-Ratner E. Facilitators and barriers to implementing a comprehensive sexual health education policy in Chicago Public Schools. J Sch Health. 2024. https://doi.org/10.1111/josh.13489.

Received on September 22, 2023
Accepted on June 5, 2024

The call for mandated comprehensive sexual health education (SHE) for students in K-12th grade settings persists,[1,2] particularly in light of the strong evidence base for comprehensive SHE.[3,4] Comprehensive SHE programs focus on building ''a foundation of knowledge and skills relating to human development, relationships, decision making, abstinence, contraception, and disease prevention.''[3,5] They are linked to improved dating and interpersonal violence-related outcomes, greater acceptance of sexual diversity among students, and improved outcomes related to social and emotional learning and

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We would like to acknowledge and express our gratitude toward the Chicago Public School principals and SHE instructors who participated in this evaluation. And, finally to Madeline Mangiaracina who contributed foundational efforts in the implementation of this work. This manuscript was supported by Grant or Cooperative Agreement number 6 NU87PS004311, funded by the Centers for Disease Control and Prevention. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the Centers for Disease Control and Prevention or the Department of Health and Human Services.

media literacy, in addition to reductions in pregnancies and STIs.[3,4] Researchers have noted that SHE is most effective when it begins as early as Pre-K and uses scaffolding as an instructional approach, as repeated exposure to this content allows students to master knowledge and skills.[3,6]

In 2013, Chicago Public Schools (CPS) mandated that all K-12th graders be taught comprehensive SHE—as defined by the National Sex Education Standards (NSES). Schools were required to (1) have 2 CPS District-trained SHE instructors; (2) deliver, annually, 300 minutes of instruction to students in grades K-4th and 675 minutes in grades 5-12th; (3) use a medically accurate, age-appropriate, NSES-aligned curriculum; and (4) provide at least 3 forms of notification of instruction to parents/caregivers.[7] An accompanying SHE curriculum and instructor training were developed by the district's Office of Student Health and Wellness (OSHW) to support this policy. The CPS SHE curriculum is aligned with the National Sexuality Education Standards. Topics and skills include consent and healthy relationships, anatomy and physiology, puberty and adolescent sexual development, gender identity and expression, sexual orientation and identity, sexual health, and interpersonal violence prevention. It was adapted from several existing evidence-based curricula that were perceived to best meet the needs of Chicago youth. More information on the policy, curriculum, training, and other programming can be found on the CPS district's website (https://www.cps.edu/services-and-supports/health-and-wellness/sexual-health-education/).

OSHW, tasked with managing the district's health and wellness initiatives, nests the SHE policy under the umbrella of its Healthy CPS (HCPS) Initiative, through which schools can earn badges and distinctions for complying with a series of health and wellness policies. Schools are asked to report compliance by completing the HCPS survey annually. One of the district goals is to increase the proportion of schools achieving compliance with the SHE policy. Survey data from the 2018-2019 academic year revealed that 80% of CPS schools reported implementing SHE but only about 40% were meeting the minimum instructional minutes for each grade, indicating an opportunity for improvement.[8]

As states and districts pass comprehensive SHE mandates,[9] attention has turned to exploring what factors could potentially affect the implementation of such policies, and what resources can be provided to support an increased uptake of comprehensive SHE mandates in schools. Among the handful of recent studies exploring factors that influence the implementation of district- and state-level SHE policies[10-17] and studies examining factors that influence SHE delivery in schools and classrooms,[18-22] several facilitators and barriers were found. These factors include the level of clarity or ambiguity in state and district SHE policies; consistency of implementation; funding, material support, and resources for SHE implementation and instructors' professional development (PD); and oversight & accountability for SHE policy implementation.[10-12,14,16,19,21,22] Other factors also include level of engagement and support from community, school, and district administration; competing educational priorities; scheduling and time available for curriculum delivery, instructors' awareness and knowledge of policy, and teacher discomfort.[11-22]

The OSHW and evaluators from the **University of Illinois Chicago (UIC) School of Public Health** set out to explore the role these factors and other factors play in SHE implementation in the district. During the academic year 2019-2020, a performance improvement case study was conducted to identify school- and classroom-level factors that influenced SHE policy implementation in the district. Evaluation findings were used to inform the district's ongoing capacity building efforts and identify lessons learned to promote SHE uptake in schools. This paper describes the findings and lessons learned from this evaluation, as well as CPS's approach to integrating these findings in their ongoing work to build schools' capacity and to update their SHE policy.

