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**SEX EDUCATION IN MONTANA SCHOOLS:
AN ASSESSMENT OF THE NEEDS OF SEXUAL AND GENDER MINORITY YOUTH**

By

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Bachelor of Social Work, University of Montana, 2014

Thesis

presented in partial fulfillment of the requirements for the degree of

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The University of Montana

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Minority Youth

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Youth are particularly vulnerable to infection from HIV and STIs. According to the Centers for Disease Control and Prevention, youth between the ages of 13 and 24 accounted for about 26% of all new HIV transmission cases in the United States in 2010. In young MSM specifically, there was a 22% increase in new infections from 2008 to 2010 (CDC, 2015). Education is one of the factors that plays a role in sexual health practices starting in high schools, yet in Montana there is no clear set of guidelines as to what is covered during sex education classes in the health classroom, especially for topics relating to the sexual and gender minority (LGBTQ+) populations. This study represented one of the first attempts to gather information about the curricula for sexuality education in high schools across the state of Montana. The survey was distributed online via social media sites and through email. Anyone aged 18 to 24 who graduated from high school in Montana was able to participate. Results of this statewide survey revealed that while the majority of respondents perceived all of the topics listed on the survey as very important, many of the topics were only partially covered or not covered at all. In fact, only 5% of respondents perceived that topics specifically related to LGBTQ+ issues were being fully covered. Fully half of the respondents believed their teachers were uncomfortable teaching sex education and an overwhelming majority believed that their sex education classes were useless. Educators' apparent discomfort in teaching sex education may contribute to the lack of coverage of many topics and to students' perceptions that the courses are not helpful. Most importantly, LGBTQ+ respondents reported attempting suicide at more than three times the rate of their heterosexual/cisgender peers when in high school. While not a panacea, it seems reasonable to assume that a sex education curriculum that is comprehensive, inclusive of LGBTQ+ students and taught by teachers who are trained and comfortable talking about the multitude of issues surrounding adolescent sexuality could only enhance the quality of life of students who believe they have no one to whom they can relate and fear others discovering their sexual and/or gender minority status.

The Montana Department of Public Health and Human Services and other health care organizations may use this information to create interventions that are tailored to the unique needs of the young sexual and gender minority youth population in Montana.

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Finally, to my daughter, Elena. I hope this project creates some change for the better, so that you can have the comprehensive education from the school system that you deserve. This project is for you, and your future.

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Chapter One

Introduction

Youth are particularly vulnerable to infection from HIV and STIs. According to the Centers for Disease Control and Prevention, youth between the ages of 13 and 24 accounted for about 26% of all new HIV transmission cases in the United States in 2010, and in that age group, young men who have sex with men (MSM) accounted for the majority of new infections. In young MSM specifically, there was a 22% increase in new infections from 2008 to 2010 (CDC, 2015).

The risk of infection with HIV or other STIs appeared to be even greater for sexual and gender minority (SGM) youth. SGM youth include gay, lesbian, bisexual, transgender, queer, and any other youth who do not identify as part of the cisgender or heterosexual youth population (NIH, 2016). In several studies researchers found that SGM youth were at higher risk for transmitting and getting STIs than their cisgender, heterosexual peers. Their higher risk appeared to be related to risk behaviors such as not getting tested, not using condoms when they have sex, and having multiple partners in a brief period of time (Delany-Moretlwe, Cowan, Busza, Bolton-Moore, Kelley, & Fairlie, 2015; Cook, Valera, & Wilson, 2014; CDC, 2015; Kurth, Lally, Choco, Inwani, & Fortenberry, 2014).

STI rates also were increasing among youth between the ages of 15 and 24. Although this age group constituted approximately one quarter of the total sexually active population in the United States, they accounted for an estimated half of all new STI cases each year (CDC 2015). From 2013 to 2014, the rates for the three reportable STIs (chlamydia, gonorrhea, and syphilis) increased in both men and women in this age group (CDC, 2015). The CDC estimated that youth account for approximately 70% of new gonorrhea cases, 49 % of new HPV cases, 45 % of new genital herpes cases, and 20 % of all new syphilis cases (CDC, 2013).

