Handbook of Sexuality-Related Measures

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STI Education Efficacy Survey

Publication details


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Published online on: 12 Aug 2010

How to cite: Patricia Barthalow Koch, Andrew W. Porter, Clinton Colaco. 12 Aug 2010, STI Education Efficacy Survey from: Handbook of Sexuality-Related Measures Routledge

Accessed on: 12 Jul 2023

4. Sex is possible in any situation  4. (same)
5. Oral sex  5. (same)
6. Anal sex  6. (same)
7. Partner’s sexual pleasure  7. (same)
8. Emotions, love  8. (same)
9. Intimate communication  9. (same)
10. Penetration 10. (same)
11. Being constantly horny  11. Men are constantly horny
12. Partner is constantly horny  12. Women are constantly horny
13. Trust in partner  13. (same)
14. Commitment 14. (same)
15. Intense passion  15. (same)
16. Feeling safe and well cared for 16. (same)
17. Spontaneity 17. (same)
18. Imagination 18. (same)
19. Unselfishness 19. (same)
20. “Pumping” (fast and deep penetration) 20. (same)

*The questions regarding the “great sex” script should be placed closer to the beginning of the questionnaire, whereas the questions concerning the pornographic script should be closer to the end.

If a respondent is male, the item should be paired with the corresponding item on the pornography inventory; if a respondent is female, the item should be paired with the next item on the pornography inventory.

*The item should be paired according to participant’s sexual orientation.

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**STI Education Efficacy Survey**

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As of June 1, 2009, 35 states plus the District of Columbia mandate STI/HIV education in their public schools (Guttmacher Institute, 2009). Yet teachers often do not have the training, including the accurate knowledge, positive attitudes, and appropriate skills, needed to implement effective STI/HIV education (Cozzens, 2006; Rodriguez, Young, Renfro, Ascencio, & Haffner, 1995–1996). Thus, the STI Education Efficacy Survey (SEES) was developed to measure educators’ level of knowledge, attitudes toward adolescent sexuality and sexuality education, STI education confidence, and readiness to implement STI education. Improving the educational efficacy of educators will then improve students’ learning and improve STI prevention. (James-Traore, Finger, Ruland, & Savariaud, 2004).

**Description**

The STI Education Efficacy Survey (SEES) consists of four sections: Knowledge of Sexually Transmitted Infections (STIs; 25 items), Attitudes Toward Adolescent Sexuality and Sexuality Education (10 items), STI Education Confidence (8 items), and STI Education Readiness (5 items). It was designed to ascertain the areas in which educators, particularly those working with young people in schools or community educational settings, need additional training, resources, or other type of support.

**Response Mode and Time**

For Part One, Knowledge of Sexually Transmitted Infections, respondents are instructed to indicate if they definitely know if each of the 25 statements is True (1) or False (2). If they do not definitely know the answer, they are to respond Don’t Know (3). For Part Two, Attitudes Toward Adolescent Sexuality and Sexuality Education Scale, respondents are asked to indicate their reactions to each of 10 statements using a 5-point Likert scale: 1 = Strongly Agree, 2 = Agree, 3 = Uncertain, 4 = Disagree, 5 = Strongly Agree.
Sexually Transmitted Infections

Disagree. For Part Three, STI Education Confidence, respondents are directed to indicate how confident they feel about each of eight aspects of teaching about STIs, using a 5-point Likert-type scale: 1 = No Confidence at all, 2 = Very Little Confidence, 3 = Somewhat Confident, 4 = Very Confident, 5 = Extremely Confident. If an item does not apply to them, they mark 6 for “Does Not Apply.” For the final part, STI Education Readiness, respondents are asked to describe their readiness (including their willingness and ability) to perform each of five educational tasks using a 5-point Likert-type scale: 1 = Not Ready at all, 2 = Hardly Ready, 3 = Somewhat Ready, 4 = Very Ready, 5 = Extremely Ready. If an item does not apply to them, they mark 6 for “Does Not Apply.” The SEES takes approximately 20 minutes to complete.

