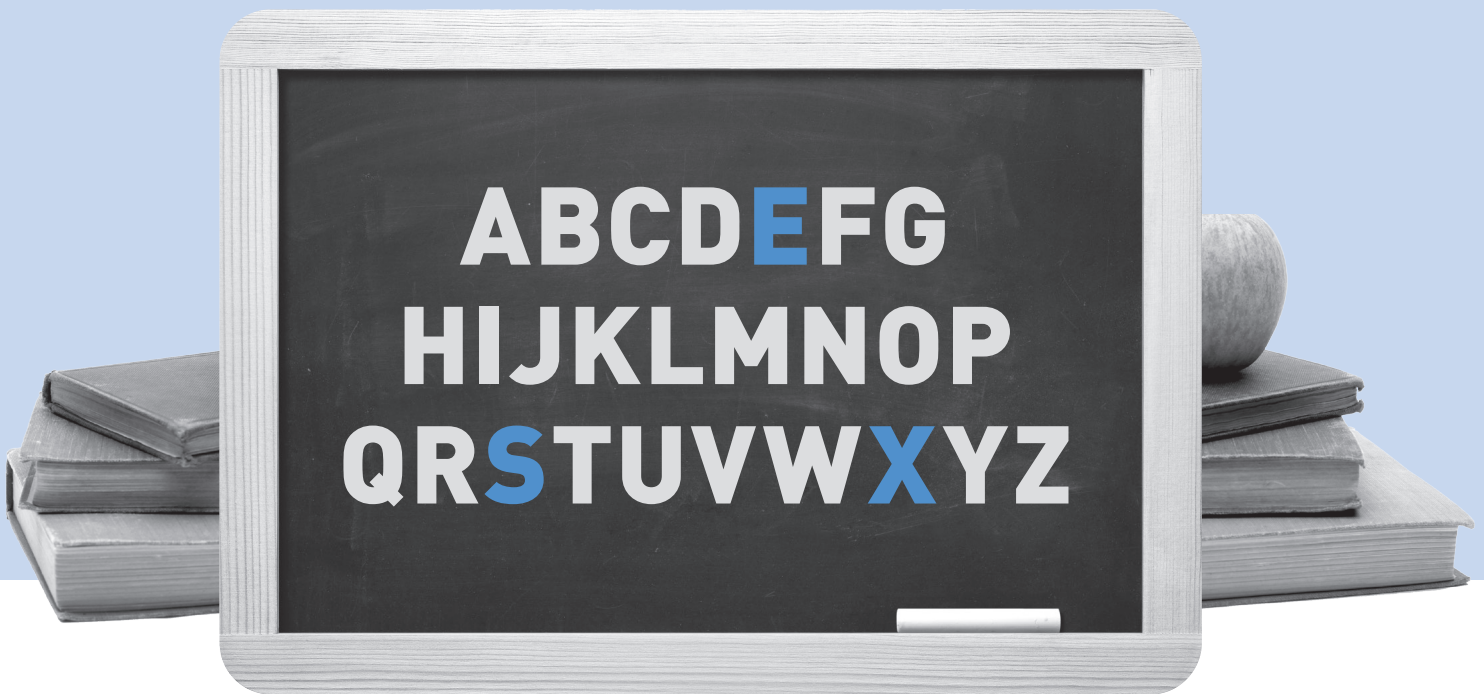


# BIRDS, BEES AND BIAS:

How Absent Sex Ed Standards Fail New York's Students

SEPTEMBER 2012



FEDERATION OF PROTESTANT WELFARE AGENCIES



hiv law project

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#### **Acknowledgments**

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The **New York Civil Liberties Union (NYCLU)** is one of the nation's foremost defenders of civil liberties and civil rights. Founded in 1951 as the New York affiliate of the American Civil Liberties Union, we are a not-for-profit, nonpartisan organization with eight chapters and regional offices and nearly 50,000 members across the state.

Our mission is to defend and promote the fundamental principles and values embodied in the Bill of Rights, the U.S. Constitution and the New York Constitution, including freedom of speech and religion, and the right to privacy, equality and due process of law for all New Yorkers.

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Founded in 1989, **HIV Law Project** was the first and today remains the only legal agency providing comprehensive legal services exclusively to low-income people living with HIV/AIDS in New York City. HIV Law Project handles nearly 1,000 cases each year addressing a range of critical legal needs for positive people, including housing advocacy and eviction prevention, immigration services, and benefits issues. Informed by 20 years of experience on the front lines of HIV services, HIV Law Project also monitors policy as it impacts people living with HIV, engages in advocacy campaigns and produces policy reports on a range of domestic HIV health and human rights issues.

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The **Federation of Protestant Welfare Agencies** has been a prominent force in New York City's social service system for 90 years, meeting the needs of New Yorkers and supporting the agencies that deliver human services. Founded in 1922 to coordinate the efforts of New York's Protestant child care agencies, today FPWA is one of the city's premier social service support organizations.

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## Executive Summary

# Birds, Bees and Bias: How Absent Sex Ed Standards Fail New York's Students

According to the Centers for Disease Control and Prevention, 44.5 percent of New York's male high school students and 39.6 percent of female students are sexually active—but a third of sexually active boys report that they don't use condoms, and nearly 80 percent of sexually active girls say they don't use oral contraceptives. The need for comprehensive sex education is explicit and urgent—but New York does not require sex education in public schools.

Students who don't receive quality sex education enter adolescence ill-informed and miseducated; they become sexually active without the knowledge that responsible sexuality requires, and can suffer consequences for their (and their peers') ignorance—unintended pregnancy, sexually transmitted infections and discrimination. While New York State requires all public school students to learn about HIV and AIDS, it does not require general sexuality education, leaving vast gaps in skills, awareness and knowledge that risk great potential harm.

State health instruction guidelines published in 2005 specifically address sexuality and sexual health, but these guidelines are not binding on school districts and do not recommend specific curricula or instructional materials. Welcome national standards issued in 2012 set a more rigorous bar but lack teeth: They are not binding on New York school districts or individual schools. Consequently, decisions about what to teach, and how to teach it, are left to individual districts, school leaders and teachers. The lack of a mandate or binding standards requiring medically accurate, age-appropriate, comprehensive and unbiased sex education puts New York students, and the public health, at undue risk.

To better understand the depth and breadth of sex education in New York's public schools, the New York Civil Liberties Union sent freedom of information requests for sex-education materials in use in the 2009-11 academic years to 108 districts statewide; 26 provided too little information and were excluded from this study. (New York City, which recently adopted a citywide sex-education mandate, was also excluded.) The total number of students enrolled in the districts surveyed—542,955—represents nearly half of all students enrolled in New York's schools outside of New York City.

Our analysis revealed:

- Lessons on reproductive anatomy and basic functions were often inaccurate and incomplete; pervasive factual limitations reflected gender stereotypes and heterocentric bias.
- HIV instruction, required by state law since 1987, is the most consistently robust element of sex education in New York State; 93 percent of districts we studied

provided instruction about HIV and how it is transmitted, although only 56 percent offered complete and scientifically accurate information. Outdated information—on prognosis, drug therapies, prevention and transmission—undermined instruction in some districts.

- Lesbian, gay, bisexual, transgender and queer/questioning (LGBTQ) students are largely stigmatized or ignored entirely in health education classrooms. Few districts discussed sexual orientation and gender identity. Fewer still discussed sexuality that ventured beyond heteronormative, penis-in-vagina sex, effectively excluding LGBTQ students and same-sex parented households. Some districts refer to gay men only in the context of lessons on HIV.
- Persistent heterocentric bias dominates instruction about dating, relationships, marriage, sexuality, sexual assault and dating violence.
- Moral overtones and shame-based messages regarding sexuality, abstinence, pregnancy and teen parenting strongly pervade instructional materials in all districts—and textbooks in wide use across New York State.
- Many students do not learn the full range of methods for preventing pregnancy or sexually transmitted infections. Too few school districts provide students with information about how to access local health resources or their right to confidential reproductive and sexual health care.

Overall, students receive little education or instruction to foster tolerance, awareness or support of non-traditional sex roles and gender models (gender norms). Sex-ed lessons often reinforce, rather than debunk, sex stereotypes. LGBTQ students receive little or no relevant information on safe sex and healthy relationships.

The physical health and sexual and emotional well-being of New York's youngest residents is being compromised daily in its schoolrooms. Low sex-ed literacy results in unplanned pregnancies, sexually transmitted infections including HIV and a lowered well-being for the state's youth. All of these factors together limit young people's education, hobbling their potential for personal and economic independence, and adding significant costs to the state.

Building on nationally recognized guidelines for sex education and New York's current health-education guidelines, the NYCLU strongly recommends that all public school students in New York receive comprehensive, medically accurate, age-appropriate and unbiased sexuality education.

To achieve this goal, the New York State Education Department should amend the Commissioner's Regulations on health education to require comprehensive sexuality education in the public schools—or set rigorous learning standards for voluntary sex-education curricula—in order to ensure that young people have the foundation, skills and knowledge to support a healthy and productive future.

# I. Introduction: Comprehensive Sex Education Works

New York teens need comprehensive, effective sexual health education. Millions of teenagers are sexually active but do not practice safer sex. According to the Centers for Disease Control and Prevention (CDC) 2011 Youth Risk Behavior Surveillance System, 5.7 percent of students in New York reported having had sexual intercourse before the age of 13.<sup>1</sup> In 2011, 44.5 percent of male high school students and 39.6 percent of female students in New York reported having had sex.<sup>2</sup> One-in-three boys (33 percent) said they didn't use condoms; nearly 4-in-5 girls (79 percent) said they didn't use the birth control pill.<sup>3</sup> As a result, New York teens have high rates of pregnancy—in a 2010 report, the Guttmacher Institute ranked New York as having the 11<sup>th</sup> highest rate amongst the 50 states.<sup>4</sup> According to the New York State Department of Health, 114,590 girls between the ages of 15 and 19, and 2,557 girls between 10 and 14, became pregnant in New York between 2007 and 2009.<sup>5</sup> This translates to 56.2 pregnancies for every 1,000 girls between the ages of 15 and 19, and 1.4 pregnancies for every 1,000 girls between 10 and 14. According to a recent CDC study of teens who had unintended pregnancies and ultimately gave birth, approximately one-third of teen mothers had not used contraception because they thought they could not get pregnant; nearly one-quarter had not used contraception because their partner did not want them to.<sup>6</sup>

Unintended teen pregnancies often result in negative educational outcomes. For example, teen mothers are more likely to drop out of high school. According to the CDC, approximately 90 percent of women who have not given birth during adolescence graduate from high school, but “[o]nly about 50% of teen mothers receive a high school diploma by 22 years of age ... .”<sup>7</sup>

Similarly, young people in New York contract sexually transmitted infections (STIs) and HIV at disproportionately high rates. Approximately 33 percent of new STIs diagnosed in New York each year occur among young people 19 and younger.<sup>8</sup> In 2009, the New York State Department of Health reported that 1,747 New Yorkers between 13 and 19 years old and 3,358 New Yorkers between 20 and 24 were living with HIV or AIDS.<sup>9</sup> Nationally, one in four sexually active teenagers contracts an STI each year.<sup>10</sup> The trend persists into young adulthood: While 15- to 24-year-olds represent only one-quarter of the sexually active population, they account for nearly half (9.1 million) of new STI cases each year.<sup>11</sup> In 2009, young people aged 13 to 24 were 20 percent of new HIV infections in the United States.<sup>12</sup>

Like adults, teens encounter relationship violence and abuse, including rape and sexual assault. According to the CDC's 2011 Youth Risk Behavior Surveillance System, at least 9.4 percent of New York's high school students reported suffering physical violence by a boyfriend or girlfriend, and 8 percent reported being physically forced to have sex.<sup>13</sup> A 2011 CDC study of risk behaviors among lesbian, gay and bisexual-identified high school students documents even higher rates of dating violence and coerced sex.<sup>14</sup> Middle school students are also affected by relationship abuse and violence. A 2012 study revealed that 1-in-3 seventh-graders was a victim of “psychological dating violence,” 1-in-3 experienced “electronic dating aggression,” and nearly 1-in-6 had been a victim of “physical dating violence.”<sup>15</sup>



Teens also encounter violence, bullying and harassment in schools. According to the CDC, in 2011 17.7 percent of New York high school students reported being bullied in school.<sup>16</sup> Lesbian, gay, bisexual, transgender and queer/questioning (LGBTQ) students, in particular, endure disproportionately high rates of school bullying and harassment. Nearly 9-in-10 LGBTQ students reported being harassed at school, and two-thirds reported feeling unsafe.<sup>17</sup>

Comprehensive sexual health instruction yields better health outcomes than abstinence-only education. Comprehensive sexual health programs that emphasize the importance of delaying sexual activity *and* teach proper condom and contraceptive use delay the initiation of sex; reduce the frequency of sex, the number of partners and the incidence of unprotected sex; and increase the use of condoms and contraception, once teens become sexually active.<sup>18</sup>

Teens who received comprehensive sex education were 50 percent less likely to get pregnant than those who had abstinence-only education.<sup>19</sup> When teenagers access confidential reproductive health care such as contraception and STI testing, the rates of unwanted pregnancy and STI infection decline.<sup>20</sup>

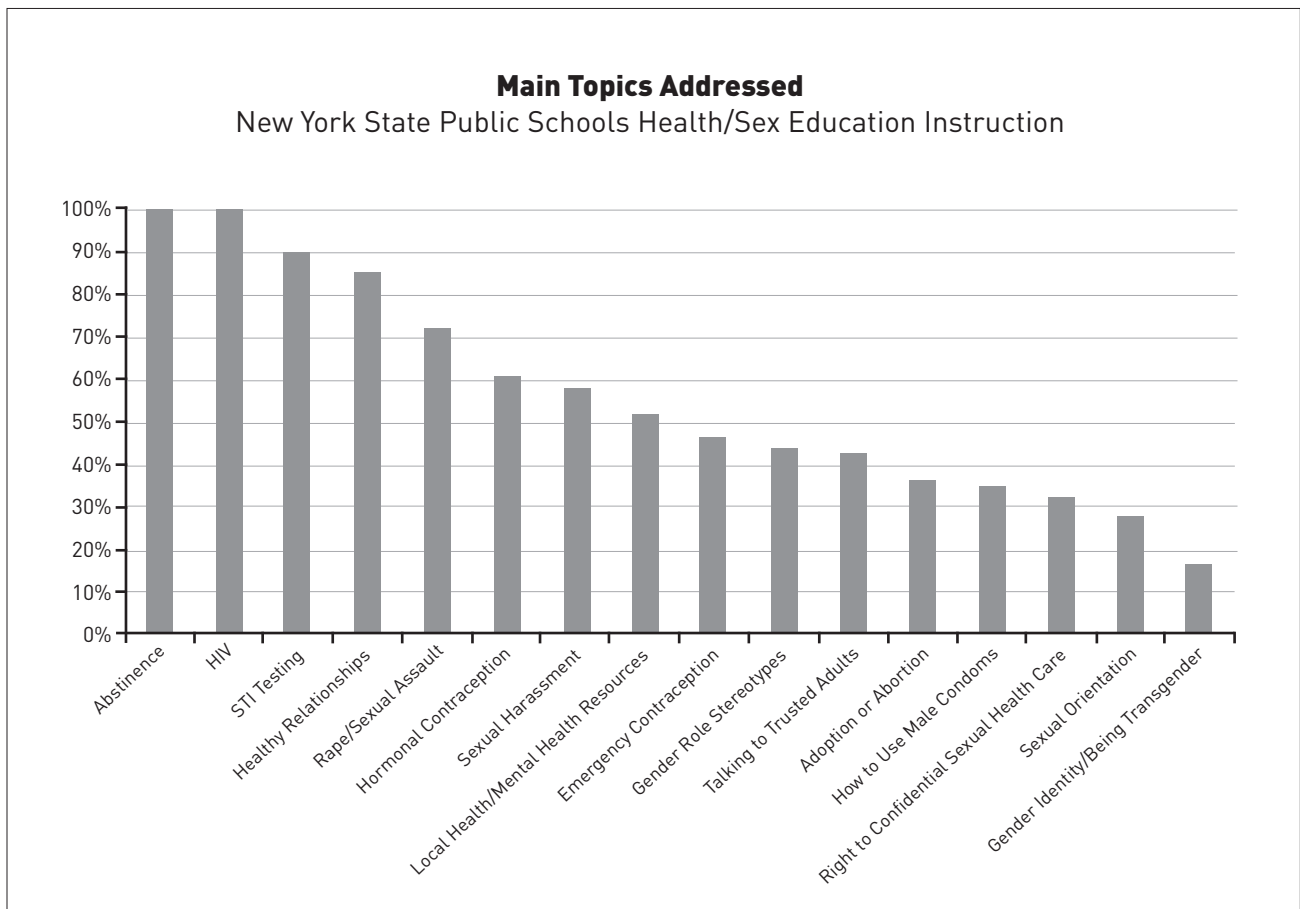
Parents, educators, health care experts and advocates consistently voice the need for comprehensive sex education, which many states presently require, but New York does not.

