HIV Prevention & Sex Education in Minnesota:

What's Being Taught in the Classroom

Results from the 2006 Health Implementation Survey
Safe and Healthy Learners Unit HIV Prevention Program
Minnesota Department of Education

January 2007

Acknowledgements

Report prepared in partnership by

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MOAPPP gratefully acknowledges the support of the Jay and Rose Phillips Foundation, the Ms. Foundation for Women and the Public Welfare Foundation

This publication was developed under a cooperative agreement with the Division of Adolescent and School Health, National Center for Chronic Disease Prevention and Health Promotion of the U.S. Centers for Disease Control and Prevention, Atlanta, GA: grant #U87/CCU522598-04. 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.

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Introduction

Minnesota statute requires school districts to provide students with a program to prevent and reduce the risk of sexually transmitted infections, including HIV/AIDS.[1] These programs are to be comprehensive in nature, providing technically accurate information that includes helping students to abstain from sexual activity until marriage. While this statute outlines what is expected in terms of HIV/AIDS education, there is currently no statewide requirement for broader sex education.

Using data from a survey conducted by the Minnesota Department of Education Safe and Healthy Learners Unit, this report attempts to provide some insight into what is taught to Minnesota's public school students in sexuality education classes. A better understanding of what is being taught in the classrooms around the state will hopefully provide guidance to local and state policy-makers, as well as school administrators, board members and classroom teachers to ensure that students receive the best education possible.

Snapshot of Minnesota Schools

Minnesota has 339 independent public school districts and 136 charter schools that operate independently.[2] There are an additional 77 "specialty" school districts that are not included among the 339 independent districts (for a more detailed description of these districts, see footnote three).[3] Within the independent districts, there are 679 middle and secondary schools (junior high, senior high, or combined) in Minnesota, as well as 239 Area Learning Centers (also referred to as alternative schools), and 16 K-12 schools.[4] In the 2005-2006 school year, there were 828,364 students enrolled in public schools in grades kindergarten through twelve in Minnesota. Students enrolled in charter schools accounted for 2.5% of the total public school enrollment. Student enrollment for grades seven through twelve was 411,533 in the 2005-2006 school year. Enrollment by grade level is shown in Table 1.

There are an additional 30,805 students enrolled in private schools in grades 7-12 who are not included in the numbers listed in Table A. The total number of students home schooled as of October 1, 2005 was 17, 334.[5] (This number includes all students grades K-12.)

Of all public school students enrolled in grades K-12, there were six percent more male students than female. Slightly more than 20% were students of color. Breakdowns of student enrollment based on racial/ethnic groups, special education, English language learners, and free and reduced-lunch eligible are shown in Table 2.

Figure 1: Distribution of Minnesota Public Schools by Grade Level

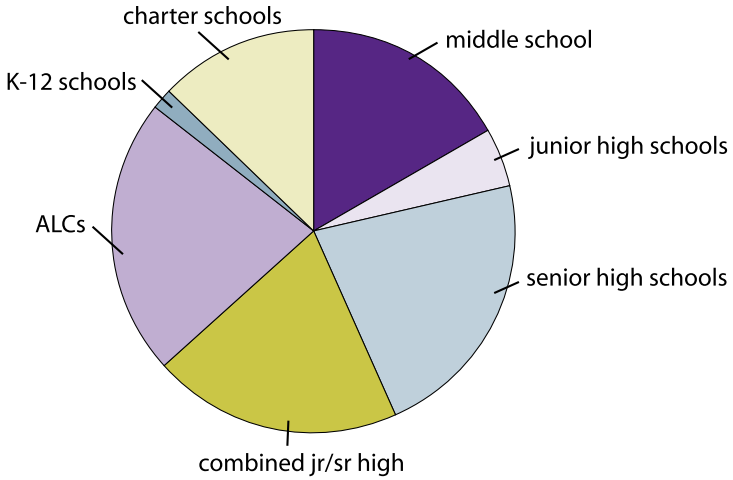


Table 1: Student Enrollment by Grade Level

Grade Level	Enrollment	Total Enrollment grades 7-12 (running tally)
7	64,261	64,261
8	65,491	129,752
9	69,404	199,156
10	71,108	270, 264
11	69,028	339, 292
12	72,241	411, 533

Table 2: Demographic Breakdowns of Student Enrollment in Public Schools

Demographic Group	Enrollment	% of total k-12 Enrollment
Native American	18,131	2.2
Asian/Pacific Islander	47,610	5.7
Hispanic	44,354	5.4
African-American	70,794	8.5
Caucasian	647,475	78.1
Special Education	103,838	12.5
English Language Learners	58,974	7.1
Free & Reduced Lunch Eligible	252,633	30.5

Health Education Requirements in Minnesota Schools

Minnesota law requires that health education be offered to all K-8 students at least once per "grade band" (e.g. once in grades 1-3, once in grades 4-6, etc.). All students in grades 9-12 are required to take health and physical education at least once each during those grades. There is no graduation standard for health in Minnesota; all standards are decided at the local school district level. The majority of teachers responding to the Health Implementation Survey are not aware of the fact that Minnesota law outlines what students are to be taught regarding HIV/AIDS (Statute 121A.23 Programs to Prevent and Reduce the Risks of Sexually Transmitted Infections and Diseases).