METHODS

Participants

School principals and SHE teachers were recruited for participation in key informant interviews. Recruitment was initiated in Summer 2019 and extended through Summer 2020. A purposeful maximum variation sampling approach[23] was initially used to invite principal interviewees based on their school's SHE implementation status. HCPS survey data was used to classify schools as having ''full'' (met the required number of minutes for all grades), ''partial'' (taught SHE but did not achieve all required minutes) or ''no'' SHE implementation. Recruitment materials were sent to potential interviewees in waves, and 2-4 follow-ups were sent to those that did not respond. A Fall 2019 teacher's strike and the onset of the COVID-19 pandemic during this time led the evaluation team to employ a criterion-based sampling approach[14] through which all trained SHE teachers were ultimately invited to participate, regardless of the classification of their school in terms of the SHE policy. SHE instructors were recruited via newsletters and the district's SHE instructor training. Educators that attended the SHE instructor training were asked to indicate their interest in participating in the key informant interviews by providing their name and email via a sign-up sheet. Evaluators followed-up with participants over email, and 2-4 follow-ups were sent to those that did not respond.

Instrumentation

Semi-structured guides for principal interviews (Data S1) and teacher interviews (Data S2) were developed by an evaluation team member and then refined through team feedback. Interview guide questions and accompanying probes focused primarily on the characteristics of SHE implementation in schools, such as staff responsible for the implementation of SHE; time of year of instruction; coordination of instruction across classrooms; planning meetings between staff and school leadership; parental engagement and feedback around SHE; usage of CPS's SHE curriculum; and how instructional minute requirements were met, and if not, what supports they would need to do so. Principals from non-implementing schools were also asked about their perceived barriers to implementing SHE, any current or previous preparations made for SHE implementation, perceived potential outcomes of SHE instruction, and resources needed to implement SHE at their school. Teachers in partially implementing schools were also asked about their perceived barriers to implementing SHE. Principals and teachers were asked about their current knowledge of the Healthy CPS program, how they understood SHE fitting into the overall program, their current Healthy CPS status, and any successes and difficulties they encountered while trying to achieve Healthy CPS status.

Procedure

The interview protocol was determined non-research due to its status as a performance improvement evaluation project. It was determined to be non-research by UIC Institutional Review Board and approved by CPS Research Review Board (RRB), which reviews all data collection in the district. Semi-structured interviews were conducted by 3 UIC evaluation team members, which included a lead evaluator and 2 assistant evaluators. The lead evaluator during this time had more than a decade of qualitative research experience and 8 years of experience conducting research in school settings. UIC evaluators obtained verbal and written consent from participants prior to conducting and recording interviews. All but 1 participant agreed to be recorded. Interviews lasted roughly 45-60 minutes, and took place in person, over the telephone, or virtually using Google Meet software. Memos were captured by the interviewer during interviews. After the interview, audio files were transcribed by a professional transcription agency. Electronic gift cards were then emailed to SHE instructors as compensation for their time and to acknowledge the additional burden placed on them during the COVID-19 pandemic. The final sample included a total of 40 interviewees which consisted of 11 principals and 29 SHE instructors employed across 35 elementary schools and high schools. Five schools in the sample had more than 1 staff member participate in interviews. The final sample size was similar to our intended total sample size of 32-42 key informant interviews, consisting of 8-10 interviews with principals of non-implementing, partially implementing, and fully implementing schools and 8-12 key informant interviews with teachers. Eight to twelve interviews were selected as it is the recommended number of interviews to ensure saturation.[24] Due to having fewer interviews conducted with principals than planned, additional key informant interviews with teachers were conducted. As such, a total of 40 key informant interviews were conducted to conduct a robust qualitative evaluation of SHE implementation in the district.