Broad public consensus supports comprehensive sex education, particularly among parents. A 2010 survey found that 73 percent of adults would prefer that young people were taught about abstinence and contraception rather than either/or.<sup>21</sup> In 2004, in a national poll that included a large number of parents of middle and high school students, 90 percent of respondents believed it is important to include sexuality education in school curricula.<sup>22</sup> Similarly overwhelming majorities of parents reported that sex education should include topics such as birth control, where to get contraceptives and sexual orientation.<sup>23</sup>

Public support for school-based comprehensive sex-education programs is also high in New York. In a 2009 poll, 87 percent of New York voters said it was important that public schools provide sex education to students.<sup>24</sup> A 2011 poll showed that more than three-fourths of New York voters favor teaching comprehensive sex education.<sup>25</sup>

The nation's leading medical, public health and education associations also support comprehensive sex education. The American Medical Association,<sup>26</sup> American Nurses Association,<sup>27</sup> American Academy of Pediatrics,<sup>28</sup> American College of Obstetricians and Gynecologists,<sup>29</sup> American Public Health Association,<sup>30</sup> Institute of Medicine,<sup>31</sup> Society of Adolescent Medicine,<sup>32</sup> American Federation of Teachers,<sup>33</sup> National Education Association,<sup>34</sup> National School Boards Association,<sup>35</sup> American Association of Health Education,<sup>36</sup> American School Health Association<sup>37</sup> and Society of State Leaders of Health and Physical Education<sup>38</sup> all support sex education that includes information about both delaying sexual activity and effective contraception. In May 2012, the Presidential Advisory Council on HIV/AIDS passed a resolution supporting accurate, comprehensive, evidence-based and LGBT-inclusive sex education in the nation's schools.<sup>39</sup>

Dozens of states require comprehensive sex education in public schools or set binding standards for sexual health instruction. According to the Guttmacher Institute, 21 states and the District of Columbia require sex education.<sup>40</sup> Laws and regulations in 27 states and the District of Columbia say that when provided, sex education and HIV education programs must meet certain general requirements. In 26 states and the District of Columbia, sex education must be age-appropriate, though only 12 states require medical accuracy.<sup>41</sup> Instruction in 26 states and the District of Columbia must cover healthy sexuality, avoiding coerced sex, healthy decision-making and family communication.<sup>42</sup> Students must be provided with information about contraception in 17 states and the District of Columbia.<sup>43</sup> Nine states require instruction about sexual orientation and nine states require that instruction to avoid bias against any race, sex or ethnicity.<sup>44</sup>





## II. New York’s Health Education Mandate

### Health Education, not Sex Education

New York’s public schools are not required to teach comprehensive sex education as part of the health curriculum. The state requires health education in public middle and high schools. New York also requires that schools provide HIV education.<sup>45</sup> But no state law, regulation or policy requires schools to teach students basic sexual health and relationship information or skills, or to provide instruction in *comprehensive* sex education.

New York education law says “an integral part” of mandated health education must include<sup>46</sup> instruction about the use of alcohol, drugs and tobacco; the prevention and detection of certain cancers; child development and parenting skills; and the distribution of pamphlets about interpersonal violence.<sup>47</sup> Moreover, the Dignity for All Students Act requires schools to provide instruction on diversity and awareness of, and sensitivity to, issues relating to gender, sexual orientation, and gender identity and expression (see Dignity, p 43).<sup>48</sup> Topics such as healthy relationship skills, STI and pregnancy prevention, puberty, anatomy and other core aspects of effective, comprehensive sex education are not required.

The New York State Education Department Commissioner’s Regulations, another source of binding health education requirements, also fail to require comprehensive sexual health instruction. The regulations mandate that health education be provided in elementary, middle and high school levels (one semester each in middle and high school),<sup>49</sup> by certified health teachers.<sup>50</sup> The regulations specify that, among other things, middle and high schools must provide instruction about the misuse of drugs, alcohol and tobacco, and HIV/AIDS.<sup>51</sup> The regulations also permit school boards to provide for condom availability programs in schools.<sup>52</sup>

#### **New York’s HIV Education Requirement**

New York has required AIDS education in kindergarten through 12<sup>th</sup> grade since 1987.<sup>53</sup> The state requires every district to teach each of the following topics: the nature of the disease, methods of transmission and methods of prevention.<sup>54</sup> Further, schools are required to present abstinence as the most effective and appropriate premarital protection against AIDS.<sup>55</sup> The information taught must be age-appropriate and consistent with “community values.”<sup>56</sup> The content of the instructional program is to be determined by each district’s board of education and trustees, pursuant to input from an advisory council made up of members of the school community.<sup>57</sup> In practice, implementation varies widely both within and among districts. Although the state has never mandated that schools use a particular curricula or materials, general treatment of the indicated topics is standard practice in the classroom.

## State Guidelines, National Standards: Good Intentions, Little Accountability

The New York State Learning Standards for Health, Physical Education and Family and Consumer Sciences set broad, binding standards for health knowledge and skills students must obtain in elementary, middle and high school. The standards specify some sex-ed topics and skills, but they overlook core sexual health topics, such as pregnancy and STI prevention through methods beyond abstinence, sexual identity or healthy sexual relationships.

In 2005, the State Education Department issued a *Guidance Document for Achieving the New York State Standards in Health Education*, which specifically addresses sexuality and sexual health instruction, and outlines the functional knowledge students should learn about HIV/AIDS, sexual risk, family life/sexual health and violence prevention. Additionally, it addresses teaching about condoms and contraceptives, STI testing, teenagers' rights to obtain confidential sexual and reproductive health care services, healthy relationships, gender stereotypes, sexual orientation, sexual harassment, and sexual violence and relationship abuse. But the state guidance is not binding on schools; schools that voluntarily elect to teach sexual health education are in no way required to cover all of the components it describes.

In January 2012, leading health and education associations published national standards for sex education.<sup>62</sup> These standards provide guidance on the "essential

New York also lacks any binding requirements that voluntary sexual health instruction must meet certain minimum standards, cover certain key topics, or be medically accurate or age-appropriate.

The *New York State Learning Standards for Health, Physical Education and Family and Consumer Sciences* set broad, binding standards for health knowledge and skills students must obtain in elementary, middle and high school.<sup>58</sup> Generally speaking, students must be provided the knowledge and skills necessary to "maintain personal health," to "create and maintain a safe and healthy environment," and to understand, manage and access "personal and community [health] resources."<sup>59</sup> The standards specify some sex-ed topics and skills (puberty, dating violence and assault, communication and decision-making, respect for self and others, social and emotional health, prevention and risk reduction strategies and accessing local health resources). But with the exception of sexual abstinence skills that should be taught in middle school, the standards do not speak specifically to core sexual health topics, such as pregnancy and STI prevention through methods beyond abstinence, sexual identity or healthy sexual relationships.

In 2005, the State Education Department issued a *Guidance Document for Achieving the New York State Standards in Health Education* (hereinafter, "state guidance document").<sup>60</sup> The document was intended to specify the skills and functional knowledge health educators should teach in order to fulfill state learning standards.

The state guidance document specifically addresses sexuality and sexual health instruction, and provides clear guidance on health education skills students must obtain and the sequential steps to obtain them (i.e., self-management, relationship management, stress management, communication, decision-making, planning and goal-setting, and advocacy). The guidance document also lays out the functional knowledge students should obtain in the areas of, among other things, HIV/AIDS, sexual risk, family life/sexual health and violence prevention. The guidance document addresses teaching about condoms and contraceptives, STI testing, teenagers' rights to obtain confidential sexual and reproductive health care services, healthy relationships,

gender stereotypes, sexual orientation, sexual harassment, and sexual violence and relationship abuse. Despite its good intentions, the guidance document is sorely limited because it is not binding on schools. It does not require schools that elect to teach sexual health education to actually cover all of the components it describes.<sup>61</sup> Moreover, it does not recommend, evaluate, or supply specific curricula or materials to help teachers achieve the guidance principles—or that have proven effective, comprehensive or medically accurate.

minimum core content for sexuality education that is developmentally and age-appropriate for students in grades K-12.”<sup>63</sup> They address a comprehensive array of skills and content in anatomy and physiology, puberty and adolescent development, identity, pregnancy and reproduction, sexually transmitted diseases and HIV, healthy relationships and personal safety.<sup>64</sup>

The national standards are more rigorous and comprehensive than the state guidance document, but like the state guidance document, the national standards are not binding on New York schools. Their recommendations do not have the force of law.



### III. National Sexuality Education Standards

In January 2012, leading health and education associations published the first-ever national standards for sex education.<sup>65</sup> These standards provide guidance on the “*essential minimum core content*” for sexuality education that is developmentally and age-appropriate for students in grades K-12.<sup>66</sup> They address a comprehensive array of skills and content in anatomy and physiology, puberty and adolescent development, identity, pregnancy and reproduction, sexually transmitted diseases and HIV, healthy relationships and personal safety.<sup>67</sup>

The national standards are more rigorous and comprehensive than the state guidance document, particularly with regard to skills and knowledge that middle school students should learn about sexual health, pregnancy and STI prevention. They are also more advanced and specific, for example, about correct condom use, pregnancy prevention, sexual orientation and gender identity, unhealthy relationships and personal safety.

Like the state guidance document, the national standards are not binding on New York schools. Put plainly, nothing requires New York health educators to follow the comprehensive national standards. The current legal and policy climate permits schools in New York to decide what, if any, sex education they will teach beyond the mandated HIV education. As a result, whether New York’s teens graduate from high school with the information and skills crucial to making lifelong healthy and informed decisions about sex and relationships rests in the hands of each individual school district, principal and health education teacher, with little guidance and even less oversight.



## **New Sex Education Requirement in New York City**

As of January 2012, all public New York City middle and high schools are required to include sexual health education as part of comprehensive health education.<sup>68</sup>

The New York City Department of Education (DOE) does not mandate a particular curriculum for sexual health, but recommends *HealthSmart MS* for middle school and *HealthSmart HS* and *Reducing the Risk* in high schools, with special modifications created in conjunction with the publishers to ensure age-appropriate instruction.<sup>69</sup> *Reducing the Risk* is a research-based, risk-reduction curriculum that studies have shown produces positive health results for teens. The DOE provides the recommended curricula for free to any teacher who attends a free training.

Schools that decide *not* to use the recommended curricula must provide instruction that comports with the state guidance document, as well as specific guidance issued by the DOE that requires medically accurate and age-appropriate instruction about:

- Self-esteem and perceived social norms.
- Making responsible sexual choices and avoiding high-risk behaviors.
- Abstinence as the best and most effective way to prevent pregnancy and STIs.
- The effectiveness of condoms and other birth control methods, including their consistent and correct use to reduce the risk of pregnancy and STIs.
- Recognizing healthy and unhealthy relationships.
- Developing communication and interpersonal skills to avoid and address high-risk situations.
- The right and responsibility of young people to access medically accurate information and appropriate health care.
- Human anatomy, physiology and the reproductive system.
- Human sexuality and sexual identity.<sup>70</sup>

Parents have the right to opt their children out of prevention lessons involving condoms and contraception only.

How the DOE enforces the new requirement and assesses whether it leads to healthy, informed student decisions about sex and relationships remains to be seen. Strong monitoring and evaluation mechanisms are essential to ensure that students get the information they need to make good choices.

# Methodology

## Purpose and Design

Because there are no binding standards for sex education in New York State, the goal of our study was to understand whether and how districts used the non-binding standards. We reviewed materials from many types of school districts and many regions of the state. While we did not design a scientific sample—we cannot generalize from our findings to make inferences about other districts in the state—our study highlights trends and examples of curricula that are likely in wide use across the state. Importantly, our sample provides a good understanding of the roles that state and national guidelines play in many students’ education.

To select a diverse sample for our study, we divided all the school districts in the state into categories based on enrollment and selected districts of varying sizes from each county in the state to ensure geographic diversity.

Size of district* (no. of students)	Small (<1,000)	Medium (1,001-3,000)	Large (3,001-5,000)	Very Large (>5,001)	Total
Number of districts selected	10	42	27	29	108
Combined enrollment	8,228	90,247	110,272	334,208	<b>542,955</b>

\*Districts that enroll only special-needs students or which lacked a high school were excluded.

The total number of students enrolled in the districts we surveyed—542,955—represents a nearly half of all students enrolled in districts outside of New York City. We requested materials from each of the five largest districts outside of New York City—Rochester, Buffalo, Syracuse, Yonkers and Brentwood—but only Rochester provided a complete response. We were able to include some information about the Buffalo City School District and Brentwood Union Free School District based on the textbooks in use and limited classroom materials provided. The Syracuse and Yonkers districts failed to adequately respond to our request.

## **Why Not New York City?**

Even though it is the largest district in the state, and the country, we did not include New York City in this study. This was primarily a decision of efficiency. At the time our study began, city schools did not have a sex education mandate, and principals had the option to provide sex education in their school, or not. Sampling individual schools in a pool of 1,700 would have been extremely inefficient and would have added little to our analysis. In January 2012, New York City announced a sex education requirement for all public middle and high schools. Instruction began citywide in February 2012. We look forward to reviewing New York City data and instruction at a future date.

## **Analysis**

We sent 109 freedom of information requests to New York school districts. Districts that ignored our request or provided responses with too little information to perform a meaningful review of our topics were excluded from our analysis. For the portion of the report on HIV education, the total number of districts analyzed is 89; for all other portions, it is 82.

When a district satisfactorily answered our information request, we analyzed the materials it provided based on a 94-point rubric, developed in large measure on the state guidance document. We designed the rubric to measure key elements of comprehensive sex education, including:

- Discussion of topics such as delaying sex, proper use of condoms and contraceptives, preventing STIs, recognizing intimate partner violence, understanding confidentiality, responding to sexual harassment, and obtaining STI and HIV/AIDS tests and treatment;
- Approach to gender bias and stereotypes (reinforced, ignored or actively debunked);
- Support for students to seek help from trusted adults, including parents, local health care providers and domestic violence advocates;
- Awareness of the needs of LGBTQ students and students whose parents identify as LGBTQ.

We supplemented the responses to our information request by purchasing the most frequently used textbooks and analyzing the portions indicated on class syllabi where possible. Our goal was to evaluate how successfully New York's guidance document on sexual health and the recent national sexuality education standards are being applied in classrooms. The present study does not generalize about sex education in every district. Rather, we hope our findings will spur readers to learn more about sex education in their local schools.

Throughout the report, percentages may not add exactly to 100 due to rounding.

## **Limitations**

This study has some limitations. For instance, because we were only able to measure information contained in records obtainable under New York’s Freedom of Information Law, we cannot evaluate whether or how topics were covered during classroom discussion. We were also rarely provided with written materials used by guest speakers and do not wish to discount or dismiss the valuable contributions of well-trained educators and expert speakers.

Second, when a district provided a curriculum that excluded one or more topics, we proceeded under the assumption that those topics were not taught—although some omissions may have been due to clerical error, or may reflect that the topic is covered through some means other than written materials.

Third, we did not analyze the videos that are played in many sex-education classes, though we found this to be a common feature across many districts.

Responses from districts often did not discern whether a particular document or text was used for middle or high school classes. Where that information was available and clear, it is included in the analysis. Occasionally, this limited our ability to measure accurately whether a district met the applicable learning standards and guidelines, which differ for middle and high school students.

Finally, because of the length of time inherent in collecting and analyzing such a large volume of information, we are unable to reflect accurately what materials districts may *currently* be using. The records we analyzed are reflective of curricula in use in the 2009-11 academic years. It is possible that districts have since changed or updated their materials. For that reason, statements about districts’ materials are presented in the past tense. We encourage readers to follow up with individual districts for the most timely information.