The reasons for the increase in infections in this population were complex and unclear. What was clear, however, was that comprehensive sex education programs had been shown to help youth delay the onset of sexual activity, reduce the frequency of sexual activity, reduce the number of sexual partners, and increase condom and contraceptive use (Santelli, Ott, Lyons, Rogers, Summers, & Schleifer, 2006). Therefore, the CDC (2015) has recommended that public schools across the nation adopt a comprehensive approach to sex education that addresses the needs of all youth, including the unique needs of SGM youth.

Traditionally, the sexuality education needs of students in public high schools were met through health education classes. In Montana, Health Education standards, updated in 2015, were vague when it comes to describing what should be covered in sexuality education in the public schools. At the end of grade 12, students were expected to “develop personal health-enhancing strategies that encompass substance abuse, nutrition, exercise, sexual activities, injury/disease prevention, including HIV/AIDS prevention, and stress management.” According to Montana’s Office of Public Instruction (OPI), the content of the human sexuality component of a Health Enhancement program was a decision for the local school board, which is comprised of community members and school leaders, not a decision for the state. OPI dictated only that the contents reflect the values of the community (Office of Public Instruction, n.d.). The ambiguous nature of the standards allowed each school district to design its own sexuality education curriculum and made it difficult to determine the comprehensiveness and range of topics included in high school sexuality education courses across the state. Of particular interest in this study was whether or not the curricula in Montana classrooms met the HIV and STI prevention needs of sexual and gender minority youth.

Purpose of the Study

The purpose of this study was to determine the sex education needs of sexual and gender minority youth in Montana. Specifically, this study examined the perceptions of youth regarding the content of their sex education classes, their perceptions of the importance of specific sex education topics, and the challenges they currently face or faced as sexual and gender minority students in schools in Montana.

Statement of the Problem

The rates of STIs among our nation's youth are on the rise as are the rates of HIV infection; specifically among young MSM. Multiple studies had demonstrated that an effective way to reduce these rates is through comprehensive sex education in the schools. Unfortunately, Montana's Office of Public Instruction (OPI) provided no guidelines for teaching about sex in public schools. Thus, there was a scarcity of information about the scope and practice of the curricula as it is currently implemented, especially in smaller school districts. This study intended to examine the scope and practice of sex education through the eyes of the students who are enrolled in, or have graduated from, Montana's high schools.

Significance of the Study

Information from this study was used to increase understanding about the sex education curriculum in Montana's high schools and its relevance to sexual and gender minority students. Educators, public health workers, policy makers, researchers, and health care providers that work with sexual and gender minority youth will have a better understanding of the sexual health needs of this population. More specifically, the Montana Department of Public Health and Human Services' (MTDPHHS) HIV Planning Group (HPG) will use the information from this study to increase awareness of the need for sex education that addresses the unique needs of sexual and gender minority youth and has the potential to reduce the risk for infection with HIV and other sexually transmitted infections.

Research Questions

Descriptive Analysis:

1. What are the perceptions of sexual and gender minority youth, ages 18-24, regarding:
 - a. the topics covered in their sex education courses in middle and high school
 - b. the importance of those topics to them personally
 - c. the comfort level of their teachers in addressing topics related to sexual and gender minorities
 - d. the biggest challenges faced in middle and high school related to being a member of a sexual or gender minority group
 - e. the most helpful person or resource in regard to their sexual health in middle and high school
 - f. the specific activities that are considered “having sex”
2. What do sexual and gender minority youth know about HIV transmission and prevention?
3. What are the reported rates of extreme sadness and suicide attempts among sexual and gender minority participants?

Comparison of Means:

4. Is there a difference in perception of topics covered and importance of topics between cisgender, heterosexual participants and sexual and gender minority participants?
5. Is there a difference in reported rates of suicide attempts and sadness between cisgender, heterosexual participants and sexual and gender minority participants?