Of the districts represented in this survey, health education is required in 95% of the middle schools and 97% of the high schools. More than 80% of the districts report that they have either already adopted health education standards or are in the process of doing so; 97% of those that have adopted standards say that their district standards reflect at least some of the National Health Education Standards. These National Standards serve as guidelines for local school districts when creating their own standards for health education. The standards encourage schools to address a broad range of skills in health, including decision-making, interpersonal communication, and personal advocacy. A summary of the seven national standards developed by health education experts in Minnesota is shown in Appendix A.

Background on the Survey

In April 2006, the Minnesota Department of Education's Safe and Healthy Learners Unit sent a Needs Assessment Survey to all 853 public school classroom health teachers in the state. 350 paper and pencil surveys were returned. Of those 350 respondents, 140 agreed to complete a more extensive Health Implementation Survey. This report primarily uses data from the Health Implementation Survey that was completed by 140 teachers. (Data from the Needs Assessment Survey are discussed in the section on teacher training near the end of the report).

More than 70% of those taking the survey teach at the high school level; greater than 90% of those who took the survey are licensed to teach health in Minnesota. Teachers who completed the survey represent all regions of Minnesota, including the metro area as well as Greater Minnesota communities. Approximately one-third of the teachers live within the seven county metro area.[6] Only four of the teachers represent St. Paul, and none of those taking the survey were from Minneapolis. A map illustrating the communities represented by the teachers who completed the survey is shown in Appendix B.

Highlights of the Findings

Topics covered in the classroom:[7]

1. An overwhelming majority of districts use an abstinence-based approach to sex education.

The vast majority, 86%, of high schools characterize their district's sex education as abstinence-based, while nearly 71% of districts characterize the focus of their middle school curriculum as abstinence-based.[8] Furthermore, 64% of those who characterize their middle school curriculum as abstinence-only report that their high school curriculum is abstinence-based, suggesting that the number of students receiving abstinence-only curriculum throughout their school career is likely low.

2. High school students receive instruction in a wide range of topics essential to quality sex education.

Data from this report indicate that, in general, the sex education that Minnesota students are receiving at both the middle and high school levels is broad-based and comprehensive. More than 90% of districts report covering a range of topics that are central to a comprehensive sexuality education curriculum. The one topic that receives considerably less attention is sexual orientation. The following table shows the percentage of districts that report teaching about each specific topic discussed in the survey. (The remaining percentages are a combination of those who answered the topic is either "not taught" or "don't know" if it is taught.)

Table 3: Percentage of Districts Teaching Topic in High School

Topic	Percent of districts teaching topic in High School*
Healthy relationships	94.1
Pregnancy	94.1
Sexually transmitted diseases / HIV	94.1
Reproductive anatomy	92.1
Abstinence	92.1
Sexual decision-making	89.1
Contraception	85.1
Sexual abuse, rape and sexual assault	83.2
Childbirth	82.2
Media influence	81.2
Changes associated with puberty	70.3
Sexual orientation	53.5

*Percentage is based on total of 139 survey respondents.

3. **While still fairly broad-based, there is slightly more variation in what topics are covered at the middle school level.**