Scoring
Scores on the Knowledge of Sexually Transmitted Infections scale can range from 0 (none correct) to 25 (all correct). A score of 0 is given to an incorrect response or a response that the respondent marked as “Don’t Know.” The following items are true: 1, 2, 6, 8, 9, 10, 11, 14, 15, 16, 18, 20, 22, 23, 24, 25. Scores on the Attitudes Toward Adolescent Sexuality and Sexuality Education scale can range from 0 (least positive attitudes) to 50 (most positive attitudes). The following items are reverse scored: 26, 29, 32, 34. Scores on the STI Education Confidence scale can range from 8 (if all the items applied to the respondent), indicating the least confidence, to 40 (if all the items apply to the respondent), indicating the highest confidence. Scores on the STI Education Readiness scale can range from 5 (if all the items apply to the respondent), indicating the least readiness, to 25 (if all the items apply to the respondent), indicating the highest level of readiness.

Reliability
Reliability was calculated from a sample of 120 middle and high school teachers from around the state of Pennsylvania (Koch, 2009). Approximately two-thirds were women and 75% had been working in their position for more than 5 years. Using the Kuder-Richardson alpha statistic, the reliability of the Knowledge of Sexually Transmitted Infections scale was calculated to be .89. Using the Cronbach alpha statistical method, the reliabilities for the Attitudes Toward Adolescents and Sexuality and Sexuality Education, STI Education Confidence, and STI Education Readiness scales were determined to be .75, .92, and .89, respectively.

Validity
Content validity for the Knowledge of Sexually Transmitted Infections scale was determined from information gathered from the Centers for Disease Control and Prevention (2009) and the Kaiser Family Foundation (2006). A panel of five sexuality educators, three of whom were experienced with providing STI/HIV education to professionals and two of whom taught STI/HIV education to youth, reviewed the initial pool of items for relevance and redundancy and reached a consensus of 25 items using the Delphi method (Adler & Ziglio, 1996). Guided by Ajzen and Fishbein’s attitudinal theory (1980), this same panel generated separate items for the Attitudes Toward Adolescent Sexuality and Sexuality Education, using recommended guidelines and evaluation research provided by the Sexuality Information and Education Council of the United States (2004). Using the Delphi method to reach consensus, 10 items were agreed upon. Finally, the panel of experts independently generated lists of tasks that are relevant to providing effective sexuality education. Using the Delphi method to reach consensus, eight items were identified for the STI Education Confidence scale and five items for the STI Education Readiness scale. Once these scales were completed, five middle and high school teachers reviewed them for relevance and wording. The SEES was then used for pre- and posttest evaluation of three professional workshops attended by teachers from around the state of Pennsylvania. After attending the all-day workshops, the participants demonstrated significant improvement in STI knowledge (p < .001), positive attitudes toward adolescent sexuality and sexuality education (p < .05), and STI education confidence (p < .001; Koch, 2009).

References
Exhibit

STI Education Efficacy Survey

The following statements are to assess your understanding of STIs.

If you definitely know that a statement is True, answer 1
If you definitely know that a statement is False, answer 2
If you do not definitely know the answer (Don’t Know), answer 3