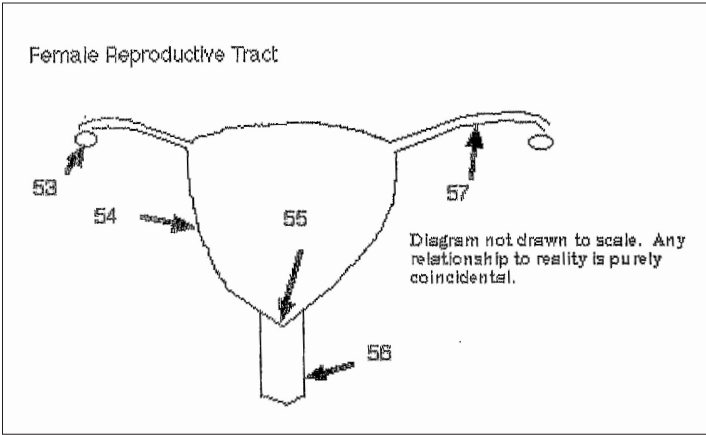
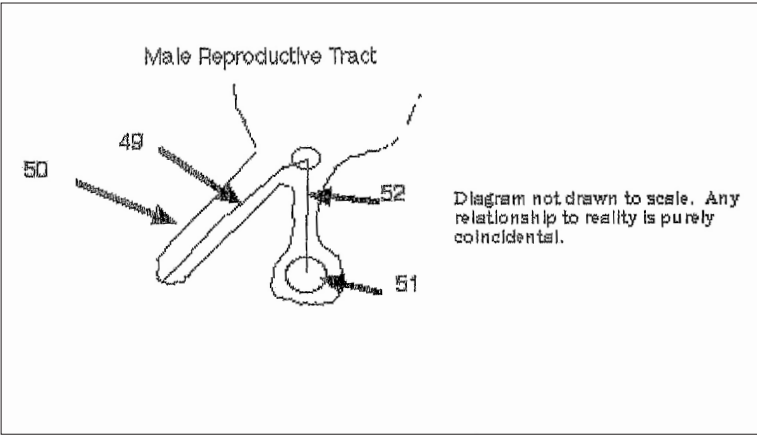
# IV. Findings

## The Body and Sexual Health

Both the national and state learning standards indicate that, by the end of middle school, students should be able to describe parts of the body and their functions, particularly as they relate to puberty and reproduction. The state guidance document and the national learning standards extend this goal to students being able to understand the emotional pressures associated with puberty, including self-concept, body image and societal expectations. Finally, the national standards include a provision that, by the end of high school, students will be able to describe the human sexual response cycle, including the role of hormones.

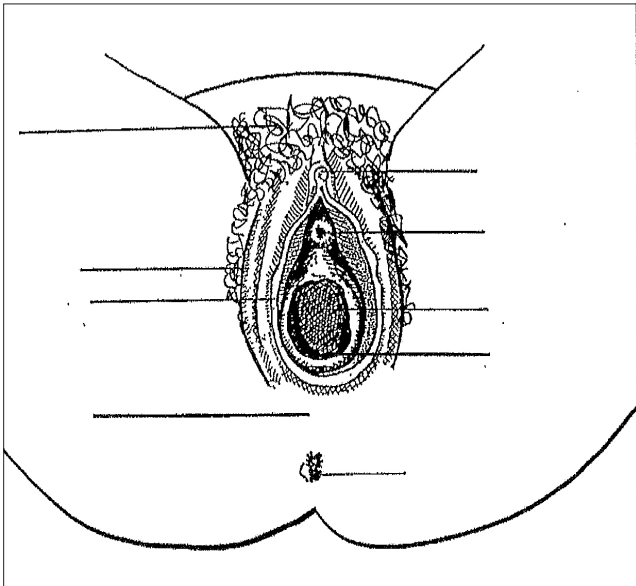
Of all the materials we reviewed, the lessons on reproductive anatomy and the functions of various body parts were among the most inaccurate and incomplete. By and large, students in the districts we studied were taught little if anything about human sexual response or non-reproductive aspects of anatomy and sexuality. Anatomy lessons, particularly regarding women’s bodies, are influenced by value judgments and heterocentric gender norms.

Many of the anatomy lessons we reviewed were factually limited and often reflect gender and heterosexual bias. For example, most districts in our study used materials that teach students that the female reproductive system consists entirely of internal organs. Of the districts sampled, 69 utilized some illustration of male and female genitalia and reproductive organs. But nearly two-thirds excluded any mention or depiction of external female genitalia.



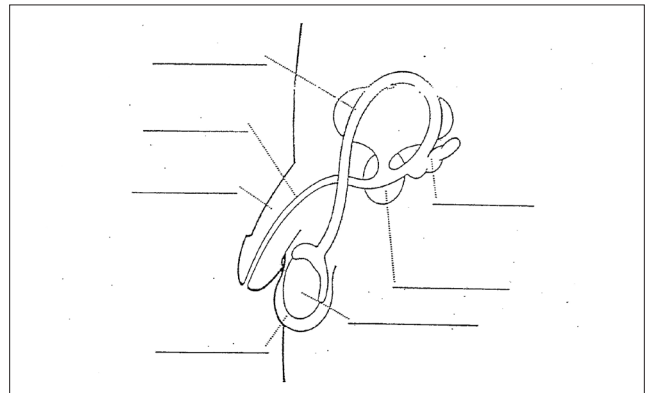
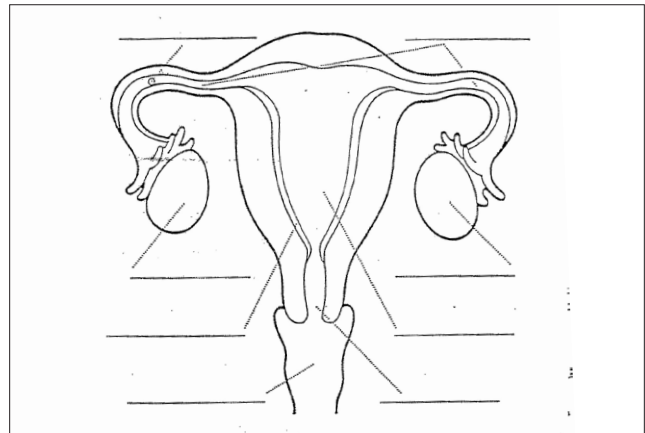
A handout showing rudimentary illustrations of reproductive “tracts” demonstrates the lack of medically accurate and complete information students learn in basic anatomy lessons. The instructor acknowledged this gap, captioning the images “any relationship to reality is purely coincidental.”

Sometimes the diagrams depict a disembodied uterus, Fallopian tubes and ovaries. Other times, they show a woman’s body with internal reproductive organs and no external genital features. Only a handful depict the female bladder and urethra, while generally all images depict the male counterparts. The clitoris was mentioned (though not necessarily defined or diagrammed) in a little more than half of the districts.



ABOVE: A worksheet identifying parts of the external female genitalia. Images like this one were used in too few districts.

RIGHT: Representations of male and female anatomy typical of those used in many districts that depict both internal and external male anatomy, but only internal female anatomy.

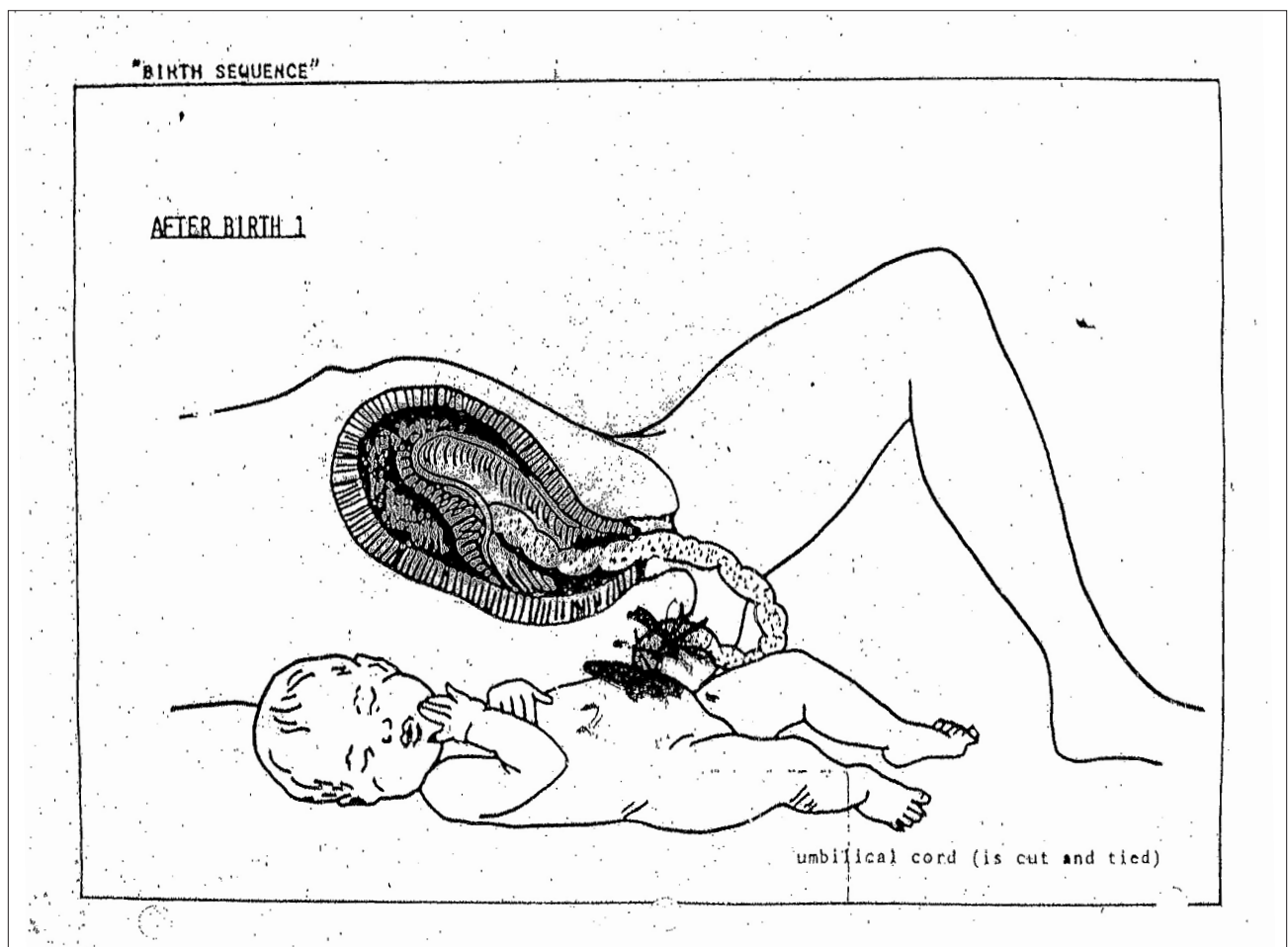


Sexual pleasure is rarely discussed in sex education or health class, except in the context of resisting sexual urges. Seventeen of the districts that responded to our request (20 percent) did not discuss orgasm or sexual pleasure at all. At least 46 districts (56 percent) included discussion of male orgasm but not female orgasm. Just 17 districts (20 percent) covered sexual excitement, orgasm or arousal for both men and women.

Nearly across the board, definitions of reproductive organs and genitalia reinforce harmful gender stereotypes and often exclude material that would be relevant to students who engage in sexual activity other than “penis-in-vagina” sex, including LGBTQ students. Nearly one-third of districts include at least one definition of female anatomy that references male anatomy or body fluids, penis-in-vagina sex, or pregnancy and childbirth (many include medically-accurate definitions along with problematic ones). For example, one district used the definition “sperm deposit” for the word “vagina.”<sup>71</sup> Holt Lifetime Health, a textbook used in at least five districts, defines the vagina as the

organ that “receives sperm during reproduction.”<sup>72</sup> Male anatomy is sometimes described using non-medical definitions, though far less often. One district defined the penis as “sperm gun” and described the vagina as “penis fits in here.”<sup>73</sup> Others define the penis as a “tube shaped organ made of spongy tissue with lots of blood vessels”<sup>74</sup> and “a tube-shaped organ that extends from the trunk of the body just above the testes. The penis is composed of spongy tissue that contains many blood vessels.”<sup>75</sup>

More than a dozen districts limited their definition of a woman’s anatomy to its reproductive purpose: A vagina is a “birth canal”<sup>76</sup> and a uterus is “where baby grows.”<sup>77</sup> A large number of districts use medically inaccurate terms to describe fertilization, pregnancy and fetal development, referring to a pregnant woman as a “mother” and a fetus as a “baby.” In one district, sexual intercourse was defined as “the reproductive process in which the penis is inserted into the vagina and through which a new human life may begin.”<sup>78</sup>



This image of a woman who has given birth indicates only her abdomen, vaginal canal and one leg, reducing the woman’s identity to that of a vessel for gestation and de-emphasizing her active role in giving birth. These values were common to many curricula.



These factual deficiencies in anatomy lessons may shape students' views about their bodies as incomplete or abnormal, unless they engage exclusively in penis-in-vagina sex or sex for the purpose of reproduction—a viewpoint that not only perpetuates stereotypes but devalues students' personal autonomy, their physical bodies and their experiences.

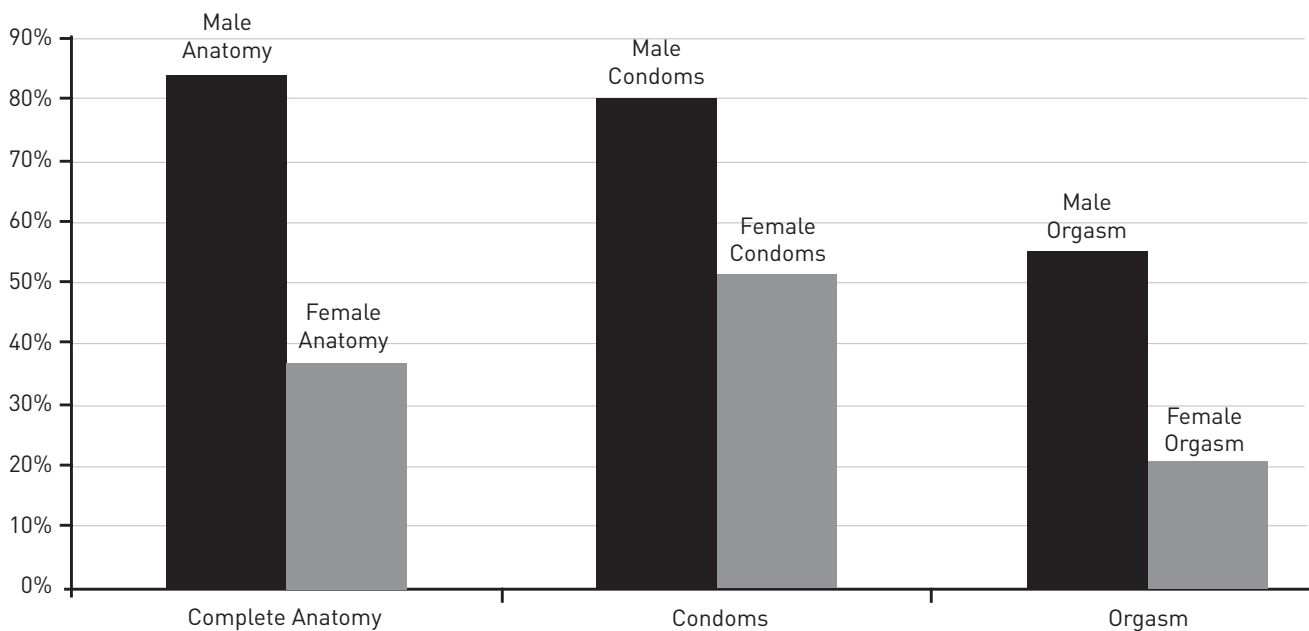
### Risk, Prevention and Protection

According to the CDC, 5.7 percent of New York students report having had sexual intercourse before the age of 13.<sup>79</sup> Yet the state guidance document does not include instruction to middle school students on the biological relationship between sex and reproduction, signs of pregnancy, prenatal care, options for pregnant women or parenting skills. Though districts sometimes did not differentiate between middle and high school materials they provided to us, our analysis indicates that few middle school students received information on prevention of pregnancy. Lessons at the high school level—while more universally taught—were often incomplete and sometimes inaccurate.