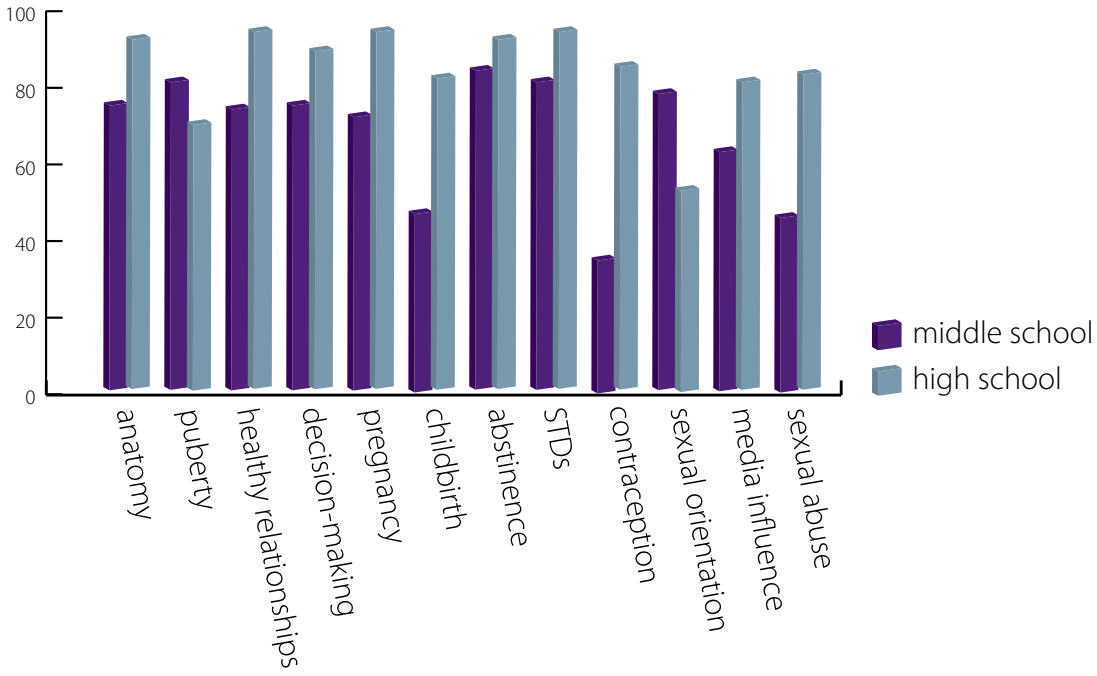
There is less consistency at the middle school level in topics that are covered in sex education classrooms. While some of the main topic areas are widely taught (e.g. anatomy, puberty, healthy relationships, sexual decision-making, pregnancy, abstinence, STDs), they are not taught as consistently as at the high school level. More topics get significantly less coverage at the middle school level as well, namely childbirth, contraception, media influence, and sexual abuse. As seen at the high school level, few districts at the middle school level address sexual orientation. The following table shows the percentage of districts that report teaching about each specific topic discussed in the survey.

Table 4: Percentage of Districts Teaching Topic in Middle School

Topic	Percent of districts teaching topic in Middle School
Abstinence	84.6
Changes associated with puberty	81.5
Sexually transmitted diseases / HIV	81.5
Reproductive anatomy	75.4
Healthy relationships	75.4
Sexual decision-making	75.4
Pregnancy	72.3
Media influence	63.1
Childbirth	47.7
Sexual abuse, rape and sexual assault	46.2
Contraception	35.4
Sexual orientation	18.5

The following chart illustrates a comparison between middle and high schools in terms of what specific topics are covered at each level.

Figure 2: Comparison Between Middle and High Schools Regarding Topic Taught



4. **The vast majority of teachers report teaching assertiveness skills (91.5%), how to set limits in relationships (92.2%), and effective communication skills (87.7%)**

Slightly fewer report teaching skills related to accessing health care services and resources (81%).

5. **Only 32% of teachers report having students practice how to correctly use condoms.**

6. **Sexual orientation is taught in fewer districts than any other topic discussed in the survey.**

District and Classroom Procedures:

7. **The majority of districts do not require parental consent in order for students to participate in sex education.**

In nearly 60% of the responding districts, parental/guardian consent is not required for a student to participate in sexuality education. Only 25% of the districts surveyed report that parents must be given written notification prior to a sex education unit. In 36% of the districts, parents must sign a form to opt their child out of sexuality education. Only 6% of the districts surveyed require active parental permission before a student can participate in sexuality education. Slightly more than 60% of the districts report that they do NOT require all sex education classroom materials be made available for preview by parents before a unit begins.

8. **There is wide variation in the number of hours of sex education students receive.**

The average number of hours of sex education instruction was roughly 15 and 18 hours respectively for middle and high school students. The standard deviations from these numbers, however, were 17.66 and 21 respectively for middle and high school, indicating a large range in the actual number of hours of instruction students receive. The average number of hours of HIV/AIDS instruction was slightly less than four hours for both middle and high school students, although, again the standard deviations from this number were significant. Taking into account the requirements listed above, this indicates that many students receive fewer than twenty hours of instruction in all of their middle and high school years.