1. About one-half of 12th graders have engaged in intercourse and one-half have not.
2. About one in five young people have had intercourse before their 15th birthday.
3. Oral sex is more common among many teenagers than is engaging in vaginal-penile intercourse.
4. About one in 10 sexually active youth have a sexually transmitted infection (STI).
5. Half of the people in the U.S. will acquire at least one STI by age 35.
6. Human papilloma virus (HPV) is the most common bacterial STI in the U.S.
7. The majority of females with chlamydia do not have any detectable symptoms.
8. Vaginal infections, like trichomoniasis, can not be transmitted to males.
9. People know when they get syphilis because a very painful sore, or chancre, appears.
10. Females are more likely to have symptoms of gonorrhea than are males.
11. All bacterial STIs can be cured with penicillin.
12. HPV accounts for about 90% of cervical cancer risk.
13. HPV can still be spread even when there are no warts present.
14. The most effective method to cure genital warts is through surgical removal.
15. Herpes is only infectious when there are open lesions present.
16. Herpes Simplex I (oral herpes/cold sores) can not be transmitted to the genital area.
17. Hepatitis B is more infectious than HIV.
18. HIV can not be transmitted through oral sex.
19. A person can be HIV-infected but still test negative.
20. Heterosexual females and males are at little risk for AIDS.
21. The most common cause of infertility among U.S. females is chlamydial infection.
22. Currently there are no vaccines to prevent becoming infected with any type of STI caused by a virus.
23. Natural membrane condoms are more effective in preventing STIs than latex condoms.
24. Oil-based products, such as Vaseline, are good to use for added lubrication with condoms so that they don’t break.
25. Because of an emphasis on abstinence-only education, the U.S. has lower rates of STIs than western European countries.

Adolescents and Sexuality/Sex Education

Please indicate your reactions to the following statements on your response sheet:

1 Strongly Disagree
2 Disagree
3 Uncertain
4 Agree
5 Strongly Agree

26. Sexual expression is a natural part of development for adolescents.
27. Most high school students are not mature enough to act sexually responsible even when they know the facts.
28. Young people need to remain sexually abstinent until marriage.
29. Young people should not think of sexuality as taboo, shameful, or dirty.
30. Most teenagers do not want sexuality education from their parents or in school.
31. Having information about contraceptives, including condoms, only encourages young people to be promiscuous.
32. Young people need as much information as possible in order to make responsible decisions.
33. Abstinence-only education is more effective in preventing STIs than education that discusses safer sex as well.
34. Young people who receive more comprehensive sexuality education are less likely to engage in intercourse at younger ages and are more likely to use contraception when they do have intercourse.
35. Most parents in the U.S. do not support the teaching of sexuality education in the schools.
STI Education Efficacy

In teaching about STIs/HIV, please indicate how you feel about the following using this scale:

1. No Confidence at all
2. Very Little Confidence
3. Somewhat Confident
4. Very Confident
5. Extremely Confident

36. The currency and accuracy of my knowledge.
37. The comprehensiveness of my knowledge.
38. My comfort level in talking about these topics with young people.
39. My comfort level in talking about these topics with my colleagues and supervisors.
40. My ability to develop lessons and learning activities to effectively teach about these topics.
41. My skill in developing open communication with young people about these topics.
42. My ability to develop curriculum or programs on these topics.
43. My understanding of the experiences of today's young people that impact their sexuality and STI risk.

When it comes to STI education, how would you describe your readiness (including your willingness and ability) to:

1. Not Ready at all
2. Hardly Ready
3. Somewhat Ready
4. Very Ready
5. Extremely Ready

44. Advocate for better education and services for teens.
45. Share my knowledge and skills with my colleagues.
46. Serve as a resource person for people who need help with these topics.
47. Influence curriculum/program development in my school or agency related to these topics.
48. Influence policy either in my school, agency, or community related to these topics.

STD Attitude Scale

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Researchers have found that attitudes are best described as multidimensional, having the three components of cognitive (belief), affective (feeling), and conative (intention to act). Beliefs express one's perceptions or concepts toward an attitudinal object; feelings are described as an expression of liking or disliking relative to an attitudinal object; and intention to act is an expression of what the individual says he/she would do in a given situation (Bagozzi, 1978; Kothandapani, 1971; Ostrom, 1969; Torabi & Veenker, 1986). Attitudes are one important component determining individual health-risk behavior. More attention is now given by health educators to improving or maintaining health-conducive attitudes. A scale designed specifically to measure the components of attitudes toward sexually transmitted diseases (STDs) can be valuable to educators and researchers in planning STD education and determining risk correlates of individuals.

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