Limitations and Delimitations

Delimitations

1. The study will be delimited to self-identifying sexual and gender minority youth aged 18 to 25 who went to high school in Montana.
2. Data will be collected through an online questionnaire from individuals in the sexual and gender minority communities.
3. Data collected from participants will be self-reported.
4. Participants will be anonymous volunteers who will be able to exit the study at any time.

Limitations

1. Data collected will be limited to the experiences and memories of the participants. This could potentially lead to some inaccurate results, if the participants do not fully remember what was taught in their sex education class in high school.
2. There could potentially be participants who did not attend school on the day or days that their teacher covered sex education as well, which will lead to different results than if they had been able to go to school.
3. Data collected will be limited to individuals who have access to social media sites such as Facebook. This limitation will potentially lead to a lesser number of youth taking the survey, because they do not have the access or the security to take a survey like this online.

Definition of Terms

Cisgender:

A person who identifies as the gender that they were assigned at birth (Merriam-Webster, 2015). For example, someone who is assigned as a male at birth would be considered cisgender if they identify as part of the male gender later in life.

Gender Identity:

How people identify their own gender, whether they identify as male, female, or something else (CDC, 2015).

HIV:

Acronym for the human immunodeficiency virus. This virus attacks the body's immune system so that the body cannot fight off other infections. This virus is usually spread through sexual contact with someone who has the virus, though it can be spread through other body fluids such as blood (CDC, 2015).

LGBTQ+:

Acronym for lesbian, gay, bisexual, trans*, queer/questioning, and any other sexual or gender identity or expression that does not fall under the cisgender and heterosexual identification.

Out:

A term for being open about one's sexual or gender identity, with oneself and others, or how one comes to terms with one's self-identity (Gender Equity Resource Center, 2014).

Sexual and Gender Minority:

Anyone whose sexual orientation, gender identity or expression, or practice does not fit into the views of what is normal in the society (NIH, 2016).

Sexual Identity:

How a person identifies their sexual preferences for a sexual or romantic partner (CDC, 2015).

STI:

The acronym for sexually transmitted infections.

Chapter 2: Review of Literature

Sexual and Gender Minority Youth

The National Institutes of Health (NIH) defines sexual and gender minority as follows: “an umbrella phrase that encompasses lesbian, gay, bisexual, and transgender populations as well as those whose sexual orientation, gender identity and expressions, or reproductive development varies from traditional, societal, cultural, or physiological norms” (2016). It is difficult to place a number on how many youth in the United States fall under this category, because some are not “out”, or have identified themselves as part of this group to themselves or other people, and even if they are out to some, they may not be out to the world and would not identify as such in a survey. Some researchers estimate that about 2.5 percent of the youth population in high school identifies as part of the sexual and/or gender minority population, and that as many as one in ten students may be struggling to identify their sexual or gender identity (Santelli et al., 2006). Another study done in Boston, Massachusetts reviewed the results of a survey of over 1,000 high school students showing that 10% of students who answered the survey identified as part of the sexual or gender minority population (Almeida, Johnson, Corliss, Molnar, & Azrael, 2009).

For this study, researchers make the assumption that Montana public high schools are representative of the youth population in the United States. Given that assumption, in a rural school consisting of 200 students, approximately 25 are likely to either identify as a sexual or gender minority or report struggling with their identity.

There are several issues that sexual and gender minority youth face, not the least important being their mental health. Sexual and gender minority youth tend to have higher rates of depression and suicidal ideations than their cisgender, heterosexual peers (Needham and Austin, 2010; Mayer, Bradford, Makadon, Stall, Goldhammer, & Landers, 2008). These higher rates have been partially attributed to negative social

environments, where these youth feel targeted for ridicule because of how they identify sexually or by gender (Birkett, Espelage, & Koenig, 2009). In addition to mental health issues, sexual and gender minority youth also have a higher risk of transmitting or getting STIs than their cisgender, heterosexual peers (Cook et al., 2014). Young MSM are 22% more likely to contract HIV than any other youth population (CDC, 2015).