9. **Minnesota Department of Health and the Centers for Disease Control and Prevention were the overwhelming choices for teachers to obtain medically accurate information.**

10. **Ninety-four and a half percent (94.5%) of teachers report that they provide HIV/AIDS instruction in their classroom setting, as opposed to using instructors from outside the school setting.**

The most commonly used packaged health education curricula are Reducing the Risk, Safer Choices, and Life Skills Training.[9] These curricula have all been evaluated for use in the classroom and have a body of evidence showing their effectiveness.

11. **Teachers report using a wide variety of teaching methods for sex education instruction,** including cooperative groups (83.5%), summarizing and note-taking (84.2%), lecture and large group discussion (88.5%), large group and individual process activities (72.7), written assignments (86.3%) and individual or group presentations (79.1%).

Training Needs for Teachers

The Needs Assessment Survey administered by MDE's Safe and Healthy Learners Unit was completed by 350 classroom teachers. Proposed future workshop topics that garnered the most interest were:

- ✓ Adolescent mental health issues
- ✓ HIV/Sexuality curricula
- ✓ Advanced information on HIV/AIDS
- ✓ Alcohol / Tobacco prevention

Limited professional development days, prohibitive costs and distances too far to travel were the most frequently reported reasons teachers gave for not attending health education workshops.

Teachers report they would be more willing and likely to attend trainings if trainings were held in the summer (47%), offered college credit (49%), or were offered on Saturdays (25%).

Discussion

The following are a few caveats of the survey to bear in mind when interpreting and discussing the results:

- ✓ **All 140 teachers who took the survey voluntarily self-selected themselves to take the survey**. Whenever self-selection occurs, one has to keep in mind what the motivations might be for a teacher to take the survey and how these motivations might make them a special sample as compared to the rest of the general population of health teachers. Teachers who completed the survey do, however, represent a varied sampling from communities across the state.

- ✓ **Those taking the survey were individual classroom teachers.** Many of the survey questions ask what is taught in the district, not in the individual classroom. This could potentially interfere with the reliability of the answers if teachers are unsure what is taught in their district overall. Teachers from large districts in particular may not be aware of what is taught district-wide. There may have been fewer "I don't know" responses if teachers had been asked to speak only about what they teach in their classroom.

- ✓ **Because the survey was administered by the Department of Education's Safe and Healthy Learners HIV staff, teachers may have over-reported what they actually teach about HIV prevention.** It is possible that they could have perceived there might be repercussions for honestly reporting what they do and do not teach, although survey instructions were clear that their survey answers would not be linked with them individually.

- ✓ **We tried to analyze the data based on how teachers characterized their district's curriculum ("abstinence-based" vs. "abstinence-only") in an attempt to distinguish how this characterization affected what topics were addressed in the classroom.** Because the number of districts that reported using an "abstinence-only" focus for their curriculum was so small, it was difficult to compare the two groups, as they did not provide comparable sample sizes. Only seven districts responding at the high school level and 17 at the middle school level report employing an abstinence-only focus. There does not seem to be much difference in what is taught at the high school level between the abstinence-only and abstinence-based districts, however we can not say this with any confidence from a sample size of seven. There was more variation between the two groups at the middle school level, with abstinence-based districts reporting that they cover all the topics more consistently (with the exception of a few items addressed in the next point).

- ✓ **Some inconsistencies in the data may indicate confusion about the terms "abstinence-based" and "abstinence-only," even though those terms were defined at the beginning of the survey.** There were inconsistencies between how teachers characterized their sex education curriculum and what they reported was taught in the district. For example, of the seven high school teachers who indicated their high school curriculum was abstinence-only, only four teachers reported that they teach abstinence, while one reported "I don't know" and two skipped the question. (Again, with a sample size of seven, when two people skipped the question and one answered, "I don't know," we are left with four reports and it is difficult to generalize from a sample size of four.) Similarly, at the middle school level, one of the 17 teachers who characterized their district's curriculum as abstinence-only reported abstinence is not taught in the district, and another reported, "I don't know." Also at the high school level, four of the seven "abstinence-only" teachers reported teaching about contraception, which is inconsistent with the definition of "abstinence-only" as defined at the beginning of the survey.

Further Observations and Recommendations

- ✓ **One of the most striking findings of the survey was the number of hours of sex education instruction that Minnesota students receive.** The majority of students are getting somewhere between 10 to 25 hours total in their entire K-12 career. While that may sound like a lot on the surface, when one considers the breadth of topics that need to be covered in an effective sex education program, this number is hardly sufficient. Perhaps the argument should not be over the curriculum (abstinence-only vs. abstinence-based), but rather over how little time overall is dedicated to sex education. Recommending strategies that teachers could use to integrate sex education topics into other curriculum areas may potentially increase students' interest in many other topic areas and, as an added benefit, increase the number of hours of instruction related to sex education topics that students receive.