Data Analysis

Written transcripts were entered into MaxQDA's qualitative data analysis software for coding and analysis. Two UIC evaluators reviewed the transcripts of key informant interviews that were held with principals. A set of a priori codes were developed based on the interview guide, and emergent codes were identified as the transcripts were reviewed by the evaluators. Overarching codes and subcodes were developed to capture the participant's role; their school characteristics; their SHE-related knowledge, attitudes, and views; and their knowledge of the CPS SHE policy and training. Codes were also created to capture how SHE planning and implementation was done in schools, participants' feedback on the district's SHE training and curriculum, and factors that facilitated or impeded SHE implementation.

UIC evaluators then coded 4 key informant principal interview transcripts using the list of developed codes. The coded text segments were compared for the first set of transcripts, and evaluators reached an initial 79% agreement rate. UIC evaluators discussed the application of the codes to transcripts, and revised coding applications. Codes were then subsequently applied to 2 additional sets of key informant principal interviews, containing 2 transcripts each, with evaluators eventually achieving an 87% agreement rate. The remaining transcripts of the key informant interviews held with principals and teachers were coded by 1 evaluator, with ongoing discussion with the other evaluator to examine areas of coding agreement.[23] Key factors that influenced SHE implementation were identified during the initial round of coding. After several rounds of coding, a set of themes that cut across these factors were identified, refined, and summarized by the evaluators. Themes identified during analysis are presented here in this paper.

RESULTS

Evaluators interviewed key informants employed across 23 elementary and 12 high schools in the CPS district. Table 1 provides an overview of the characteristics of the schools where principals and teachers worked. There was a relatively equal mix of schools from the northern, southern, and western regions of the city, with slightly fewer schools located on the west side of Chicago. Schools in the sample were predominantly Hispanic and had partially or fully implemented SHE in compliance with the CPS SHE policy.

As described above, data were examined to explore school- and classroom-level factors that influenced SHE policy implementation in the CPS district, and themes that cut across these factors were identified. Discussions with key informants revealed the following 3 themes: (a) that principal prioritization helps ensure SHE is implemented, (b) the expansion of school and teacher capacity facilitates SHE implementation in the district, (c) and the creation of accountability mechanisms in classrooms and schools fosters adherence to SHE policy in the district. The findings below are reported under headings aligned with these 3 themes, and Table 2 provides an overview of these themes and examples of illustrative quotes from teachers and principals. Principal and teacher responses together contributed to the overall themes, and are therefore discussed and presented together below.

Principal Prioritization Helps Ensure SHE Is Implemented

Principals that prioritized students' overall health and recognized the need for SHE actively ensured that it was taught in compliance with the district's policy.

Table 1. **Sample Schools Characteristics**

Characteristic	n (%)
Geographic region	
North side	12 (34.0)
West side	9 (26.0)
South side	14 (40.0)
Racial demographics*	
Majority African American	11 (31)
Majority Hispanic	20 (57)
Majority White	4 (11)
School type	
Elementary school (K-8th grade)	23 (66.0)
High school (9th-12th grade)	12 (34.0)
SHE implementation status	
Full implementation	16 (46.0)
Partial implementation	18 (51.0)
No implementation	1 (3.0)

*"Majority" in this case means the racial/ethnic demographic of students that makes up the largest portion of the school population. Racial demographics are presented this way to protect the identity of schools in the sample. However, 26 schools in the sample had 50% or more students belonging to one racial/ethnic category.

During interviews, principals discussed the importance and the impact of setting SHE as a school priority, which determined whether it was accomplished during a given school year. As one principal explained, ''I would say it has to be prioritized at all levels, and so usually that has to start with the principal because the principal sets the tone for what the school focuses on.'' [Principal 4]. This prioritization extended beyond merely articulating it as a priority. Schools that had implemented SHE in accordance with the policy had principals that reported engaging in the following activities: (1) creating a plan for SHE delivery, (2) ensuring that the appropriate staff members were trained and prepared for delivery, and (3) creating a school master schedule that ensured students had access to a teacher that could teach SHE. One elementary school teacher expressed the difficulties of implementing SHE without principal engagement stating, ''. . . if you don't have a supportive admin, who's going to make sure that the schedule works, and that you have enough people trained in your school to teach it . . . it's not going to happen.'' [Teacher 5].