Health Issues Related to Risky Sexual Behaviors

HIV rates. While HIV is not the predominant health issue facing youth when they choose to have sex, transmission rates in this population are a concern. HIV-related deaths in youth increased 50% from 2005 to 2012. This increase in mortality is particularly alarming since the total average of HIV deaths in the entire population fell by about 30%. (Lall, Lim, Khairuddin, & Kamarulzaman, 2015). In 2012, 5 million of the 35 million people living with HIV were aged 10-24, and over a third of all new HIV diagnoses occurred in this age group (Lall et al., 2015). The populations more at risk for transmitting and contracting HIV are youth populations, such as transgender individuals and young men who have sex with men (Delany-Moretlwe, Cowan, Busza, Bolton-Moore, Kelley, & Fairlie, 2015). According to the CDC, 72% of youth who were infected with HIV in 2010 were infected through male-to-male sexual contact, either by being male and having sex with another male or their partner had sex with a male who has had sex with another male (Cook, Valera, & Wilson, 2014). Researchers have found that 50% of new HIV infections occur in populations like the ones described above, where risk taking is much higher than in the average population (Delany-Moretlwe et al., 2015). This higher degree of risk is associated with behaviors such as not getting tested, not using condoms, and not disclosing their health status to partners (Kurth, Lally, Choco, Inwani, & Fortenberry, 2014).

STI rates. Nationwide, youth between the ages of 15 and 24 account for about half of all new STI reports, and one in four female youth are estimated to have an STI (CDC, 2015). According to the CDC, the 8 most common STIs are chlamydia, gonorrhea,

hepatitis B virus, herpes simplex virus type 2 (HSV-2), syphilis, HIV, human papillomavirus (HPV), and trichomoniasis. An estimated 20 million new cases occur each year, and CDC estimates say there are more than 110 million total cases of STIs in the United States (CDC, 2013).

In Montana, the state public health department mandates the reporting of three sexually transmitted infections, chlamydia, gonorrhea, and syphilis. Chlamydia is the most common STI in Montana. In 2014, 4,193 cases of chlamydia were reported, with 69% of reported cases being females. Over 60% of new chlamydia cases reported in 2014 were in the age groups between 15 and 24 (MTDPHHS). Gonorrhea cases increased from 2013 to 2014 by almost 100% in Montana with a total of 434 cases reported in 2014. Approximately 51% of those cases were female. Approximately 70 of the new cases were in individuals younger than 20 years old (MTDPHHS). Syphilis, the least common of the three reportable infections, was reported at nine cases in 2014.

Unfortunately, rates for all three infections have increased over the past 10 years. According to the MTDPHHS, about 4600 cases of STIs were reported in 2014. In addition, there is a strong possibility that many cases go unreported, because people are not getting tested, thus are unaware of their health status (MTDPHHS, 2014).

Two Main Approaches to Sex Education in the U.S.

Abstinence-Only Sex Education

Political groups, such as the Moral Majority and Focus on the Family have long influenced sex education in America. These groups made an impact at the local level by going to school boards with the message that abstinence-only education was the only way to make sure teens were not having sex (Saul, 1998).

The main focus of abstinence-only sex education is on teaching students to wait to have sex until they are married. Information that addresses how to prevent STIs and HIV, as

well as pregnancy may be included, but abstinence is touted as the only way to prevent the negative psychological and physiological consequences of sexual intercourse (Weaver, Smith, & Kippax, 2005). Abstinence-only education encourages saving first sexual encounter until marriage, and is the more popular method of sex education in the United States since the federal government started offering funds in 1983 (Yoo, Johnson, Rice, & Manuel, 2004).