The guidance document does indicate that middle school students should be taught that STIs exist and how they are transmitted; high school students should understand that abstinence is 100 percent effective against pregnancy and STIs; and that contraceptives and condoms, when used correctly and consistently, also provide protection. Our study revealed that nearly every district

### Topics Addressed by Gender

New York State Public Schools Health/Sex Education Instruction



taught that abstinence is the best prevention and most also taught some lessons on other forms of prevention. At least nine districts (10 percent) taught an abstinence-only curriculum in middle school. Only four districts taught no prevention methods other than abstinence in high school.

Our analysis showed that all of the most commonly used health textbooks in use in our sampled districts are abstinence-only (Glencoe Health, Glencoe Teen Health Courses 1-3, Meeks Heit Health and Wellness, Prentice Hall Health and Holt Lifetime Health). Abstinence-only textbooks teach students how to prevent pregnancy and STIs by practicing abstinence but do not mention condoms or contraceptives. As a result, many districts that teach comprehensive prevention methods must rely on materials that are teacher-created or provided by guest speakers and which may not meet the state's guidance criteria.

Abstinence materials often contained strong moral overtones. Twenty-seven districts (33 percent) suggested to students that not practicing abstinence was an immoral choice, or one that would cause students to become social outcasts, suffer emotional or psychological harm, or fail in other aspects of their lives. For example, one instructor-created presentation stated: "compared to teens who are not sexually active, teenage boys and girls who are sexually active are significantly less likely to be happy and more likely to feel depressed."<sup>80</sup> One textbook (a version of which was in use in 10 districts) counsels students that:

- "Waiting until marriage to have sex preserves traditional marriage ... Actions that preserve traditional marriage preserve the family. Actions that weaken traditional marriage lead to the breakdown of family life and much unhappiness."<sup>81</sup>
- "Being sexually active interferes with your values and family guidelines."<sup>82</sup>
- "Having sex outside of a loving, committed marriage increases your risk of feeling rejected, being compared to someone else, and feeling used by a partner."<sup>83</sup>
- "When you practice abstinence, you will not be guilty of having sex with an unwilling partner. You will not be accused of date rape."<sup>84</sup>
- "Character is a person's use of self-control to act on responsible values. When you have good character, you uphold family values and practice abstinence from sex."<sup>85</sup>

The majority of districts in our study clearly indicated that they taught some lessons on contraceptive and condom use to prevent pregnancy, most consistently at the high school level. Eighty percent of the districts we studied taught students about condoms but only 29 (35 percent) actually taught students how to use them correctly. After condoms, hormonal birth control was the most commonly discussed form of contraception (50 districts, or 60 percent). About half of all districts sampled (38) offered students some information about emergency contraception; 47 districts (57 percent) mentioned female condoms.



The state guidance document provides that by the end of high school, students should learn the effects of alcohol and tobacco use on a fetus. The national standards further direct that students should be able to describe harmful prenatal practices and identify medically accurate sources of pregnancy information and support. Forty-nine districts in our study (59 percent) provided students with at least some information on prenatal care and activities that can harm a fetus.

Finally, the national standards provide that by the end of high school, students should be able to identify laws related to reproductive health care and compare and contrast laws relating to pregnancy, adoption, abortion and parenting. Only 30 districts (36 percent), however, provided any information on adoption or abortion. One school district misleadingly taught that abortion in New York is legal “throughout the first trimester” without providing information on the availability of abortions later in pregnancy. Another described “Post Abortion Syndrome,”<sup>86</sup> which was debunked by the American Psychological Association in 1989—before New York’s current generation of public school students was born.<sup>87</sup>

The state guidance document clearly states that by the end of middle school, students should learn that adolescents are not capable of responsible parenthood. By the end of high school, they should understand how becoming a parent would affect their short- and long-term goals. Most districts are compliant with this goal. But 31 districts—close to 40 percent—described teen pregnancy in ways unnecessarily shaming of teen parents. Some textbooks so exaggerated the horrors of teen parenting that a pregnant or parenting student would likely feel alienated if not humiliated. Students whose own parents were teens when they gave birth to them are also given overwhelmingly negative messages about their parents and themselves. For example, one textbook with editions in use in at least 10 districts in our study contains the following lesson on teen pregnancy:

- Teen mothers and fathers are less likely to graduate from either high school or college. They have difficulty earning enough money to support their families because they have no skills. Babies who are born to teen parents are more likely to have birth defects and to be raised in poverty.<sup>91</sup>

Twenty-nine districts in our study (35 percent) used materials or textbooks with an anti-abortion bias. For example, many commercially-created materials incorrectly referred to a fetus and embryo as a “baby;” several districts used materials that stated, inaccurately, that pregnancy begins with fertilization (one claimed that “fertilization occurs when a man and a woman have sexual intercourse”<sup>88</sup>); and many referred to pregnant women as “mothers.” One handout defined sexual intercourse as “the reproductive process in which the penis is inserted into the vagina and through which a new human life may begin.”<sup>89</sup> Another school district provided what appeared to be an instructor-created lesson that read: “Even before someone realizes it, they are pregnant! A test does NOT show a positive before 6 weeks, and by then the baby has already reached important milestones.”<sup>90</sup>

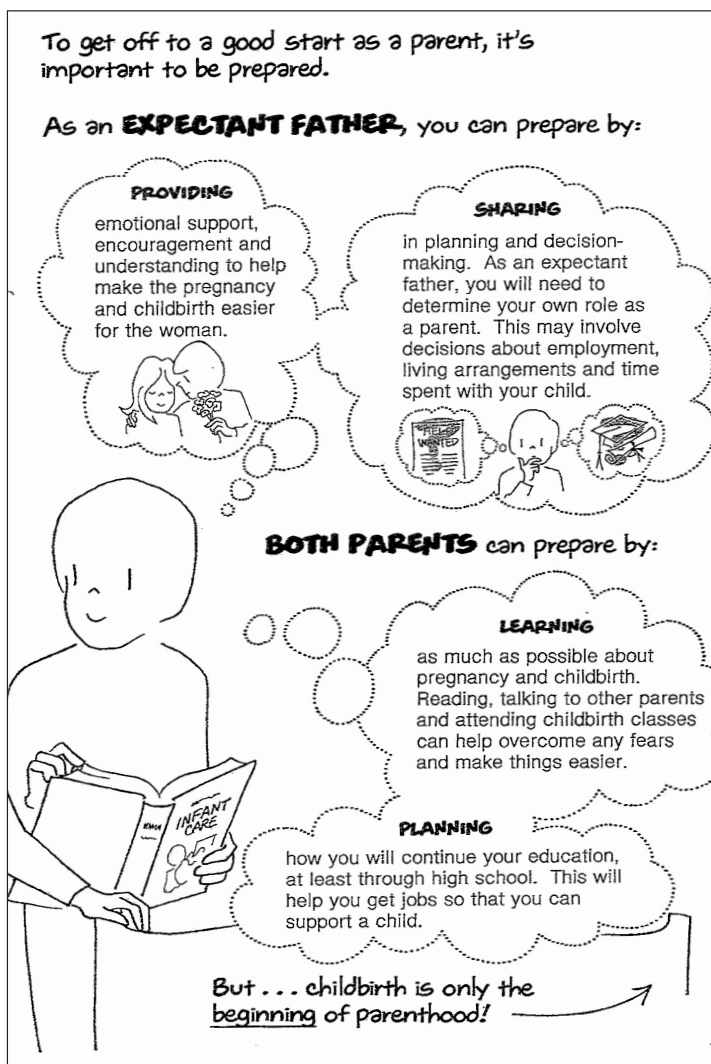
- The number of teen parents who abuse and neglect their children because of frustration is extremely high.<sup>92</sup>
- Most teen mothers are not married. They do not have the emotional support of a loving husband. Their babies do not live with a father who can love and nurture them. Teens who marry have a lower continuing financial status than they would have had if they had married and had children in their twenties.<sup>93</sup>

While it is important that students learn how teen pregnancy and the decision to become a parent can affect their goals, it is equally vital that schools support students who actually *are* pregnant and parenting in order to reduce the cycle of dropping out and poverty. Nearly every district provided us

with a written policy about helping pregnant students stay in school, yet the materials taught in class consistently conveyed the opposite message. In addition, schools need to support students who may themselves have been raised by teen parents, rather than denigrating their families.

Given that New York's teen pregnancy rate is among the highest in the nation, students likely have peers who are pregnant or parenting.<sup>94</sup> It is important to teach students the issues facing teen parents without demonizing teens who choose to carry a pregnancy to term and raise a child, or casting the children of young parents as hopeless.

Fourteen districts (17 percent) used curricula with a strong bias against teen fathers. Mention of teen fathers was usually in the context of the financial implications of teen parenthood. Several lessons promoted assumptions about the absence of teen fathers in the lives of their children. Almost no lessons included discussions of the emotional commitment of fatherhood or responsibilities beyond financial. One district's handout describing how expectant mothers and fathers could prepare for childbirth, including emotional and psychological considerations, was a notable exception.<sup>95</sup>



This image, used by only one school district in our study, depicts teen fathers in a positive light and emphasizes non-financial aspects of parenthood.

## Sexually Transmitted Infections

Most districts provided lessons on common STIs, their symptoms, and the importance of seeking testing and treatment. Fewer than half of the lessons, however, discussed specific means of STI transmission beyond “sexual contact.” For example, only 47 percent of districts (39) indicated that some STIs can be transmitted through skin-to-skin contact. The lack of complete information may limit teens’ ability to protect themselves from infections that are transmitted in ways other than oral, anal and vaginal sex.

Of the primary STIs covered by the districts we studied (Chlamydia, gonorrhea, herpes, HIV, syphilis, genital warts and the human papillomavirus [HPV]), we found the most inaccurate and incomplete information regarded HPV and genital warts. Often, the two conditions were inaccurately described as the same infection. If they were described separately, the connection between them was not explained. Less than 40 percent of districts discussed the availability of HPV vaccines for young women.

Unfortunately, STI prevention lessons omitted information that would be useful to students who engage in sexual contact beyond penis-in-vagina sex. Specifically, districts rarely provided information relevant to young women who engage in sexual activity with same-sex partners. For example, only 15 districts (18 percent) taught students about dental dams as a prevention method. Information on male condoms was generally more complete.

Nearly 90 percent of our sample, or 73 districts, provided students with information on treatment of STIs. These districts generally also included information on the importance of STI testing for students who are sexually active. Unfortunately, some districts used outdated or medically inaccurate information. For example, one document titled “Straight Talk, The Truth about STDs and AIDS” from the early 1990s stated “... if you get AIDS you will probably die of the disease, but that’s all we know.”<sup>96</sup> An accompanying handout encouraged students to use condoms with Nonoxynol-9, a spermicide that has been discredited by experts, including the World Health Organization, as a means of avoiding HIV transmission.<sup>97</sup>

As in the pregnancy-prevention lessons, some districts communicated shame-based messages about STIs rather than medically accurate, opinion-neutral information. A 1997 pamphlet from the U.S. Department of Health and Human Services that was used in at least one district in our study warned:

Maybe you think your friends will say you’re cool if you have sex. Well, just wait until you catch a sexually transmitted disease. Every year, thousands of teenagers do. And the sex that was supposed to make them so popular, turns them into the school’s biggest outcasts overnight.<sup>98</sup>

Most districts are working hard to supplement abstinence-only textbooks with valuable materials on prevention and risk reduction. Most districts provide information to students about condoms and their proper use; fewer provide valuable information on other forms of contraceptives. Unfortunately, moral overtones, shame-based messages about sexuality and strongly heterocentric gender values pervade materials in all districts. These materials, unlike medically-accurate,

opinion-neutral information, risk alienating students from otherwise valuable prevention lessons. Specifically, lessons on teen pregnancy rely on fear and shame, offering no support for students who choose to raise a child or students who were themselves raised by teen parents.

## **HIV Prevention: Gaps in Instruction**

New York law requires information about HIV—at a minimum, instruction about the “nature of the disease,” methods of transmission and methods of prevention, including abstinence—be taught in all public schools, kindergarten through 12<sup>th</sup> grade.<sup>99</sup>

The state guidance document gives a more detailed outline of the functional knowledge that students should learn about HIV/AIDS. As early as elementary school, students should learn that “HIV is the virus that causes AIDS” and that the “virus weakens the ability of infected individuals to fight off disease.” Transmission methods are incorporated at the middle school level, specifically that “HIV can be transmitted through blood-to-blood contact; sexual contact with an infected individual; by using needles and other injection equipment that an infected individual has used; and from an infected mother to her infant before or during birth or through breast milk.”<sup>100</sup> The state guidance document stresses abstinence but includes instruction about other prevention information including condoms, monogamy and how to access confidential health services.<sup>101</sup> The national standards also provide for comprehensive instruction about HIV transmission, prevention, testing and treatment.<sup>102</sup>

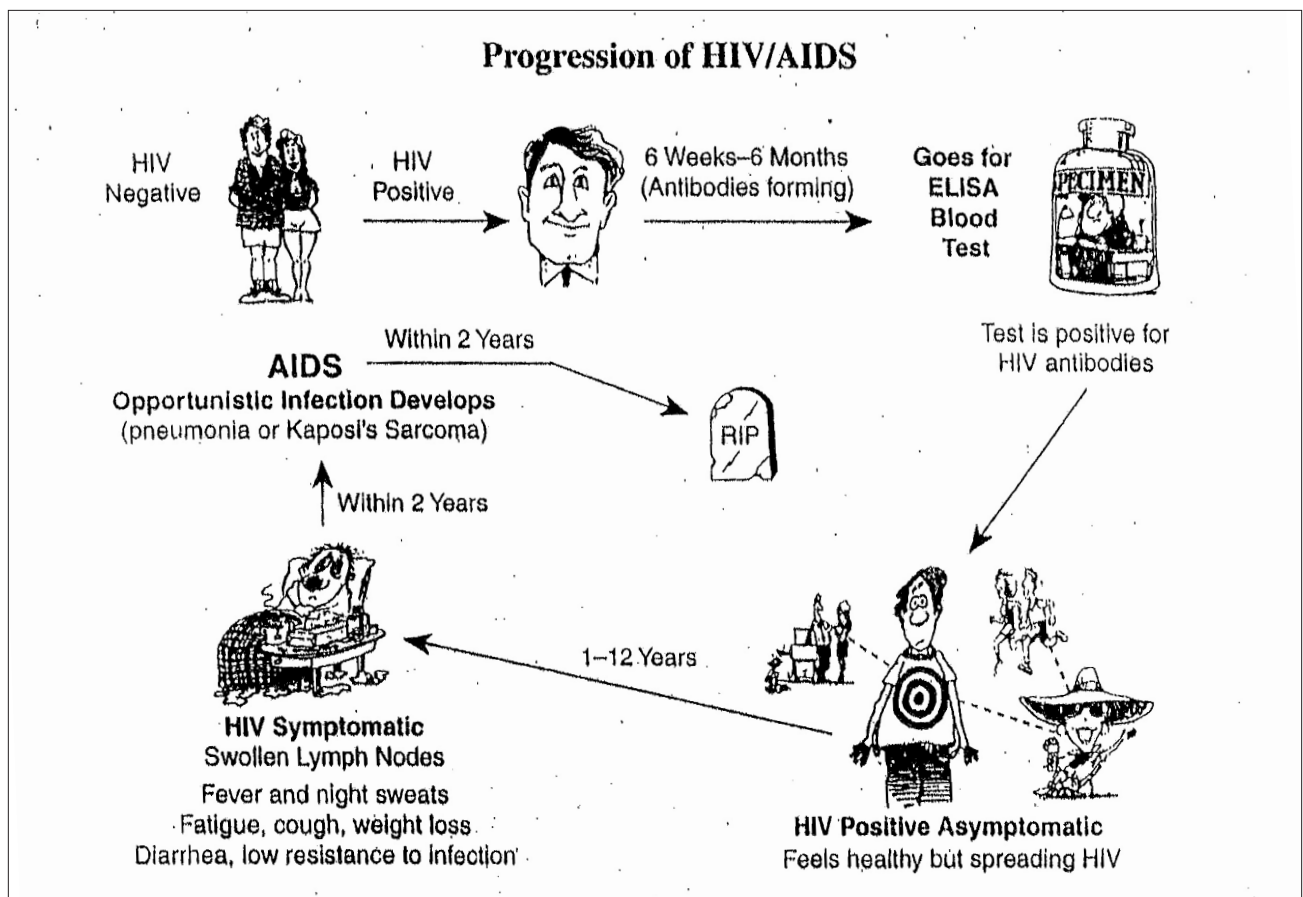
While the various elements of New York’s HIV education requirement are analyzed below, it is helpful to note that 50 districts (56 percent) provided complete and scientifically accurate information about both the nature of the disease and transmission. A further 33 districts (37 percent) made some mention, even if somewhat inaccurate or incomplete, of both of these. Of these 83 districts, only 19 (21 percent) provided complete, accurate information about the basics of male condoms, including information about what a condom is and condom efficacy. An additional 59 (66 percent) provided some information about male condoms, even if partially inaccurate or incomplete. In sum, 78 districts (88 percent) provided information of varying accuracy and completeness about the nature of the disease, transmission and male condom use. This review suggests that while there are gaps in instruction, New York’s AIDS education mandate has likely played a significant role in ensuring that most districts are teaching the required topics, though there is ample room for improvement.