Some principals delegated these activities to a staff member or an administrative department to fulfill this role. For example, one elementary school teacher stated, ''at my current school, our counselor and the IB coordinator were basically designated [by the assistant principal] to make sure the school is meeting the requirements. So, I was kind of directed by them to do it.'' [Teacher 1]. During interviews, some teachers also mentioned taking the initiative themselves to be trained, and roughly two-thirds of teachers in our sample described having the latitude to create their own schedules to implement SHE. Many teachers felt their principal trusted them and would provide assistance if faced with barriers to obtaining training and scheduling SHE. For example, one teacher mentioned having to remove content from the science curriculum to incorporate SHE, and stated ''But I would say, because we have support from our administrators to have a little flexibility in our time and our schedule, that it allowed us to do that.''[Teacher 2].

However, some teachers felt they needed explicit and direct support from the principal to implement SHE. For example, one teacher explained that principal support is essential when scheduling SHE ''because whatever you are doing is taking away from something else; So like if I'm pulling kids for sex ed, then I'm taking the PE teacher's time or in some cases even the Art teacher's time.'' [Teacher 6]. As such, successful SHE implementation in schools where principals were less involved in planning depended on the amount of autonomy and authority teachers were given by the principal. Many teachers felt they could lead SHE implementation in their schools because their principals had explicitly delegated this responsibility to them.

Table 2. **Themes and Illustrative Quotes**

Themes	Illustrative Quotes
Principal Prioritization Helps Ensure SHE is Implemented	"And what I pay attention to is what they pay attention to, the teachers. So, the fact that I was adamant about this, and the fact that I put a system in place for it to be implemented. . . . And I make the time, I help teachers arrange their schedules so that they can figure out how this is going to be taught."—Elementary School Principal 2 "They [administration] looked at the schedules and sent out a recommended time slot to be able to teach that [sex ed], and they looked for input to see what would be the best time of the day that it would not interfere with other learning . . . Once they did, they sent the schedule around and they made sure that everybody knew in advance where it was going to be taught, what it was going to look like. . . . "—Elementary School Teacher 8
Expanding School and Teacher Capacity Facilitates SHE Implementation in the District	
Schools' capacity to implement SHE depends on availability of personnel, classroom space, and time	"I remember I was an assistant principal when they first put out the new curriculum . . . We were trying to think at that time who was going to deliver the curriculum and how . . . So then I came into my current role already knowing about it, particularly because we had resources to have a health teacher, I was able to make sure that that curriculum is being delivered . . . unfortunately, it's at the sacrifice of the arts."—Elementary School Principal 3
Teacher's capacity to implement SHE depends on the teachers' skills, comfort, and behavior	"Interviewer: . . . Do you do a condom demonstration with the middle school? Teacher: So, that was . . . I think if I remember that's one of those lessons that's optional . . . And I just remember . . . I remember thinking if it's optional, like, I'm going to opt out of it because I just think that there'd be a lot of push back from parents on that."—Elementary School Teacher 10
The creation of accountability mechanisms in classrooms and schools fosters adherence to SHE policy in the district.	
School accountability is influenced by district-level programs and initiatives	". . . so there's three classes that students have to take. You have to take driver's education, students have to pass the public and law exam, and students have to do financial literacy [for high school graduation] . . . So, everything that CPS has to do is say, "Guess what? . . . mandate it including the sexual education component."—High School Principal 5
School accountability is influenced by teachers' tracking and reporting behaviors	". . . we're making sure there's enough weeks and time to teach the 300 minutes. There's this tracking log that we receive during the training, and we just mark it down there."—Elementary School Teacher 1

Expanding School and Teacher Capacity Facilitates SHE Implementation in the District

Schools' capacity to implement SHE depends on availability of personnel, classroom space, and time. Key informant interviews revealed that schools needed capacity at the school- and classroom-level to ensure that SHE was fully implemented. The ''school-level'' dimension of school capacity is related to having the personnel, as well as resources, such as classroom space and time, to support having SHE instruction. One elementary school principal noted that having the funds available to hire an external health educator to teach students was crucial to their ability to implement SHE. For some schools, the use of P.E. to incorporate SHE meant redirecting resources from other programs. One elementary school principal cited having the resources to support a P.E. and Health teacher, but this was at the expense of an arts/music teacher [Principal 3]. Other principals, particularly at the elementary school level, talked about having a piecemeal approach of assigning the responsibility of teaching different grades to the PE teacher, counselor, and science teacher.