When the federal government started allocating funds to promote using abstinence-only education in the classrooms, there were eight main topics that were required to be covered in the curriculum. According to the Family and Youth Services Bureau (FYSB) (2015), these topics help youth most at risk for having children outside of marriage by delaying sexual activity. In order to receive funding from this federal grant, all schools must cover these topics:

1. List the social, psychological, and health gains of abstaining from sexual activity;
2. Emphasize that abstinence from sexual activity outside of marriage as the expected standard for all children in school;
3. Emphasize that abstinence is the only sure way to prevent pregnancy and STIs;
4. Emphasize that monogamy in the context of marriage is the standard of human sexual activity;
5. Teach that sexual activity outside of marriage is likely to have negative physical and psychological consequences;
6. Teach that bearing children outside of marriage is likely to have consequences for the child, the parent, and society;
7. Teach youth how to refuse sexual advances and teach how drugs and alcohol can affect those refusals
8. Teach how important it is to attain self-sufficiency before starting to engage in sex (FYSB, 2015).

Comprehensive Sex Education

Comprehensive sex education is sex education that starts with abstinence-based curriculum, and includes other information about healthy sexual behaviors for students who choose to have sex. Abstinence is taught as being the only way to 100% guarantee STI and pregnancy prevention, while other methods of birth control are included, such as how to use a condom, or where to get contraceptives or have an abortion. It also covers how to have conversations with partners about using birth control, and teaches skill sets for how to keep oneself safe from STIs and HIV (Fonner, Armstrong, Kennedy, O'Reilly, & Sweat, 2014). Comprehensive sex education programs teach the facts about what happens when people have sex, and teaches youth how to protect themselves from the potential negative consequences of having sex (i.e. unintended pregnancy or STI transmission). Comprehensive sex education also helps empower youth by giving them the tools to take personal responsibility for keeping themselves healthy and safe, and by providing a sex positive atmosphere where students are able to ask questions and get the information they need (Weaver et al., 2003). Comprehensive sex education programs that cover HIV and STI prevention help youth build skills to engage in useful problem-solving and practice healthy behaviors such as using condoms and having conversations about safety with partners (CDC, 2015).

Comprehensive sex education has been shown in reviews of programs to increase the use of birth control during sex and delay the time when students start having sex (Waxman, 2004). In a review of the results of 28 studies of comprehensive and HIV/STI prevention programs in the United States, researchers found that most programs were able to effectively delay the initiation of sexual intercourse in adolescents compared to a control group. In contrast, a review of several abstinence-only programs found that only three programs delayed sexual intercourse compared to the control group. It is important to note, however, that most of the abstinence only programs the researchers

reviewed showed a delay in the onset of sex were from non-peer-reviewed studies, and there were study design flaws in the methodology of all studies (Santelli et al., 2006).

In another review done by Douglas Kirby, 56 studies were reviewed, nine that looked at abstinence-only programs and 48 that examined comprehensive sex education and HIV/STI prevention programs. Only three, or one-third, of the nine abstinence-only programs showed significant positive influence on preventing sexual behavior in youth, while over two-thirds of the comprehensive programs had a positive effect on delaying sexual activity (Kirby, 2008). These reviews show that comprehensive sex education programs can be more effective at delaying sexual activity and reducing negative health consequences of having sex, such as unintended pregnancies or transmitting STIs.

Federal Investigation of Sex Education Programs

Overtime, public skepticism regarding the effectiveness of abstinence only curricula grew and resulted in a federal investigation. Results of the federal review of abstinence-only programs funded under Title V were published in 2004. The review compared high school students who received abstinence-only sex education with a control group of students who did not receive sex education. Results of the investigation showed that youth in the control group were no more likely to start having sex than students in the abstinence-only groups, concluding that the abstinence-only programs were not as effective as anticipated (Waxman, 2004). Some of the other important findings from the investigation of abstinence only programs are as follows:

- Abstinence-only curricula falsified information about effectiveness of contraception.
- Curricula contained falsified information about health and future pregnancy risks after an abortion.
- Religious ideology was presented as science.
- Curricula had stereotypes about girls and boys, as well as sexual minority youth.
- Scientific and medical errors were found in over two-thirds of the curricula. .