- ✓ **There appears to be a lot of uncertainty among teachers about what is being taught in grades other than their own.** While it is hard to know what exactly is behind the unusually high rates of "I don't know" answers in the survey, this observation suggests that increased communication is needed between middle and high school teachers in order to provide more continuity in curriculum for students.

- ✓ **While it is not surprising that middle schools report with less frequency that they address many of the subjects, it is important to keep in mind that a quality comprehensive sex education program is age-appropriate.** So while it may seem that certain topics, particularly contraception and childbirth, are less relevant to middle school students, if the topics are covered in a manner that is consistent with the students' development, then they do not need to be ignored or skipped. Administrators and educators need to remember that students frequently report getting information in these areas too late as opposed to too early. There is no educational or developmental reason why sexual abuse and sexual orientation are as widely neglected, as these topics appear to be.

- ✓ **There is a fairly large difference in the percentage of districts that report teaching about sexual abuse to middle school students and high school students.** Discussion of sexual abuse at the high school level is nearly double that at the middle school level. While we cannot know from this survey the reason behind that discrepancy, we can speculate that perhaps high school students are perceived to be at a much higher risk for sexual abuse than middle school students. Given the fact that children of all ages are sexually abused, the topic of sexual abuse should be discussed in an age appropriate manner at the middle school level as frequently as it is at the high school level.

- ✓ **It was surprising that such a low percentage of districts require that materials be made available to parents for review before the sex education unit begins.** This could be a potential point of concern. Proposed changes to the state statutes for comprehensive sex education currently pending in the Minnesota legislature do include provisions to improve parental involvement in school-based sex education.

Appendix A

National Health Education Standards - Summary

These standards were adapted by the Quality Teaching Network in Health Education and Physical Education in cooperation with the Minnesota Department of Education; January 2006.

1. Students will comprehend concepts related to health promotion & disease prevention.
2. Students will demonstrate the ability to access valid health information and health promoting products and services.
3. Students will demonstrate the ability to practice health-enhancing behaviors and reduce health risks.
4. Students will analyze the influence of culture, media, technology and other factors on health.
5. Students will demonstrate the ability to use interpersonal communication skills to enhance health.
6. Students will demonstrate the ability to use goal-setting and decision-making skills to enhance health.
7. Students will demonstrate the ability to advocate for personal, family and community health.

Appendix B

Map of Communities Within Minnesota Represented Among Survey-Taker

Map 1: State map (metro area magnified and shown in Map 2)

Map 2: Metro area communities represented among teachers completing the survey:

Endnotes

1 MN State Statute 121A.23, retrieved from MN State Legislature website at http://ros.leg.mn/bin/getpub.php?pubtype=STAT_CHAP_SEC&year=current&section=121A.23&image.x=0&image.y=0&image=Get+Section

2 Retrieved from MN Department of Education website at http://children.state.mn.us/mdeprod/groups/InformationTech/documents/Report/009585.pdf Data are for the 2005-2006 school year, which is the same school year when the health implementation survey was administered.

3 The additional 77 "specialty" districts include non-operating common school districts (2), special schools districts (2), intermediate school districts (3), integration districts (5), Tribal schools (4), state schools & academies (2), education districts (17), miscellaneous cooperative districts (20), special education &/or vocational cooperative districts (14), and telecommunications districts (9).

4 Middle and high schools include grades 6-12; of the 679 middle and high schools, 49 are junior high, 235 are senior high and 214 are combined.

5 Data on curriculum for private and home-schooled students are not included in this report, as surveys were only sent to the public and charter school health teachers.

6 Teachers were not asked on the survey in which district they teach; because most of the teachers completed the survey online, we were able to figure out in which district they teach from their email address; for those teachers that took a pencil and paper survey, we only know the city in which the teacher resides, not necessarily in which district they teach.

7 For the sections of the report that discuss what specific topics are taught in the district, data were separated based on what level the teacher taking the survey actually teaches, i.e. we only used data about what is taught in high school from the high school teachers, and middle school teachers with middle school topics. There seemed to be unusually high rates of teachers answering, "I don't know" when asked what specifically is taught, and these rates did go down somewhat when data were analyzed based on what level they taught.

8 In this survey, "abstinence-based" was defined as "students are taught about the importance of abstaining from sex and are also taught about condoms and other forms of contraception as a means of reducing risks for HIV/STDs and pregnancy"; "abstinence-only" was defined as "students are taught about the importance of abstaining from sex and are not taught about condoms and other forms of contraception as a means of reducing risks for HIV/STDs and pregnancy"

9 More detailed information about which curricula are used is provided in the data of the full survey.