Many teachers who had difficulties meeting the minute requirements for SHE noted limited access to classroom space and time. The use of P.E. to incorporate SHE also made it difficult for instructors to obtain classroom space that was large enough to accommodate their class size, and a suitable setting for the delivery of SHE. For example, one high school teacher remarked, ''That's a problem, that PE classes are so large and space is limited.'' [Teacher 13]. Another high school teacher described the effect of such settings on students by noting that it was difficult for their students to concentrate in a small, crowded classroom [Teacher 12]. An elementary school teacher described the necessity of having access to suitable classroom space by stating, ''. . . you got to give them a good space . . . where kids can learn this stuff. A stage behind a gym, a noisy gym, that's not the best way to do it.'' [Teacher 10]. One high school P.E. teacher described their ability to implement SHE due to having space and built-in time in their schedule, stating ''I see my students for 50 minutes every day. So that's pretty easy . . . If we need a couple more days here or there,

I could just pull them into the classroom. I don't have to worry about coordinating any space.'' [Teacher 11]. In addition to time and space, high schools also faced competing educational priorities. Participants reported it being easier to implement SHE during P.E. and Health in 9th grade. However, there was less time and staff to dedicate to these courses beyond 9th grade due to competing educational priorities.

Teacher's capacity to implement SHE depends on the teachers' skills, comfort, and behavior. The ''classroom-level'' dimension of school capacity is related to teachers' skills, comfort, and behavior. Teachers needed time to print copies, gather materials, and prepare materials for games, group activities, etc. The lack of time available to prepare for the SHE delivery was a common barrier to completing certain lessons or adequately covering content. One teacher remarked ''.... If I'm not getting time to plan, I feel that sometimes I am kind of rushing it. In order to do it justice, I believe we need planning time.'' [Teacher 9].

Several teachers also felt discomfort and difficulty delivering certain SHE content. Content that was most frequently cited by teachers, especially elementary school teachers, were related to LGBTQ+ identities and condom demonstrations. One teacher stated, ''the only thing I had a problem with is the whole LGBTQ thing. It was hard for me to teach that ... I think for one of them, I just skipped it because I'm just like, ''I don't feel confident doing this ...'' [Teacher 4]. Teachers that expressed reluctance in doing condom demonstrations cited reasons such as perceived lack of parental comfort, lack of administrative support, age or maturity of their students, and lack of personal comfort. One-fourth of teachers also cited concerns of ensuring student comfort when teaching mixed gender classrooms. For example, one teacher described teaching mixed-gender classrooms as ''very hard to do,'' because when teaching their students about ''body parts,'' their students became ''very nervous and very quiet.'' [Teacher 3].

Teachers across grade levels frequently expressed concern and fear that saying the wrong thing would result in disciplinary action, especially with certain topics, such as sexual consent. A few principals noted that their teachers were not comfortable with the material and wondered whether that influenced their delivery of the content. For example, one high school principal noted their teachers were uncomfortable with teaching SHE because there was so much ''scrutiny around it,'' and later stated, ''I think for the teachers having the curriculum, they're like we taught the lesson and that's the end of it. I don't know that that's necessarily the best for kids ... because depending on the teacher, their comfort level will probably dictate how much support and information they're willing to give ...'' [Principal 6]. During key informant interviews, many interviewees believed that elementary classroom teachers were better suited for delivering SHE instruction to mixed gender classrooms and covering sensitive topics with their students because rapport has already been built among students and teachers. One classroom teacher remarked they were best suited to teach SHE to their students because they were ''around them so much'' and ''embedded within their social circle,'' and could use their knowledge of their students when teaching SHE. They said, ''I can note these things and bring what I learn into what I'm teaching.'' [Teacher 7].