Other findings revealed that students who pledged to keep their virginity until marriage had the same rates of STIs as students who did not pledge. Furthermore, over 80% of pledged students had premarital sex (Government Accountability Office, 2006).

Funding for Sex Education in the United States

Abstinence Only Funding:

Federal funding for sex education programs in the schools began in 1981 when Sens. Jeremiah Denton (R-AL) and Orrin Hatch (R-UT), both opponents of the Title X family planning program, which they believed promoted teen sexual activity and abortion, called for a new approach to teen pregnancy—one emphasizing morality and family values. As a result of their efforts, in 1983 congress enacted the Adolescent Family Life Act (AFLA) (Guttmacher Institute, 1998).

Adolescent Family Life Act: Known as the “Chastity Act”, the three goals were to prevent teen pregnancies through messages of “chastity and self-discipline”, to promote adoption as the only acceptable choice for pregnant teens who were not planning on having children yet, and to care for teens who were pregnant or parenting (Perrin et al., 2003, p. 446). Some of the programs that were developed under AFLA used fear and shame to help instill the ideals of waiting until marriage to engage in sexual contact with another person (Perrin et al., 2003).

Four years after the inception of the act, in 1985, the American Civil Liberties Union challenged the AFLA in court because of its religious bias. Although the AFLA’s approach to sex education was found unconstitutional and future funding was distributed only if programs excluded religious ideology (Guttmacher Institute, 1998), the ideology of abstaining from all sexual activity until marriage continued to thrive in two other federally funded, abstinence-until-marriage programs.

Title V Abstinence-Only-Until-Marriage Program: In 1996, the Temporary Assistance for Needy Families Act (TANF), better known as “welfare reform,” was signed into law. Title

V, Section 510(b) of the Act established a new federal funding stream to provide grants to states for abstinence-only-until-marriage programs. The Maternal and Child Health Bureau (MCHB) at the U.S. Department of Health and Human Services (HHS) originally administered the program. Similar to AFLA, this program was enacted quietly, without public or legislative debate.

Community-Based Abstinence Education: In 2000, the federal government created yet another funding stream to support abstinence-only-until-marriage programs. Under this funding stream the federal government awarded grants directly to state and local organizations. Until fiscal year 2005, the Maternal and Child Health Bureau administered CBAE within the Health and Human Services (HHS). Beginning in fiscal year 2005, however, this funding stream was moved to HHS, Administration for Children and Families, which at the time was more conservative (Government Accountability 2006).

Funding provided by HHS for the three abstinence-until-marriage programs increased from about \$73 million in fiscal year 2001 to about \$158 million in fiscal year 2005. After 2005, funding for abstinence only programs began to decline (Government Accountability Office, 2006).

Comprehensive Sex Education Funding

Skepticism over the effectiveness of abstinence-only sex education, and resistance to federal funding for these programs led to dozens of studies questioning the federal support. Several systematic reviews concluded that abstinence-until-marriage programs are ineffective in delaying sexual debut or reducing sexual risk behaviors among sexually experienced teens (Bennet, 2005; Underhill 2007; GOA, 2008). In sharp contrast, evaluations of comprehensive sex education programs find greater efficacy; in Kirby's most recent review, two-thirds of 48 comprehensive programs teaching both abstinence and the use of birth control had positive behavioral effects (Kirby, 2008). Given the overwhelming evidence, funding for comprehensive sex education became a priority.

Teen Pregnancy Prevention Initiative: In 2009, President Barack Obama signed the Consolidated Appropriations Act of 2010, which included \$114.5 million for the President's Teen Pregnancy Prevention Initiative (TPPI). This created the first federal funding stream that could be utilized for more comprehensive approaches to sex education (SEICUS 15, 16). Congress also allowed the third funding stream, the Title V abstinence-only-until-marriage program, to expire in 2009. Unfortunately, in March of 2010 it was resurrected as part of the Patient Protection and Affordable Care Act (SEICUS, 2015).