### The Nature of the Disease

A complete discussion of the nature of HIV/AIDS includes mention that HIV is a virus that affects the immune system, that HIV can lead to AIDS and that while there is no cure, there are several forms of treatment. The majority of districts complied with this piece of the mandate. Nearly two-thirds (56 districts) provided a complete and accurate discussion of the nature of the disease. Five districts (6 percent) did not discuss the nature of HIV at all, while 29 districts (33 percent) did so, but incorrectly

or incompletely, largely because discussions of treatment that suggest that HIV is a virtually untreatable and fatal illness, which is no longer true. In four districts, for example, materials made grossly inaccurate warnings, such as: "Once you have AIDS you will live from 6 months to 3 years,"<sup>103</sup> or that HIV "kills an individual."<sup>104</sup>

While the majority of districts discussed the existence of HIV treatment, these discussions included anachronistic and occasionally inaccurate information. One district, for example, discussed only azidothymidine (AZT)<sup>105</sup>—the original antiretroviral medication, first used in 1987—although tremendous progress has since been made in developing effective HIV medications. Another district framed the effects of medication as not entirely known: "Antiretroviral medications, as well as medications which help to prevent serious opportunistic infections, are thought to be partially responsible for extending the life of HIV-infected individuals."<sup>106</sup> This language is unnecessarily tentative, suggesting that antiretrovirals are only "thought," rather than proven, to be effective. In fact, numerous studies have demonstrated that antiretroviral medications prolong life for people with HIV/AIDS, slow disease progression from HIV to AIDS and significantly reduce viral loads and levels of infection in the body.<sup>107</sup>



This handout fails to explain HIV/AIDS treatment options or how to reduce transmission. The headstone as an inevitable endpoint exploits outdated fears without providing students with additional information.

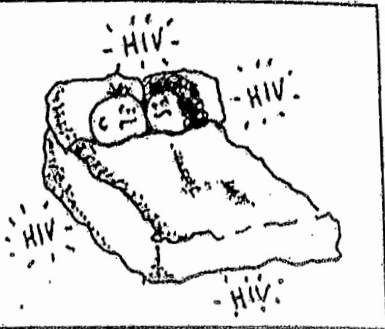


## Transmission

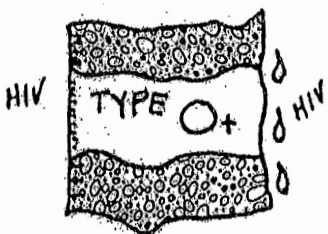
The state guidance document indicates that all middle school students should learn about HIV transmission via body fluids, sex, shared needles, and from mother to infant during birth or breastfeeding. All districts except one addressed transmission methods, but 27 (30 percent) used incomplete or medically inaccurate materials. In addition, 15 districts (17 percent) included inaccurate information about transmission routes. Three districts, for example, discussed open-mouth kissing as a route of transmission, though transmission of this nature is exceedingly rare and requires both the presence of blood from the HIV-positive partner and an open wound in the mouth of the other partner. Additionally, nine districts (10 percent) failed to discuss perinatal transmission. Of the districts that did mention mother-to-child transmission generally, 38 (43 percent) provided incomplete information, such as failing to discuss transmission via breast milk.

**HOW AIDS IS SPREAD (SE-47)**

**1. SEX:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



The illustration shows a couple lying in bed, partially covered by a blanket. The word 'HIV' is written in a dotted, radiating font around the couple, suggesting a pervasive or contagious presence.



**2. Blood transfusion with \_\_\_\_\_ blood or blood products.**

The illustration shows a blood bag with a label that reads 'TYPE O+'. The word 'HIV' is written on either side of the bag, and there are small blood drop symbols next to it, indicating that the blood contains the virus.

This worksheet uses inaccurate terminology and overstates the risk of contracting HIV through blood transfusions. The illustration of HIV surrounding the couple in bed communicates a fear message, with no useful information for students.

Materials about transmission also included stigmatizing comments that were both inaccurate and, in some cases, fear-mongering. Materials from one district included warnings relating to activities that pose no danger, such as manicures or sharing personal hygiene items.<sup>108</sup> Another district taught that, “[d]ue to the way the AIDS virus is transmitted, it is unlikely that AIDS can be transmitted by sitting next to someone in class”<sup>109</sup>—suggesting that transmission by proximate seat placement is possible—contrary to the guidance document’s requirement that students in elementary school learn that “Individuals cannot get HIV/AIDS by being near or touching someone who has it.”<sup>110</sup>

## Demographics

Neither the state guidance document nor the national standards outline essential content related to the demographics of people infected with HIV. However, awareness of demographics informs and broadens instruction by challenging persistent myths about HIV and whom it affects, particularly the misperception that HIV affects only gay people or injection-drug users. In reality, HIV/AIDS affects a considerable number of people who are neither gay nor injection drug users, including heterosexual men and women, with all women representing approximately 27 percent of new AIDS diagnoses in the U.S. since 2000.<sup>111</sup> Accurate information about the demographics of the HIV epidemic can encourage safe behavior even as it lessens stigma and discrimination toward specific populations most stereotypically associated with HIV/AIDS. But discussions of the demographics of HIV infection also risk perpetuating stigma.

Twenty-seven districts (30 percent) did not mention demographics in their curricula at all and seven others (8 percent) provided outdated or inaccurate information. One district cited archaic statistics from 1992 and focused solely on gay men and injection-drug users as high-risk populations. Another district provided a worksheet that asked students to imagine someone infected with HIV and identify their gender, race, career, income level, physical appearance and other factors.<sup>112</sup> Such an exercise could break down stereotypes or reinforce them, implying some monolithic vision of people living with HIV/AIDS. Curricular materials in another district stated, “Ali was certain she contracted HIV that evening. She learned later that the man she had slept with had previously engaged in homosexual sex.”<sup>113</sup> Materials from another district stated, “[d]rug users get AIDS more than other people,”<sup>114</sup> portraying the people, rather than the behavior, as unsafe. These sorts of messages perpetuate HIV-related stigma and encourage stereotyping that detracts from the public health message that all students need to take steps to protect themselves from HIV.

## Prevention

Understanding an individual’s risk of HIV infection requires complete, accurate instruction about “risky” behaviors. New York State Education Regulation 135.3 requires that high school students receive “accurate information” about “methods of prevention” of HIV transmission, among other topics. The state guidance document also requires that by the end of high school, students know that “(t)he risk of becoming infected with HIV/AIDS can be virtually eliminated by practicing abstinence from sexual contact and not sharing needles to inject drugs, vitamins or steroids.”<sup>115</sup>

The national sex-ed standards offer multiple recommendations to promote understanding of risk and risky behaviors. According to these standards, students should, by the end of high school, be able to determine the potential risk of HIV transmission linked with various behaviors, including abstinence.<sup>116</sup> Students should also understand the risks that stem from substance use, and should be able to analyze the impact of alcohol and other drugs on safer sexual decision-making and sexual behaviors.<sup>117</sup> Students should, more generally, be able to analyze factors that may influence condom use and other safer-sex decisions.<sup>118</sup> Further, students should be able to develop a plan to eliminate or reduce their own personal risk for HIV.<sup>119</sup>

While nearly all districts (82, or 92 percent) discussed risky behaviors, more than half (58, or 65 percent) provided some incomplete or inaccurate information. A handful of districts identified behaviors that are not risky, such as sharing spit or earrings, as risky behaviors. Another district defined pre-marital sex as “bad health behavior,” conveying the message that all pre-marital sex puts people at high risk of contracting HIV.<sup>120</sup> Numerous districts placed an inappropriate emphasis on marriage and monogamy as prevention, stating, for example, that the benefits of marriage include “help[ing] protect [monogamous] marriage partners from infection with STDs and HIV,”<sup>121</sup> or that a monogamous relationship with someone who is uninfected and does not use drugs poses no risk for HIV.<sup>122</sup> Presuming monogamy may in fact put people at greater risk than urging individuals to take responsibility for their own sexual health by consistently using condoms.

The state guidance document states, somewhat circuitously, that by high school graduation, students should know that “(a)n individual is at greater risk of HIV infection by having one or more sexual partners who are at increased risk by engaging in sexual contact that results in the exchange of body fluids (i.e. semen, vaginal secretions, blood), and/or by using unsterile needles or paraphernalia to inject drugs, vitamins or steroids.”<sup>123</sup> While it is important for students to understand that high-risk activity increases the likelihood of transmission, some districts have applied this message in a way that again relies on crude stereotypes and judgmental labels, and results in stigmatizing certain groups.

A document from one district, for example, instructs students not to have sexual intercourse with people in high-risk groups, mentioning specifically gay and bisexual males, IV drug or steroid users, sexual partners who share these characteristics or people with many sexual partners.<sup>124</sup> Undue emphasis on the demographics of chosen sex partners, by type or by number, undermines the critical message that consistent condom use is the surest form of sexual prevention, as in a document from another district that warns: “if a person chooses the dangerous practice of having more than one partner ...”<sup>125</sup>

The state HIV requirement and the state guidance document both encourage the teaching of abstinence as a primary prevention strategy. The Commissioner’s Regulation requires that HIV instruction in New York stresses “abstinence as the most appropriate and effective premarital protection against AIDS ...”<sup>126</sup> Further, the national standards suggest that by the end of high school, students should be able to “[a]pply a decision-making model to choices about safer-sex practices, including abstinence and condoms.”<sup>127</sup>

A significant minority of districts analyzed (15, or 17 percent) omitted mention of abstinence as a form of prevention in their HIV lessons. The failure of nearly one-fifth of school districts to discuss abstinence at all in the context of HIV lessons fails to validate the experience of young people who are not yet sexually active, and misses the opportunity to offer abstinence as one form of prevention. The failure to discuss abstinence also potentially forecloses essential conversations about sexual readiness and sexual-negotiation skills. At the same time, abstinence should not be presented as a guarantee against infection, since doing so ignores modes of non-sexual transmission. Yet nearly half of the districts (39, or 44 percent) present abstinence as a completely effective form of prevention. A typical statement to this effect assures students, “Abstinence is the only 100% effective way to protect against sexually transmitted diseases including HIV/AIDS ...”<sup>128</sup> In numerous districts, the discussion of abstinence went so far as to alienate and condemn sexually active students. For example, materials from one district stated, “The proud and responsible thing to do is to practice abstinence ...”<sup>129</sup> implying that the choice to be sexually active is both shameful and irresponsible.

The state regulation requires an emphasis on abstinence, but curricula must also frankly address the range of human sexual behavior, and not frame penis-in-vagina intercourse as the sole behavior to avoid or delay in order to prevent HIV transmission. An overly narrow framing of the abstinence message fails to educate students about the risk associated with a range of sexual practices, including anal and oral sex, as well as the sexual experiences of LGBTQ students.

While HIV/AIDS education typically falls within the context of sexuality education, discussion of HIV prevention must include non-sexual prevention strategies, in particular, avoidance of sharing of drug-injecting equipment. Impressively, the curricular materials of all but one district discuss non-sexual prevention methods.

The use of a latex condom can greatly reduce the risk of transmission of HIV and many other STIs.<sup>130</sup> However, most school districts did not provide sufficient information to teach students how to correctly and effectively use condoms anywhere in their education materials. Of the 89 school districts reviewed, fewer than 1-in-4 (21 districts) provided complete and correct information about male condoms (including an explanation of what a condom is, and that condoms are highly effective in preventing transmission), though an additional 62 (70 percent) provided incomplete information about condoms and 47 (57 percent) mentioned female condoms. Only 18 districts (20 percent) provided complete instruction on how to use a male condom, and five districts (6 percent) failed to provide students with any information about male condoms.

Female condoms are far less likely to be included in curricular materials. More than half of the school districts (48, or 54 percent) failed to discuss female condoms anywhere in their materials. Among the 47 districts (57 percent) that did mention female condoms, only six (7 percent) provided correct instruction for female condom use. Thus, our analysis found that while most students in New York learn some about male condoms, they may not get all the information they need, and that information about female condoms is particularly lacking.

Myths about condom use persist in HIV/AIDS educational materials. For instance, materials from one school district<sup>131</sup> referred to a flawed and outdated 1993 analysis that showed condoms had a 31 percent failure rate in preventing sexual spread of HIV. According to the U.S. Agency for International Development (USAID), consistent and correct use of latex condoms “reduces the likelihood of HIV infection by 80 to 90 percent.”<sup>132</sup>

Condom failure has more to do with incorrect or inconsistent usage than with ineffectiveness of condoms as a prevention measure. But in at least two districts (2 percent), students were advised to use condoms only if they had sex with more than one partner.

Further, students in 14 districts (16 percent) were given incorrect and outdated information about Nonoxynol-9, a spermicide once believed to help prevent HIV transmission that was promoted as extra protection when used with condoms. But for more than a decade, Nonoxynol-9 has been known not to prevent transmission, and to possibly *increase* HIV transmission in women.<sup>133</sup> Misinformation of this nature is both medically inaccurate and potentially dangerous, and should immediately be removed from curricular materials.

## **LGBTQ and Gender Non-Conforming Students: Stigmatized or Ignored**

### Sexual Orientation and Same-Sex Relationships

According to both the state guidance document and the national standards, students in middle and high school should learn about sexual identity and the spectrum of human sexual orientations. By the end of high school, according to the national standards, students should understand sexual orientation; know how and where to access accurate information about sexual orientation; distinguish between sexual orientation, sexual behavior and sexual identity; differentiate between biological sex, sexual orientation, gender identity and expression; and analyze personal and societal influences on the expression of sexual orientation and identity.

### Teaching Students about Sexual Orientation

Instruction about sexual orientation in the sampled school districts proved consistently inadequate. For example, none of the health textbooks most commonly used in our sample addressed the topic of sexual orientation. More than half of the school districts (44, or 55 percent) did not provide any instruction about sexual orientation. Neither did they mention gay men, lesbians or bisexual people. Only 28 percent of the school districts (23) addressed sexual orientation; explained heterosexuality, homosexuality and bisexuality; or taught that same-sex attraction is normal.

Some districts cast lesbian and gay people only in negative contexts. For example, one school district mentioned gay people only related to the AIDS epidemic, noting that “The first cases of

AIDS in the United States . . . [i]nvolved homosexual, or gay, men. Homosexuals are people who are attracted to and may engage in sexual relations with people of the same gender.”<sup>134</sup> One district explained same-sex attraction under “Taboo Definitions.”<sup>135</sup> Another mentioned same-sex attraction as a cause to seek “counseling.”<sup>136</sup>

A minority of districts (14, or 17 percent) acknowledged gay people but provided no further information about sexual orientation. Moreover, the vast majority of references were made in negative contexts; namely, in discussing HIV risk or the history of HIV; in explaining that a boy’s sexual inactivity does not mean he is gay; or in discussions of rape and dating abuse, hate crimes or bullying. Common examples included:

- “Most [HIV] infected people are homosexual men and drug users who used unsterile needles.”<sup>137</sup>
- “I’m not gay. I don’t inject drugs. Why do I have to think about HIV and AIDS?”<sup>138</sup>
- Teaching that AIDS is not a “gay” disease.<sup>139</sup>

Some schools also reinforced the fallacy that being gay is a “choice”<sup>140</sup> or a “preference.”<sup>141</sup>

## Presuming Heterosexuality

An overwhelming 89 percent of school districts (73) failed to portray teenage same-sex couples in images, role plays or relationship exercises. This is true even in the minority of districts that acknowledged same-sex attraction. Most did so only in the abstract, without providing descriptions or actual examples. None of the textbooks most commonly used included images, role plays, questions or activities involving same-sex couples when discussing relationships or dating.