Some principals observed that in-person training was important to help teachers talk through these nuances. A few teachers revealed that additional support from the district was needed because principals did not always have the necessary expertise to support them in the delivery of SHE. The teacher experiencing difficulty teaching mixed-gender classrooms revealed this sentiment by saying, ''... my principal observed me, which she doesn't really know how it's supposed to be going, so it'd be nice to get some feedback on what I'm doing right and what I'm doing wrong.''[Teacher 3]. As such, principals and teachers frequently requested additional training and resources from the district office for assistance in these areas.

The Creation of Accountability Mechanisms in Schools and Classrooms Fosters Adherence to SHE Policy in the District

School accountability is influenced by district-level programs and initiatives. A few principals and teachers mentioned being held accountable to delivering SHE by their participation in the district's Healthy CPS program. The Healthy CPS initiative allows schools to earn badges, and further distinction, for complying with a series of health and wellness policies, which includes SHE. For example, one teacher stated, ''so my principal ... one of the things that he realized was if we check all the boxes for this healthy school thing, then it like boosts our rating up ... So yeah, he wanted to know about it, and of course sex ed is a big thing in that healthy CPS.'' [Teacher 10]. However, most principals reported being aware of this initiative, in contrast to most teachers who reported only being vaguely aware of these requirements, if at all.

Several respondents felt there were other opportunities at the district level to encourage adherence, such as using it as a graduation requirement or as a criterion in school ratings. One school principal mentioned that schools work on what they are judged on and noted that the School Quality Rating Policy (SQRP) tracks attendance, student test scores, and other key criteria. Because SHE is not incorporated into this rating, it does not rank among the top priorities for principals [Principal 1]. One elementary school teacher acknowledged that the SHE policy is a good mandate,

but there are no real consequences for schools when they are not compliant [Teacher 5]. Since the district only offers incentives for schools to implement SHE, instead of consequences for schools not in compliance, the principals' prioritization and enforcement of the SHE policy was important for accountability.

School accountability is influenced by teachers' tracking and reporting behaviors. At the classroom level, teachers described behaviors they enacted to hold themselves accountable to completing SHE. Teachers discussed using documents to track lessons, and creating a plan and schedule to ensure they would be finished. One elementary school teacher discussed using a tracking log received during the SHE training, to track their completion of the lessons [Teacher 1, Table 2]. However, roughly only half of the teachers reported the completed minutes to a school administrator. For example, one teacher discussed keeping track of their completion of lessons by marking off the ''two weeks that I'm working on something'' in their unit plans. However, when asked if they are required to report it to an administrator, they responded, ''No. But everybody has access to everybody's unit plans, so anybody who wanted to can just log on and see my units.'' [Teacher 2]. Principals were confident that the total required amount of SHE minutes were being taught to students, but some were not able to state definitively if the required number of minutes were met. Even so, teachers were more likely to hold themselves accountable for completing lessons when required to report them by the school administration.

DISCUSSION

Key informant interviews with principals and teachers illustrate the various school and classroom-level factors that influence SHE implementation in the CPS district. Key informant interviews with principals and SHE teachers identified 3 key themes across these factors. Findings revealed that (1) principals that prioritized and recognized the need for SHE actively ensured that it was taught; (2) the expansion of school and teacher capacity helps facilitate SHE implementation in the district; (3) the creation of accountability mechanisms in schools and classrooms helps foster school's adherence to SHE policy. These findings were used by CPS's OSHW to inform revisions to CPS SHE policy in 2020, and to adjust technical assistance and resource provision to schools.

Interviews revealed that the active prioritization of SHE by principals involved engaging in the following activities to expand school and teacher capacity to implement SHE: (1) ensuring instructors were trained, (2) making a plan for students to receive SHE, and (3) creating time in the school's schedule for SHE delivery. Other studies have highlighted the need for school administrators' involvement in these activities to successfully implement health programs in school settings.[11,12,14,15,22,25,26] These findings also highlight the principal's central role in building a school's capacity to deliver SHE. Factors related to the school's capacity at the school-level, such as the lack of trained instructors, classroom space, and time, tended to be addressed in schools with actively engaged principals. As such, the district has made the principal's role in SHE implementation explicit. SHE implementation guidance documents instruct principals to ''ensure that all SHE topics are taught annually to students,'' ''to meet with SHE instructors to strategize when and how SHE lessons will be implemented,'' and ''identify who is responsible for reporting the completion of lessons on the Healthy CPS survey.''[27] In addition, OSHW provides principals with training to promote their involvement in SHE implementation.