Personal Responsibility Education Program: In 2010, President Obama signed health care reform legislation, the Patient Protection and Affordable Care Act (P.L. 111-148), into law. This legislation created the Personal Responsibility Education Program (PREP), which provides individual states with grants for comprehensive sex education programs that provide young people with complete, medically accurate, and age-appropriate sex education in order to help them reduce their risk of unintended pregnancy, HIV/AIDS, and other STIs. The program totals \$75 million per year in mandatory funding for the period 2010–2014 (SEICUS, 2015).

Current Sex Education Policies in the United States

In January 2015, the National Conference of State Legislatures (NCSL) published a list of policies that are in place for each state (NCSL, 2015). Currently, 22 states are required to have sex education curriculums in public schools and 33 states require HIV and AIDS education (NCSL, 2015). However, only 19 states explicitly require that the information presented has to be “medically factually, or technically accurate” (NCSL, 2015). Some states, such as California, have legislation in place requiring sex education curricula to include information about birth control methods and sexual orientation. Curricula in California must be age-appropriate, medically accurate, and culturally appropriate and unbiased. Montana does not have those guidelines (GI, 2016). While sex and HIV

education are mandatory for the state, Montana legislation does not require that education be medically accurate, or age appropriate (GI, 2016). Education also does not have to be culturally appropriate and unbiased, and schools are not explicitly forbidden from promoting religion if the teacher wishes (GI, 2016). Because there are no set guidelines for what Montana educators must include in their sexuality education curriculum other than a mandate to include information about HIV and STIs - not much is known about the nature of the curriculum.

Sex Education in Europe

In several countries in Europe, the rates of unintended teenage pregnancy and STI transmission have been lower than in the United States. Teenagers in the United States experienced approximately 30 births per 1000 teenagers, compared to approximately 3 per 1000 teenagers in the Netherlands, Australia, and France. Gonorrhea rates in the United States are about 70 times higher than the Netherlands or France, and about 9 times greater than rates in Australia. These lower rates in European countries have been attributed to higher rates of condom and contraception use during first intercourse (Weaver et al., 2005).

Comprehensive sex education is the choice of educators in countries with lower rates of pregnancy and STIs. In the Netherlands, for example, students are provided in school with the knowledge and tools to help them decide how to keep themselves safe if they do decide to have sex, and these materials are available for all students, teachers, parents or guardians, clinics, and the media. This way, the Netherlands' school systems are ensuring that students have the information they need, and that families and doctors have the tools to facilitate important conversations about health sexual behaviors and practices. In Australia, a national policy was created in 1998 to promote the sexual health of the youth in the country in response to the AIDS crisis. There are five components to this policy: involving the whole school, acceptance of youth as sexual beings; providing students with the tools and skills to enable them to control and

enjoy sexual activity; providing information about the sexual diversity of the human population; and providing “appropriate” and comprehensive education in areas like social justice, sexual health, and personal decisions and behaviors (Weaver et al., 2005).

Overview of the National Standards for Sex Education

Prior to the publication of The National Standards for Sex Education in 2012, the United States lacked guidelines for teaching about sex in our nation’s schools. The non-profit organization, the Future of Sex Education (FoSE), in collaboration with the National Education Association, the American Association of Health Education, and the American School Health Association developed the standards. The standards describe topics and knowledge sets that should be covered during sex education classes in grades kindergarten through 12 (Future of Sex Education Initiative, 2012). The goal of the National Standards for Sex Education is to “provide clear, consistent, and straightforward guidance on the minimum core content for sex education that is developmentally and age-appropriate for students in grades K-12”. These standards were based on the National Health Education Standards (NHES) and the Center for Disease Control and Prevention (CDC)’s Health Education Curriculum Analysis Tool (HECAT)(Future of Sex Education Initiative, 2012).