Only six school districts (7 percent) used role plays, movies or exercises that provided examples of same-sex teen couples grappling with the same kind of relationship and health decisions as heterosexual couples. Six districts (7 percent) used gender-neutral or ambiguous names in role plays and couples exercises, but this does not guarantee that same-sex couples were cast in gender-neutral exercises.

Thus in health class, LGBTQ teens—presented only with boy-girl images and descriptions—are hard-pressed to find positive representations of themselves or to experience lessons directly applicable to their lives. Instead, students received the message that attraction, sex and relationships always involve the opposite sex. Teens in the sampled school districts routinely encountered the following types of statements and exercises:

- “Students will demonstrate the ability to describe the significance of sexual differences in boys and girls and the male and female sexual roles in our society, as related to wholesome boy-girl relationships, marriage, parenthood and family life.”<sup>142</sup>

- “One aspect of emotional growth during adolescence is a change in feelings toward members of the opposite gender.”<sup>143</sup>
- “What Do I Really Want,” an activity that asks boys what they will look for in their future “wife” and girls the same about their future “husbands.”<sup>144</sup>
- A benefit of dating is meeting members of the “opposite sex.”<sup>145</sup>
- “Dating” defined as “developing a relationship with a member of the opposite gender, which you feel attracted to.”<sup>146</sup>

The heterosexual bias extends to portrayals of adult relationships. Although the materials we analyzed pre-dated the ability of same-sex couples to marry in New York, same-sex couples have been permitted for some time to marry in a number of other states and countries. Yet no textbooks and lessons about marriage used materials that acknowledged or depicted marriages among same-sex couples. (Although at least two school districts discussed the then-current political debate about whether same-sex couples *should* be allowed to marry.)

Indeed, many school districts taught that marriage is limited to heterosexual couples. For example:

- One commonly used textbook addresses only “traditional marriage,” defined as “an emotional, spiritual, and legal commitment a man and woman make to one another.”<sup>147</sup>
- Another widely used text defines marriage as “a lifelong union between a husband and a wife, who develop an intimate relationship.”<sup>148</sup>
- Exercises and worksheets use restrictive language, such as “bride,” “groom,”<sup>149</sup> and mock-contracts in which “him” and “her” are agreeing to certain terms.<sup>150</sup>
- A marriage worksheet explains: “In a well-adjusted marriage . . . [t]he husband and wife had a close association prior to marriage.”<sup>151</sup>

Students with same-sex parents do not often find their families represented or acknowledged in health class. Only five school districts (6 percent) used materials that acknowledged, discussed or portrayed same-sex parents in discussions about family structure and relationships. Nearly all school districts (77, or 94 percent) failed to acknowledge same-sex parents. Indeed, many districts described families with more than one parent as explicitly limited to heterosexual couples. For example:

- A “nuclear family” defined as a mother, father and children<sup>152</sup> or “a mother, father and natural or adopted children living together as a unit.”<sup>153</sup>
- Health insurance can come from a “woman’s employer or husband’s employer.”<sup>154</sup>

- Domestic life may include “the wife balancing the budget because she is good at math and her husband is not,” and “the husband and wife take turns cooking the meals because they both work.”

## Implications of Heterosexual Bias for LGBTQ Students and Safer Sex

Although both the state guidance document and the national standards articulate learning goals about sexual identity and the spectrum of human sexual orientation, including gender identity and expression, few districts actively depict or discuss same-sex relationships.

One consequence of school districts’ near-universal failure to portray same-sex teenage or adult relationships is that LGBTQ students could mistakenly believe that the instruction they have received does not apply to them. This is particularly risky when it comes to lessons about safer sex. Studies of lesbian, gay and bisexual (LGB) students have shown that they are at greater risk than their heterosexual peers of engaging in high-risk sexual behaviors such as unprotected sex, as well as using substances to cope with stress, suffering from depression or emotional distress, experiencing physical and sexual assault, and attempting suicide.<sup>155</sup> In at least one study, LGB students reported earlier age of first intercourse, more sexual partners, and increased likelihood to use alcohol or drugs before sex—but no greater or lesser condom use—than their heterosexual peers.<sup>156</sup> According to the National HIV Behavioral Surveillance System, 43 percent of men aged 18 to 24 who have sex with men had unprotected anal sex with a casual partner in the last year.<sup>157</sup> Young women who have sex with women experience STIs at similar rates to all women. However, they are less likely to use protection during heterosexual intercourse and they experience *higher* rates of unintended pregnancy than their heterosexual peers.<sup>158</sup> Yet safer-sex exercises in health class are almost exclusively geared to heterosexual relationships.

Few studies compare health outcomes for straight, gay and bisexual students who had received inclusive HIV prevention education and those who had not. But one such study in Massachusetts found that LGB students who had *not* received inclusive education were more likely to report becoming or getting someone pregnant and having more sexual partners, and were found to be at greater risk for HIV infections, pregnancy and suicide as well as bullying, injury or threats of injury at school.<sup>159</sup> Lesbian, gay and bisexual students who *did* get an inclusive HIV education reported less sexual risk behaviors.<sup>160</sup> Inclusive sex education is not only consistent with state and national standards, and important for all students’ well-being, it is a public health necessity.

Our analysis shows that classroom instruction about sex typically depends on two key premises: a boy and a girl are involved, and the activity involves a penis and a vagina. These premises exclude many LGBTQ students before the conversation even begins. Two “Sex Jeopardy” game questions used in one school district are illustrative: “When a woman has sex, the man’s penis enters what?” and “What erect male body part enters a female?”<sup>161</sup> This description of sex is consistent: “sexual intercourse occurs when the man’s penis enters the woman’s vagina.”<sup>162</sup> Penis-in-vagina bias also stems from the fact that, to the extent the “mechanics” of sex are taught at all, their singular



purpose is to explain biological, heterosexual reproduction. Moreover, nearly all safer-sex role-play exercises, such as refusal skills and condom negotiation, involved boy-girl pairings.

The twin assumption that the sex concerns reproduction and only involves boys and girls also surfaces in the definitions students are taught about their own bodies and human anatomy. For example:

- A penis is a “male reproductive organ that removes urine from the male’s body and that can deliver sperm to the female reproductive system;”<sup>163</sup> the vagina is “the organ that receives sperm during reproduction.”<sup>164</sup>
- A vagina is where the “penis fits”<sup>165</sup> and “the organ into which the penis is inserted.”<sup>166</sup> It is a “sperm deposit”<sup>167</sup> and “where the male’s penis is inserted during intercourse.”<sup>168</sup>

Moreover, STI prevention lessons often use the terms “sex” and “sexual contact,” without a specific explanation of what those terms mean. If the only sexual acts students learn about are those that result in procreation—in other words, penis-in-vagina sex—students likely have only that in mind when they hear or read the terms “sex” or “sexual contact.” Other forms of sex students of all sexual orientations are likely to explore or consider—namely, oral and anal sex—are far less frequently acknowledged, discussed or described in classroom materials. Oral sex is entirely ignored in 32 districts (39 percent), not mentioned even as part of STI prevention lessons. The same is true of anal sex. Over a third of school districts (29, or 35 percent) did not acknowledge anal sex at all.

When they are acknowledged, oral and anal sex are mentioned peripherally, in statements about STI transmission through “vaginal, oral, or anal sex,” without further elaboration. What the terms “oral sex” and “anal sex” mean are then left largely to students’ imaginations. Of districts that mention oral sex, only 9 percent (seven) explained the distinction between fellatio and cunnilingus; the rest simply used the phrase “oral sex.” Some districts mentioned oral sex only when discussing male condom use, implying that oral sex is performed on men alone.

Moreover, oral and anal sex were almost invariably described in negative lights. Anal sex was almost always mentioned in the context of transmitting disease and described as a “high-risk” or “risky” behavior.” Eighty-one percent (43) of the 53 districts that mentioned anal sex did so only when describing STI transmission. Some schools mentioned anal sex only as a type of sex students should avoid or in descriptions of sexual assault and child abuse. Similarly, 84 percent (42) of the 50 districts that mentioned oral sex did it only to describe STI transmission risk. Some districts, moreover, mentioned oral and anal sex only in the context of the crime of sodomy, implying criminality and coercion. For example, one district’s materials said: “Forced Anal or Oral Sex is called Sodomy, also referred to as a Sexual Assault.”<sup>169</sup> In another district, sodomy was defined as “forced sexual contact other than intercourse.”<sup>170</sup>

## Talking to Trusted Adults, Accessing Local Resources

Few school districts instructed students to talk with trusted adults about sexual orientation issues, which should be considered a first-line sex-ed resource. Only 4 percent addressed the subject and provided students with strategies for how to seek advice from parents and trusted adults. Among the districts surveyed, 96 percent (79) do not mention speaking to one's parents about sexual orientation at all.

Only 6 percent of districts (five) provided students with any information about national or local resources, service providers or LGBT organizations to help students grapple with sexual orientation or gender identity-related issues.

### **Gender, Gender Identity and Gender Non-Conformity**

Both the state guidance document and the national standards say high school students should learn about gender stereotypes and how stereotypes about gender roles can be limiting for men and women. The national standards add that middle and high school students should learn about gender identity; gender expression; transgender people, sex stereotypes and gender non-conformity; and that biological sex, gender identity, gender expression and sexual orientation differ.

#### **Important Terminology**

**Sex:** The physical characteristics of one's body, including genitalia, hormone levels and sex chromosomes. At birth, people are assigned a legal sex.

**Gender:** Socially determined characteristics, roles, behaviors and attributes a society expects from and considers appropriate for men and women; these characteristics are often referred to as "feminine" and "masculine."

**Gender identity:** A person's own internal sense of their gender and the gender they see themselves as, which may or may not correspond to the sex they were assigned at birth. One's gender identity can include refusing to label oneself with a binary gender.

**Gender expression:** The way a person expresses their gender identity. A person's external characteristics and behaviors – such as dress, grooming, mannerisms, speech patterns and social interactions that are socially identified with a particular gender.

**Transgender:** An umbrella terms for people whose gender identity or gender expression—their psychological sense of their gender – differs from, and does not (or is perceived to not) match societal norms and expectations of the sex they were assigned at birth.

**Gender non-conforming:** Displaying gender traits that are not "typically" associated with one's legal sex assigned at birth.

**Sex stereotypes:** Societal norms about how women and men "should" act, feel, look and behave.

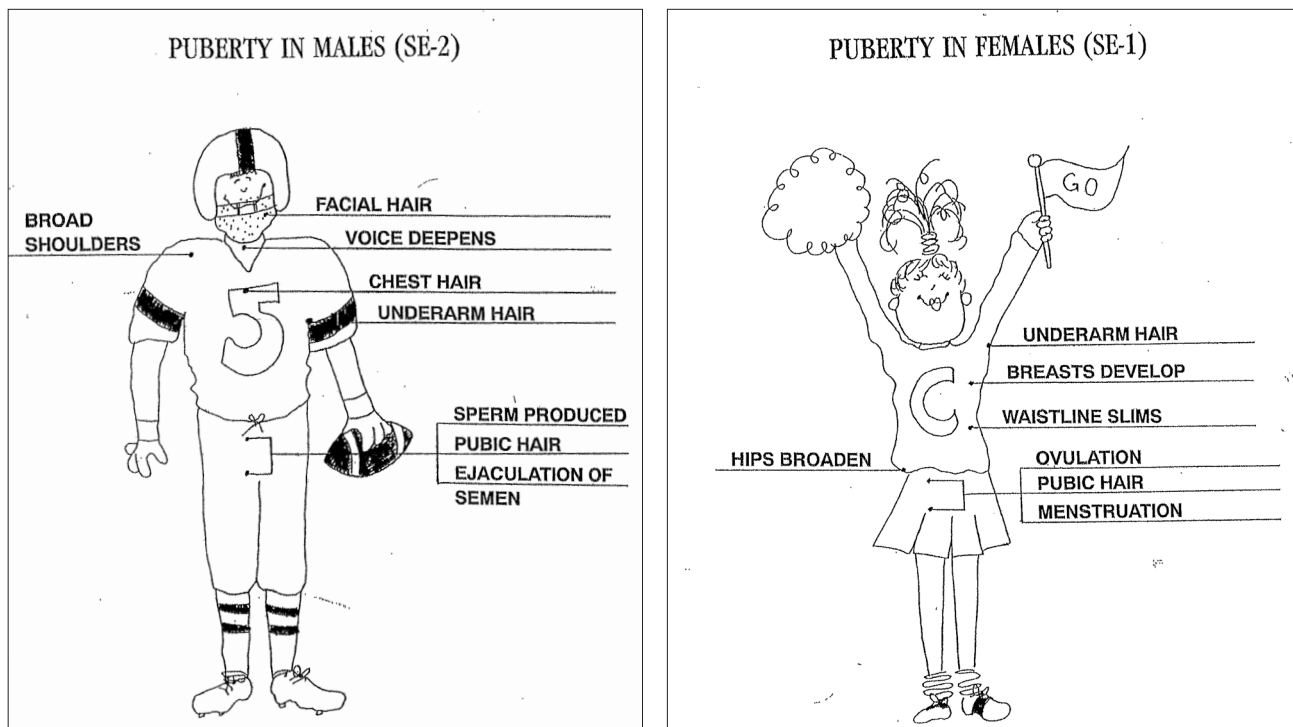
## Gender Identity and Transgender People

Our analysis showed that 83 percent of districts (68) did not teach students about gender identity or transgender people. Only 17 percent (14) discussed gender identity or how gender identity may not match biological sex designated at birth. Two districts offered out-dated and inaccurate instruction, focusing only on “transvestites” or “transsexuals,”<sup>171</sup>—older terms no longer commonly in use that refer to people who cross-dress or who have undergone treatment to alter the physical sex of their bodies.<sup>172</sup> One district cast transgender people in a negative light, mentioning “transsexuals” only in an activity sheet entitled “Taboo Definitions.”<sup>173</sup> Among all the school districts sampled, only one addressed talking to parents about gender identity and provided tips for students.

ThinkB4YouSpeak, a curriculum designed by GLSEN, and Family Life and Sexual Health (F.L.A.S.H.), designed by the Seattle and Kings County Health Department in Washington state, appear to be the only commercially available texts in use in the sampled districts that address gender identity and transgender people. None of the textbooks commonly used by the districts we sampled address these subjects. Teachers in the minority of schools that addressed gender identity in class cobbled together lessons from websites, magazine articles, movies and guest speakers, or created materials themselves.

## Gender Stereotypes, Gender Non-Conformity and Gender Roles

Only 44 percent of districts (36) taught students about sex and gender role stereotypes or provided lessons aimed at recognizing and debunking them. Only 28 percent of districts (23) specifically explained or provided concrete examples of gender non-conformity or stereotypes of how boys and



A worksheet on puberty in use in 12 districts that reinforces harmful gender stereotypes.