Notably, some schools were able to implement SHE without direct principal involvement. In these schools, a staff member or administrative department took the initiative or were delegated tasks by the principal to ensure SHE was implemented. This finding aligns with Spillane's concept of distributed leadership,[28,29] where leadership responsibilities are shared among principal and school staff. The sharing of authority and responsibilities between school leadership and staff can help facilitate the SHE implementation in schools without direct principal involvement.

As mentioned prior, expanding schools' and teachers' capacity helps foster the implementation of the SHE policy in the district. Factors related to school capacity, such as lack of trained instructors, classroom space, and time and teacher capacity, such as lack of comfort, knowledge, and skills, and perceived parental pushback were frequently cited as barriers to SHE implementation by interviewees. These findings corroborate other studies, which frequently cite such factors as barriers to implementing SHE and other school health programs.[11-21,25] To support the SHE implementation in the district, OSHW developed guidance[27] for schools which included strategies to address these issues. The guidance encourages principals to designate additional SHE instructors—1 teacher for every 100 students—to ensure enough staff are available at their school to deliver SHE.[27] Principals are also encouraged to arrange planning meetings to schedule SHE implementation and to ensure SHE instructors have sufficient space and time to deliver SHE.[27]

In our evaluation, teachers' were cited as having issues around delivering LGBTQ+ identity-related content and condom demonstrations, discussing sexual consent, and teaching mixed-gender classrooms. Teachers' reluctance in delivering certain content, such as condom demonstrations, was rooted in perceived lack of parental support. Studies have noted that ongoing PD, especially multiple forms of PD,

decreases staff discomfort, increases teacher's knowledge, and improves their SHE delivery skills.[21,30-31,26] To build teacher capacity, OSHW incorporated additional LGBTQ+ inclusive content, activities to build condom demonstration skills, and information about the importance of teaching mixed-gender classrooms during the SHE instructor training. They also created supplemental trainings, in collaboration with various community-based organizations, to increase SHE instructors' content knowledge. School-to-Home Connection toolkits were created and distributed to schools to encourage parental engagement in SHE and mitigate staff concerns around parental pushback. To build teachers' knowledge and skills around supporting LGBTQ+ students, all staff, including SHE teachers, are required to complete the Supporting Transgender, Nonbinary, and Gender Nonconforming Students training which provides staff with the knowledge and skills to implement LGBTQ+-inclusive practices in schools.[32]

Beyond building capacity, the principal's prioritization of and engagement in SHE implementation is central to fostering school accountability. Interview participants noted that the lack of consequences from the district for not implementing SHE may prevent schools from prioritizing its implementation, which can lead principals not to consider SHE a priority. These findings have been echoed in other studies on SHE implementation.[10-12,14,26] However, the district's Healthy CPS initiative motivated principals to prioritize SHE implementation in their schools in order to achieve Healthy CPS status. These findings suggest that reward-based accountability mechanisms can be an effective method to increase the uptake of SHE in schools. Although findings reveal that teacher's tracking and reporting behaviors help foster accountability among teachers to complete the delivery of lessons, there was variation among schools in whether teacher's progress and completion of SHE instruction was required to be reported to the principal or school's administration. Findings suggest there is an opportunity to create more accountability mechanisms within schools and the district to help foster adherence to the SHE policy.

IMPLICATIONS FOR SCHOOL HEALTH POLICY, PRACTICE, AND EQUITY

There are several implications for districts implementing similar SHE policies. Wilkins et al (2022) note that the delivery of SHE in school contexts is ideal for several reasons.[33] Schools have ongoing access to students during key development stages, staff and community partners with knowledge of health risk and protective behaviors, a pre-existing infrastructure that can support curricula, courses, programs, and interventions to address risk and protective health behaviors, connections to organizations and programs that serve students, and experience engaging parents.[33] Researchers have also acknowledged the need for evidence-based, strategically-planned health programs, as well as health services, as they lead to better academically performing students and helps close the achievement gap.[34] Given the benefits[3,4] of receiving SHE, the implementation of comprehensive SHE policy ensures that all students have access to the benefits of SHE.