## **LGBTQ-Inclusive Sex Ed to Combat School Bullying and Harassment**

LGBTQ youth often face harassment and discrimination in school. According to a 2009 nationwide survey:

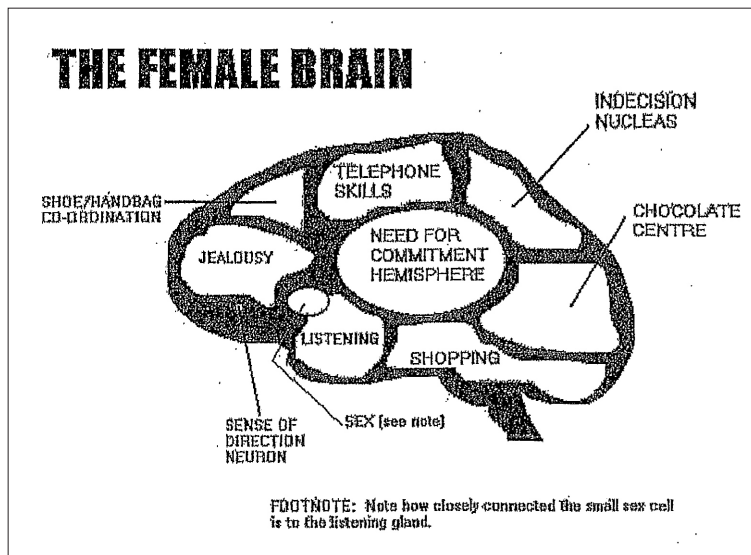
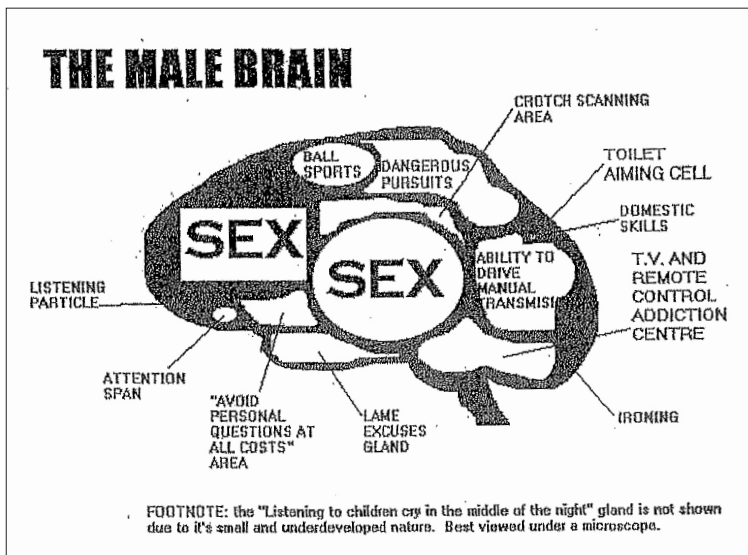
- 90 percent of LGBTQ students had been verbally harassed because of their sexual orientation.
- Most had heard homophobic remarks such as “faggot” and “dyke” from other students (70 percent) and school staff (60 percent).
- 60 percent felt unsafe at school.
- 47 percent had been victims of physical harassment by their peers.
- 20 percent had been physically assaulted.<sup>174</sup>

Transgender and gender non-conforming youth often face particularly serious difficulties at school, a 2011 study documented. Most (78 percent) experienced school harassment; 35 percent experienced physical assault and 12 percent experienced sexual violence.<sup>175</sup> More than half (51 percent) of students who had been harassed attempted suicide.<sup>176</sup>

Acknowledging and providing respectful instruction in health class about sexual orientation, same-sex relationships, gender identity and transgender people would help to ameliorate harmful bias and teach students to respect their LGBTQ peers. Indeed, the Dignity for All Students Act<sup>177</sup> recognizes that LGBTQ-inclusive curricula are key to solving school bullying and harassment issues. The Dignity Act, which took effect on July 1, 2012, focuses on prevention, education and improving school climate. Though the Dignity Act protects all students from harassment, it is explicit in its prohibition of bullying or harassment based on a student’s sex, sexual orientation, and gender identity or gender expression.

Under the Dignity Act, schools must now take affirmative steps to prevent peer-on-peer and staff-on-student discrimination, harassment and bullying, and to promote a culture of acceptance. One requirement of the Dignity Act is that all schools, elementary through secondary, adopt curricula on diversity and sensitivity and lessons on civility and citizenship. Specifically, the law requires schools to provide instruction in “tolerance,” “respect for others” and “dignity,” broadly integrated across subject areas.<sup>178</sup> Lessons must address awareness of and sensitivity to discrimination and harassment based on one’s sexual orientation and gender, including gender identity and gender expression.<sup>179</sup> Sexual health education classes are a perfect setting for deconstructing stereotypes and teaching students about different sexual orientations in a manner that promotes acceptance, which will reduce incidents of bullying in schools.

Incorporating lessons about sexual orientation and gender identity into health classes will enhance the lives of LGBTQ students and comport with state and national health standards. It will also bring school districts into necessary compliance with the Dignity for All Students Act.




This worksheet presents harmful stereotypes about “male” and “female” brains, teaching that stereotypical behavior is based in biology.

girls “should” look or act. Only 18 percent of districts (15) taught students about the difference between biological sex and the psychosocial concept of gender.

Nearly a quarter of districts (20, or 24 percent) used materials that directly *reinforced* gender stereotypes. Some were subtle. For example, a dozen districts used worksheets about puberty produced by the Center for Applied Research that featured a large image of a girl cheerleader and a boy football player. Other districts used material that perpetuates gender stereotypes in the context of sexual assault, dating abuse and teen parenting.

Other materials overtly perpetuate gender stereotypes. Among some of the most egregious examples:

- A lesson about “adolescent brains” that portrays what men and women think about and the different amounts of space in the male and female brain for skills and interests like sex, shopping, sports and parenting.<sup>180</sup>
- A handout portraying women as “hazardous material,” that describes the “properties” of the female “element.”<sup>181</sup>
- A curriculum that explains: “Sexually speaking ... men are like microwaves and women are like crock pots [because] men get stimulated more easily than women and women take longer to get stimulated. Men are visual responders and women respond when they feel connected and close to someone.”<sup>182</sup>
- Handouts explaining that men “want to conquer & dominate” whereas women try “to manipulate and control;” men see “women as a trophy” whereas women see men as

	
<b>ELEMENT:</b>	Woman
<b>SYMBOL:</b>	○+
<b>DISCOVERER:</b>	Adam
<b>ATOMIC MASS:</b>	Accepted as 55kg, but known to vary from 45kg to 225kg
<b><u>PHYSICAL PROPERTIES</u></b>	
1. Body surface normally covered with film of powder and paint	
2. Boils at absolutely nothing – freezes for no apparent reason	
<b><u>CHEMICAL PROPERTIES</u></b>	
1. Reacts well to gold, platinum and all precious stones	
2. Explodes spontaneously without reason or warning	
3. The most powerful money reducing agent known to man	
<b><u>COMMON USE</u></b>	
1. Highly ornamental, especially in sports cars	
2. Can greatly aid relaxation	
3. Can be a very effective cleaning agent	
<b><u>HAZARDS</u></b>	
1. Turns green when placed alongside a superior specimen	
2. Possession of more than one is possible but specimens must never make eye contact	

This handout presents women as unstable chemical elements for men to “possess” and use for “relaxation” and “cleaning.” Because no health-education standard prohibits bias in instruction, materials like these are effectively permitted in New York State classrooms.

“security and protector[s];” and that boys and girls “have totally opposing goals when it comes to sexual behavior ... Teenage boys want sex, teenage girls want love. They may be able to handle the mechanics of sex, but they are certainly not equipped to handle the very strong emotions that accompany a sexual relationship.”<sup>183</sup>

- A handout stating: “Most teenage girls believe that sex equals love; other teens—especially boys—believe that sex is not the ultimate expression of the ultimate commitment, but a casual activity and minimize risks or serious consequences.”<sup>184</sup>
- A textbook lesson on unhealthy relationships, where boys are cast as the “Controller” and the “Distancer,” and girls are cast as the “Enabler” and the “Clinger.”<sup>185</sup>
- A “gender roles” activity that divides a class by sex and tasks each group to describe the “ideal male/female,” including “how they should carry themselves, act, talk, walk, sit, etc.”<sup>186</sup>
- A communication lesson, stating: “Stereotypes and sex roles creep into the way we communicate with others. Men are conditioned to speak or act aggressively and women are conditioned to speak and respond passively.”<sup>187</sup>

- An article stating: “Girls are thinking about nesting, looking for long term relationships. But boys are looking for mating, physical release, and then going on to something else.”<sup>188</sup>

In a small number of districts, entire lessons about boy-girl differences are based entirely on unfounded stereotypes. For example, one district’s materials included: A “math” problem in which the “solution” is “Woman=Problem;”<sup>189</sup> a “men are from Mars, women are from Venus” exercise that exploits gender stereotypes;<sup>190</sup> and a visual portrayal of “Romance Mathematics” that states what happens when different types of men and women, smart and dumb, get together. For example, *dumb man + smart woman = marriage.*<sup>191</sup>

## Healthy and Unhealthy Relationships

Both the state guidance document and national standards provide that students in middle and high school should learn how to build and maintain healthy relationships with family, friends, and romantic and sexual partners. Students should also learn how to communicate personal boundaries, deal with anger and conflict resolution in healthy ways, and recognize and address unhealthy relationships and behaviors.

The vast majority of school districts provided students with lessons about healthy and unhealthy relationships. Only 12 school districts (15 percent) did not.

## Teaching About Rape, Sexual Assault and Dating Violence

However, instruction about specific types of unhealthy relationships and behaviors are not adequately covered in many districts. According to the state guidance document, students in middle and high school should learn about violence prevention, including rape and sexual assault, as well as relationship abuse and dating violence. The national standards specify that students should learn what constitutes sexual abuse, sexual assault, incest and rape; giving and understanding consent; sexual violence and dating abuse; how to access local resources; and that a person who has been victimized is not at fault. Students should also learn that rape, sexual assault and intimate partner violence affects both men and women.

A significant minority of school districts (23, or 28 percent) did not teach about rape or sexual assault. Slightly fewer districts (19, or 23 percent) did not teach about dating or intimate partner violence and abuse.

In some districts, rape and sexual assault were mentioned indirectly during lessons on other topics. A few used rape as a fear tactic—arguing that abstaining from sex ensures they will never be accused of or prosecuted for date rape or statutory rape. For example, one textbook in use by at least 10 school districts states that abstaining from sex “avoid[s]...situations in which you can be prosecuted for having sex with a minor,” and “avoid[s] sexual behavior for which you can be prosecuted for date rape.”<sup>192</sup>

At least a quarter of the districts accurately teach that boys and girls, straight or gay, can be victims or perpetrators of sexual violence and dating abuse. However, many districts teach students about sexual violence in a gender-bound context, insinuating that only girls can be victimized and that only boys are perpetrators or abusers, or that dating abuse affects only opposite-sex couples. For example:

- Sexual-assault lessons taught only to girl students.<sup>193</sup>
- Rape and sexual assault defined as coerced “vaginal penetration,” excluding boys as potential victims.<sup>194</sup>
- Materials used in many districts that always use female gender pronouns when referencing victims and male gender pronouns when referencing aggressors.
- Materials that reinforce the idea that boys often can’t control themselves and that girls who wear skimpy clothes are sending a “message.”<sup>195</sup>
- Materials that explain only to girls how to avoid rape and explain only to boys how to prevent their behavior from becoming rape.<sup>196</sup>

An overwhelming majority of districts (61, or 75 percent) did not provide information about local resources to help students deal with rape, sexual assault and dating/intimate partner violence.

## Sexual Harassment

The state guidance document says that by the end of high school, students should learn about sexual harassment and understand their school’s sexual harassment policy. They should know that sexual harassment is illegal, interferes with an individual’s work or school performance, and creates an intimidating, hostile or offensive environment. The national standards go further: Middle school students also should learn about sexual harassment, and high school students should be able to access accurate information and resources for sexual harassment and identify ways to respond if someone is being harassed.

Our analysis showed that 42 percent of school districts (34) did not provide any instruction about sexual harassment or the school’s sexual harassment policy in health class.

## Bullying

Both the state guidance document and the national standards state that students should learn about bullying, its negative effects and why it is wrong. Both sets of standards say that students should learn how to promote dignity, respect and empathy for others in and beyond the school community; the elements of respectful communication; and that potential consequences of bullying and intolerance include suicide or violence. The national standards add that students should learn



how to respond and help someone who is being bullied or harassed.

Although a minority of districts used well-regarded bullying lessons in health class, nearly two-thirds (52, or 63 percent) did not teach students about bullying. Districts can and should address bullying outside health class; whether they actually do is beyond the scope of this analysis. Our study, which evaluated sex education in health class, showed that most districts did not provide anti-bullying instruction in health class, as the state guidance document and national standards say they should.

In our sample, 35 percent of districts (29) taught anti-bullying lessons in health class, but three addressed only bullying of LGBTQ students, and one addressed only cyber-bullying.

### Internet Safety

Students should learn how to use the Internet safely, according to the state guidance document, including learning strategies for safe, legal and respectful use of social media. The national standards recommend that students also learn how to effectively use technologies such as email, texting and social media in a relationship.

About one-quarter of school districts (19, or 23 percent) taught lessons in health class about Internet safety, including responsible use of technology in relationships, cyber-stalking and cyber-harassment, texting and “sexting,” and potential miscommunications via email and text. More than three-quarters of the school districts (62, or 77 percent) provided no instruction to students on Internet safety; the impact of new technologies on family, friends and intimate relationships; or how technologies can become tools for potential abuse.

## VI. Information and Resources

### Access to Local Resources and Services

Both state and national guidelines recognize the vital importance of not only teaching students health information but ensuring they can access health information, services and resources as may become necessary in their lives. Students should know how to identify and access *local* STI and HIV testing and treatment services, contraceptive services, general reproductive health services, and support for relationship abuse and violence, according to the state guidance document. Additionally, the national standards say that students should learn how to identify and access resources for survivors of sexual abuse, incest, rape, sexual harassment, sexual assault, dating violence and abuse.

Nearly half of districts sampled (40, or 49 percent), however, did not provide students with any information about specific *local* resources for advice, care or services related to HIV or STI testing and treatment; pregnancy and HIV/prevention; relationship abuse and violence; teen parenting; sexual orientation or mental health issues. Of these 40 school districts, 16 provided information about national organizations, hotlines or websites, but provided no information about local resources.

Of the 51 percent of districts that gave students information about specific local resources, information most often concerned HIV and STI-related testing and treatment. Among all of the districts in our sample, 28 (34 percent) informed students about HIV-specific local resources, and 24 (29 percent) provided information about organizations that could help them with other STI issues.

Only 21 districts (26 percent) gave students information about condom and contraceptive access in their local communities or explained that local clinics, such as Planned Parenthood, provide those items for free or at a reduced cost. Of these 21 districts, six used exercises from a research-validated curriculum called *Reducing the Risk*, which requires students to visit a local reproductive health clinic and a local drugstore to learn where condoms are located and the steps required to purchase them.

Again, only 25 percent of all school districts (21) gave students information about local resources regarding rape, sexual assault and dating/intimate partner violence. A handful of districts (five, or 6 percent) provided information about local LGBTQ organizations or service providers. Fewer still (three, or 4 percent) provided information about local resources for teen parents.

Finally, 6 percent (five districts) provided students with information about local crisis pregnancy centers. Crisis pregnancy centers are “faux” clinics run by anti-abortion organizations that advertise and provide services to pregnant women and that seek to persuade women against having an abortion or using contraception. Crisis pregnancy centers often use tactics that confuse women and girls into thinking they are licensed, regulated health care clinics, but they are not licensed facilities and typically do not have licensed health care providers on staff. In one district, the only

local resource students learned about was the community’s crisis pregnancy center. Indeed, it appears that at least three school districts had representatives from local crisis pregnancy centers present as guest speakers during health class.

### Talking with Trusted Adults

Both state and national guidelines recognize the importance of teaching students about talking with parents and other trusted adults about health, identity and relationship issues and problems, including pregnancy, STI/HIV and sexual health issues; violence, bullying or relationship abuse; depression, anger or anxiety; and sexual orientation and gender identity.

Despite this clear guidance, most districts we analyzed did not explicitly address communication with trusted adults about sex and relationship issues. Only 43 percent of the districts (35) explicitly encouraged students to talk with parents or other trusted adults.

Even among districts that addressed communication with trusted adults, less than half (20, or 47 percent) provided concrete advice or tips for conversations about these difficult topics.

### Students’ Rights to Confidential Reproductive and Sexual Health Care

New York’s guidance document says that, by the end of high school, students should learn that New York law allows them to access confidential testing, medical care and services for HIV/STIs, as well as testing, medical care and services for pregnancy and pregnancy prevention. The national standards also state that students should learn about the laws related to reproductive and sexual health care services, including contraception, pregnancy options, safe surrender policies, prenatal care, and STI testing and treatment.