However, special attention needs to be paid to the implementation of these policies to realize the promises and benefits of SHE. The quality of implementation can impact an intervention's ability to achieve its intended outcomes.[35-37] For effective implementation of such policies and programs, it is important to build organizational capacity for implementation,[35-37] communicate, involve, and prepare families for implementation,[35] ensure that organizational leaders are committed and involved, and collect information about the quality and progress of the implementation of these programs.[35-37] Researchers, such as Durlak and DuPre (2008) noted that organizational capacity and support is critical to implementing programs, and support to organizations can be provided through technical assistance and training.[37] Researchers, such as Raspberry et al (2022), found that the provision of instructional materials, such as curriculum, and tailored PD to SHE instructors by schools districts was correlated with an increase in students' sexual health knowledge and protective sexual behaviors, as well as a decrease in risk behaviors or experiences, such as use of alcohol or drugs before sex or experiencing sexual dating violence.[31] Therefore, for students to receive effective SHE, teachers need the capacity to teach SHE effectively, and it should be strengthened.[33] The findings in this evaluation suggest that the following practices may improve SHE implementation in districts:

- Identify, at a minimum, what the principal's role should be when implementing SHE in schools and provide targeted guidance to principals to help them fulfill these roles,
- Consider implementing mechanisms to reward adoption of SHE policy over time,
- Identify the necessary skills, qualities, and values that are needed in SHE Instructors, particularly those that will promote the well-being and safety of LGBTQ+ students, and provide ongoing PD to build these skills,
- Implement strategies and resources that increase parental and guardian engagement in the delivery of SHE to help mitigate staff concerns around parental pushback.

Limitations

A few limitations exist related to these findings. The findings may not be representative of experiences of all schools within the district, as the schools represented in this sample are not representative of the district. Schools with predominantly Hispanic and White students were more likely to be overrepresented in the sample, while those with predominantly Black students were underrepresented. Charter schools were also underrepresented in the sample and are not held to the same policy requirements as district-run schools. Also, most schools represented in this evaluation had fully or partially implemented SHE. Only 1 school in this sample had not implemented SHE, which limits our ability to draw conclusions about barriers to non-implementation.

The recruitment of teachers occurred during the beginning of the COVID-19 pandemic. The opportunity to conduct interviews virtually, as a result of the pandemic, allowed more teachers to participate than originally anticipated due to greater flexibility in scheduling. In contrast, principal recruitment occurred prior to the pandemic and was more challenging. Therefore, there is a greater number of teachers participating in this evaluation. Findings may reflect more accurately the breadth of perspectives of teachers, as compared to principals. Principals may hold different perspectives on SHE implementation within their schools compared to teachers. These findings may also be biased toward teachers' perspectives and views of SHE implementation.

CONCLUSIONS

School principals play a crucial role in building a school's capacity to deliver SHE and promote accountability. CPS principals and teachers frequently discussed lack of staffing, space, time, and teacher comfort and skills as barriers to ensuring all grades received the required number of minutes. This was most notable among high schools, where SHE was often provided for 9th grade, but less likely to be implemented for 10th-12th grades. Principals that prioritized SHE were more likely to engage in activities that addressed identified barriers. Although participants acknowledged a need for greater accountability mechanisms in the district to ensure SHE is implemented, district initiatives, such as HCPS, helped promote accountability among schools.

Human Subjects Approval Statement

The study was determined non-research and approved by **UIC** IRB and CPS RRB. Participants provided informed consent prior to participating in this evaluation.

Conflict of Interest

The authors have no conflicts of interest or financial relationships to disclose.

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SUPPORTING INFORMATION

The following Supporting Information is available for this article:

Data S1. Key stakeholder semi-structured principal interview guide questions.

Data S2. Key stakeholder semi-structured teacher interview guide questions.

Additional supporting information may be found online in the Supporting Information section at the end of the article.