In New York, teens who are capable of giving “informed consent”<sup>197</sup> have the right to obtain a wide array of confidential reproductive and sexual health care services without parental consent, including contraceptives (and emergency contraception), condoms, pregnancy testing, prenatal care, abortion care, HIV testing, and STI testing and treatment.<sup>198</sup>

When a teen consents to his or her own to reproductive and sexual health care, all information related to that care must be kept confidential; health care providers may not share it without the teen patient’s permission, with some limited exceptions.<sup>199</sup>

Teaching teens about their confidentiality rights is crucial to encouraging students to access local resources because many teens will delay or forgo reproductive or sexual health care altogether if they think their parents will find out.<sup>200</sup>

Despite the law providing teens with confidential care rights and clear state and national guidelines, only 7 percent of districts (six) informed students about their full, legal right to access reproductive sexual and health care confidentially. The majority of school districts (52, or 63 percent) did not

inform students about their legal right and ability to obtain *any* type of confidential reproductive or sexual health care.

Of schools that mentioned students' legal right to confidential reproductive and sexual health care, most did not provide instruction about the full scope of services that students may access without parental consent. Of 27 school districts that mentioned confidentiality, 11 addressed only students' right to confidential HIV testing. Only nine districts instruct students that they can obtain confidential testing for all types of STIs, and only two informed students about confidential HIV testing and rape crisis counseling.

### **Teaching Students About Confidentiality Rights is Vital**

When teens have access to confidential reproductive and sexual health care such as contraceptives and condoms, the rates of unwanted pregnancy and STI infection decline.<sup>201</sup>

Many teens choose to involve their parents in reproductive health care decisions.<sup>202</sup> However, for good reason, some choose not to discuss these issues with their parents or guardians. Often this is because teens fear negative consequences such as physical abuse, emotional abuse and a loss of housing.<sup>203</sup>

While it is important to encourage teens to involve their parents and other trusted adults in their health care decisions, requiring parental consent can have many adverse consequences. Teens who do not wish to involve a parent will often delay or forgo reproductive health care if parental consent or notification is required.<sup>204</sup>

But parental consent or notification requirements for reproductive and sexual health care do not deter teens from having sex. In a 2002 study, nearly half of all sexually active teens visiting family planning clinics reported that they would stop using services if their parents were notified that they were seeking birth control.<sup>205</sup> Another 11 percent reported that they would delay testing or treatment for STIs including HIV.<sup>206</sup> But virtually all (99 percent) reported that they would continue having sex.<sup>207</sup> For this reason, New York has made a sound policy and public health decision to allow teens to seek confidential reproductive health care.

For more information, visit <http://www.nyclu.org/files/thl.pdf>.



## VII. Recommendations

All students attending public schools in New York State should receive comprehensive, medically accurate, unbiased and age-appropriate sex education. New York can ensure that every young person has the foundation, skills and knowledge for a healthy future by setting universal, binding and mandatory standards for comprehensive sex education in the public schools.

### Steps for New York State Education Department and Board of Regents

The New York State Education Department (NYSED) should require schools to teach comprehensive sex education as part of their health curriculum or set binding rules that outline the standards and components that voluntary sex-education programs in the state's public schools must meet. This can be accomplished through various existing mechanisms:

#### *Amend the Commissioner's Regulations to Require Sex Education and Set Basic Standards*

The current Commissioner's Regulations could easily be amended to explicitly address comprehensive sex education. One of the four existing regulations should be amended to require comprehensive sexuality and sexual health education as part of state-mandated health instruction.<sup>208</sup> This would make schools' obligation to teach some comprehensive sex education binding and clear.

The amendment could take a range of forms. For example, NYSED could broaden the definition of required health instruction to include instruction in sexuality and sexual health—or building on the HIV/AIDS instruction model, NYSED could create an independent requirement. Either way, the requirement should state that schools must provide instruction in “sexuality and sexual health that is age-appropriate, medically accurate, comprehensive, and inclusive and respectful of all students regardless of race, ethnicity, gender, disability, sexual orientation or gender identity.” Each of these terms could then be defined:

- by referencing the skills and functional knowledge laid out in the state guidance document (setting the guidance document as the official, binding floor);
- by referencing the skills and functional knowledge laid out in the national sexuality education standards (setting the national standards as the official, binding floor); or
- by listing specific, substantive requirements in the regulation or in a guidance document, ideally crafted by NYSED and a task force of experts and advocates.

A strong enforcement strategy will be critical to the move toward comprehensive sex education. In order to provide the information and resources schools need to put policy into action, the state should engage key stakeholders in designing the implementation process (i.e. superintendents, teachers, the New York State School Health Education Leadership Institute, the New York State Department of Health, sex education advocates and reproductive health professionals). NYSED's process through which it developed the 2005 guidance document is a strong model. Strong monitoring, reporting and evaluation mechanisms are also imperative.

Funding is also key. The state should consider existing funding sources such as CDC Division of Adolescent and School Health (DASH) grants or federal Personal Responsibility Education Program (PREP) funding, which was awarded under the new Teen Pregnancy Prevention Initiative to fund teacher training, monitoring and curriculum evaluation.

#### *Amend the Commissioners' Regulations to Set Minimum Standards for Voluntary Sex Education*

Should NYSED elect to stop short of *requiring* comprehensive sex-education instruction, it could amend the relevant health education regulations to establish minimum substantive criteria for voluntary sex education. As articulated above, NYSED should make clear that all sex education taught in New York schools must comport with the state guidance document, the national sexuality education standards, or a set of standards crafted by NYSED alone or in conjunction with a task force of experts and stakeholders.

#### *Amend the Health Learning Standards to Address all Relevant Topics Necessary to Teach Effective Sexual and Relationship Health*

The New York State learning standards, which govern instruction in all subjects, could be amended to include meaningful criteria for comprehensive sexuality and sexual health instruction.

#### *Recommend Comprehensive, Research-Proven and Effective Sexual Health Curricula*

School districts should be permitted to choose curricula and instruction materials that meet NYSED criteria, including curricula recommended by NYSED, as is the practice in many states. NYSED could periodically evaluate curricula changes with key education and community stakeholders or updates as the field evolves. As a starting point, evaluations of sex-education curriculum conducted in other states by state departments of education or health as well as external studies and curricula reviews can inform NYSED's process.<sup>209</sup>

#### *Recommend Improving Sex Education as a Part of the Dignity for All Students Act*

NYSED could formally recommend that districts incorporate lessons about bullying, harassment, tolerance, gender stereotyping, gender violence, sexual orientation, and gender identity and expression into health classes in response to the Dignity Act's new curriculum requirements. School leaders should consider how inclusive and comprehensive sexuality and sexual health instruction

might satisfy some of their Dignity Act requirements, including trainings and professional development to encourage a more inclusive and comprehensive approach to sexuality and sexual health instruction.

### Steps for the State Legislature

The State Legislature should improve sex education in New York by passing legislation mandating that New York's public schools teach all students medically accurate, age-appropriate, comprehensive and unbiased sex education.

The Legislature could also pass legislation that requires voluntary sex education to meet certain minimum content requirements.

Finally, the Legislature could pass legislation providing funding to school districts that teach comprehensive sex education or to NYSED to improve its capacity to help districts offer effective, comprehensive sex-education programs.

### Steps for Local School Districts

If you are a school board member, superintendent or district employee, you have important influence when it comes to sex education in your district. Consider taking some of the following actions:

- **Institute comprehensive sex education.** Consider enacting a policy at the local level that requires instruction in comprehensive sex ed, using the national standards as a benchmark.
- **Evaluate curricula and textbooks.** Make sure the materials in use in your district are up-to-date, accurate, comprehensive and inclusive of all students. Help educators select quality materials for their classes.
- **Follow the Dignity for All Students Act.** New York's anti-harassment and discrimination law took effect in July 2012. Ensure that sex-ed lessons don't undermine the goals of the law by teaching stereotypes and bias.

### Steps for Teachers

Few adults have greater impact on children than classroom teachers. Here are some steps to ensure your health classes include comprehensive, medically accurate sex education:

- **Review all materials.** Seek input from local experts, such as reproductive health care providers and LGBTQ advocacy groups, to be sure classroom materials are



accurate, accessible and inclusive. Reach out to peers in the science and physical education departments to align sex-ed instruction. Emphasize respect, dignity and inclusiveness among students to make your classroom a safe space for students with questions about sexuality, gender and sexual expression. Check out the Safe Space materials from GLSEN as a start (<http://safespace.glsen.org/>).

- **Include all students and families.** Make sure your lessons don't denigrate teen parents or their children, LGBTQ students, students in non-traditional households or students whose parent(s) may identify as LGBTQ.
- **Research textbooks.** Government agencies and non-profit organizations have reviewed sex-education materials and published information on their completeness and accuracy. Check out the Sexuality Information and Education Council of the United States (SIECUS) for a start.
- **Supplement textbooks.** Because textbooks are written for a wide audience—including states with abstinence-only decrees—they can be limited in scope and contain religious overtones. Consider supplementing textbooks with quality commercial curricula, materials from local reproductive health care providers and qualified guest speakers. Keep in mind that information enshrined in a textbook may seem more credible in students' minds; think about how you can present other information in a way that makes it stand out.

## Steps for Parents

- **Go over your child's health and sex ed lessons.** You don't have to be a scientist to spot factual gaps and inaccuracies. Look for information that seems outdated. (For example, materials that say only gay men get HIV, or that only portray heterosexual marriage.) Chances are that if a book or worksheet has some facts that seem wildly incorrect or outdated, it contains others that aren't as obvious.
- **Speak up.** Let your child's teachers and principals know if you think they are teaching bad information. Going over lessons also gives you a chance to discuss what your child learns at a school—and an opportunity to talk openly about sex, health, relationships and identity issues.
- **Talk to your child's health teachers.** Ask how they answer student questions about STIs, pregnancy, condoms and abortion. If guest speakers visit, find out who they are and the organizations they represent. Crisis pregnancy centers, for example, are not medically-licensed institutions and their employees may not be qualified to provide medical advice.
- **Talk to your school board.** If your district limits teachers' ability to discuss condoms or contraceptives, consider writing a letter or speaking at a school board meeting. There's power in numbers: Team up with other concerned parents to make sure your voice is heard. If sex ed has become an important topic in your area, consider writing

a letter to the editor of your local newspaper explaining that comprehensive sex ed results in better outcomes for young people.

- **Contact your elected representatives.** Write, email or call legislators in Albany and Washington in support of medically accurate and responsible sex education.

## Steps for Students

If you are a public school student and you are unhappy with your sex-education options, don't stay silent! Your voice, and the voices of your friends, are vital to this conversation. Here's how you can take a stand:

- **Ask questions.** Don't be afraid to seek information from a trusted adult or health care provider, especially if your sex-ed class left you with questions. Medical providers, including your school nurse, are bound by confidentiality. They can't tell anyone about your conversations. (The only exception is if they suspect, or you reveal, that you have been a victim of abuse.)
- **Start a Gay-Straight Alliance.** You have the right to start a club at school. Find a teacher who supports you and start a Gay-Straight Alliance. Schools with GSAs are safer, more inclusive places for LGBTQ students, which can lead to more affirming, inclusive sex education. If your principal stops you from starting your own GSA, contact your local NYCLU chapter. (Learn more at [www.nyclu.org](http://www.nyclu.org).)
- **Start a peer education program.** Peer education is sex education for teens by teens and has been demonstrated to lead to better health outcomes for young people, who are often more comfortable asking questions and seeking information from other young people. The Gay-Straight Alliance Network can help you get started (<http://www.gsanetwork.org>).
- **Talk to your school board.** If your school is bound by restrictions on the type of sex ed and health information it can provide, consider writing a letter to your superintendent or school board, or speaking at a school board meeting. Form a group with other students to make sure everyone's voice is heard. Find teachers, parents and other adult allies to help you communicate your message. It's your future: Your voices matter.



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- 199 N.Y. Pub. Health Law § 18(6) (requiring written authorization to release patient records to third parties); N.Y. Pub. Health Law § 17 (forbidding the release of medical records pertaining to a minor’s abortion or STI treatment to the minor’s

parents); N.Y. Pub. Health Law § 18(2)(c) (allowing parents or guardians access to a minors' medical records only for care to which the parent or guardian consented or in cases of emergency; stating a health care provider must not reveal the information to a patient's parents if he or she determines that disclosure would be detrimental to the provider's relationship with the minor, or to the minor's relationship with his or her parents); N.Y. Pub. Health Law § 18(3)(c) (a patient over the age of twelve years may be notified of any request by a qualified person to review his/her patient information, and, if the subject objects to disclosure, the provider may deny the request).

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208 This could be accomplished by amending 8 N.Y.C.R.R. § 135.3 (providing for health education in elementary and secondary schools) to require comprehensive sexuality and sexual health education as part of the required health instruction, 8 N.Y.C.R.R. § 135.2 (providing that all schools are responsible for teaching health), or 8 N.Y.C.R.R. § 100.3, 8 N.Y.C.R.R. § 100.4, or 8 N.Y.C.R.R. § 100.5(a) (requiring health instruction at each schooling level as well as student attainment of the health and parenting learning standards).

209 See, e.g., Kirby, *Emerging Answers*, *supra* note xviii, at X (reviewing the existing universe of reliable studies of both abstinence-only and comprehensive sex ed programs in school, community, and clinic settings); Wash. Off. Superintendent Pub. Instruction, *Sexual Health Education Curriculum Review: 2009 Report*, available at <http://www.k12.wa.us/CurriculumInstruct/pubdocs/PublishersNotices/2009SexualHealthEdCurricReviewReport.pdf> (reviewing an assortment of sex education curricula for compliance with both the state's Healthy Youth Act, 20 regulatory requirements concerning specific sex education content and attributes, the national HECAT model); Wash. Off. Superintendent for Pub. Instruction, *Sexual Health Education Curriculum Review: 2011 Report*, available at <http://www.k12.wa.us/HIVSexualhealth/pubdocs/2011SexualHealthEducationCurriculumReviewReport.pdf> (reviewing an assortment of sex education curricula for compliance with both the state's Healthy Youth Act, 20 regulatory requirements concerning specific sex education content and attributes, the national HECAT model); Advocates for Youth, *Science and Success: Sex Education and Other Programs that Work to Prevent Teen Pregnancy, HIV & Sexually Transmitted Infections* (2d. ed. 2008), available at <http://www.advocatesforyouth.org/storage/advfy/documents/sciencesuccess.pdf> (recommending some school-based programs that met rigorous criteria in reliable studies and demonstrated concrete positive behavior changes in teens); Cal. Healthy Kids Resource Cent., *Sexual Health Evaluations*, <http://www.californiahealthykids.org/sexualhealthevaluations.html> (last visited July 24, 2012) (evaluating curricula commonly used in California for compliance with sexual health statutory and very specific regulatory requirements); Minn. Org. Adolescent Pregnancy, Prevention & Parenting, *Minnesota Sexuality Education Resource Review Panel: Education Material Review Form*, available at <http://www.moapp.org/Documents/MSERRP/MSERRPReviewForm.pdf> (assessing curricula against 11 criteria/questions); Mass. Dept. Elementary & Secondary Educ. AIDS Advisory Panel, *Curriculum Reviews Completed*, available at <http://www.doe.mass.edu/cnp/hprograms/aids.html> (assessing curricula against 14 criteria/questions); Iowa Dept. Educ., *Age-Appropriate/Research-Based Information for Human Growth and Development*, available at [http://www.educateiowa.gov/index.php?option=com\\_docman&task=doc\\_download&gid=6217](http://www.educateiowa.gov/index.php?option=com_docman&task=doc_download&gid=6217) (recommending age appropriate and research validated curricula that covers certain subjects); Sexuality Info. & Educ. Council U.S., *Guidelines for Comprehensive Sexuality Education: Kindergarten-12<sup>th</sup> Grade* (3d ed. 2004), available at [http://www.siecus.org/\\_data/global/images/guidelines.pdf](http://www.siecus.org/_data/global/images/guidelines.pdf) (sex education guidelines); Sexuality Info. & Educ. Council U.S., *Curricula, Lesson Plans & Resources for Teaching about Sexuality*, <http://www.sexedlibrary.net/index.cfm?pageId=778> (last visited July 25, 2012) (recommending curricula and lesson plans for consistency with all or most of SEICUS-created sex education guidelines and whether the materials "[follow] the values inherent in the Guidelines").







FEDERATION OF PROTESTANT WELFARE AGENCIES



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