The Standards outline the characteristics of effective sex education, which, according to the standards, help make curricula more inclusive and educational for all students. Some of these characteristics include focusing on specific behavioral outcomes, addressing social pressure and influences, building personal competence, providing adequate time for instruction and learning, and providing opportunities to reinforce skills and positive health behaviors (Future of Sex Education Initiative, 2012). These characteristics help improve the quality of education for students because they are able to personalize the information, making it more relatable to their own lives; they are able to build and practice skills, understand the social norms, and help build self-efficacy

when it comes to making choices about their sexual experiences (Future of Sex Education Initiative, 2012).

There are seven topics that are covered by the National Standards for Sex Education.

These are:

- Anatomy and Physiology
- Puberty and Adolescent Development
- Identity
- Pregnancy and Reproduction
- Sexually Transmitted Diseases and HIV
- Healthy Relationships
- Personal Safety (Future of Sex Education Initiative, 2012).

Each of these topics is addressed in accordance with the eight National Health Education Standards. In other words, each topic contains the following core concepts: Analyzing Influences, Accessing Information, Interpersonal Communication, Decision-Making, Goal-Setting, Self Management, and Advocacy (Future of Sex Education Initiative, 2012). These topics are then separated by grade level, since a third grade student will not be learning the same thing as an eighth grade student. The final document is separated into tables to make it easier to read.

Overview of Montana State Sex Education Standards

Because of the statutes that prevent the federal government from requiring sex education curriculum in public schools, each state is responsible for its own curricula when it comes to sex education (Weaver et al., 2005). The Montana Health Education standards, updated in 2015, are vague when it comes to describing what should to be covered in sexuality education in the public schools. At the end of grade 12, before graduation, students are expected to “develop personal health-enhancing strategies

that encompass substance abuse, nutrition, exercise, sexual activities, injury/disease prevention, including HIV/AIDS prevention, and stress management” (Office of Public Instruction, 2015). That is the extent of what Montana educators are required to teach in health class when it comes to sex.

Depression and /or Suicide Rates

Higher rates of depression and suicide attempts have been associated with a student’s sexual or gender orientation status. Sexual and gender minority youth have been found to have higher rates of depression and suicide than their heterosexual and cisgender classmates. Researchers have postulated that higher rates of suicidal thoughts and depression are related to negative experiences in youth such as bullying or discrimination, as well as less parental support as adolescents transition into young adulthood (Needham & Austin, 2010; Marshal et al., 2011).

In a survey done in Oregon 2006-2008, over 31,000 participants answered questions about sexual orientation and depression and suicidal thoughts and actions, among other topics. Through the survey results, researchers found that students who identified as gay, lesbian, or bi-sexual were more likely to have attempted suicide in the past year than their heterosexual classmates. Over 20 percent of gay, lesbian, or bi-sexual youth who completed the survey had attempted suicide at least once, compared to just over 4 percent of heterosexual youth (Hatzenbuehler, 2011). Some of the risk factors for this higher percentage were directed towards the social environment. Sexual minority youth were much less likely to attempt suicide when they reported having a supportive home and school environment. The risk of attempting suicide at least once increased by about 20 percent in sexual minority youth when they were in a more negative social environment, compared to a 9 percent increase in risk in heterosexual students (Hatzenbuehler, 2011).

Bullying and harassment have been found to be strongly correlated to increased depression or suicidal ideations in sexual and gender minority youth. Birkett, Espelage, & Koenig explored homophobic bullying and the moderating effects of school climate on negative outcomes such as increased risk of depression (2009). Results of national surveys revealed that students who identified as part of the sexual minority youth population were much more likely to report incidences of bullying or harassment than their heterosexual classmates (2008). In one survey, 70% of sexual or gender minority youth reported being bullied or harassed, and of those students, 59% said that a school personnel member was present but did not intervene (Birkett et al., 2009). Researchers also found that students who were questioning their sexual orientation or identity were even more likely to experience harassment or bullying incidences while at school (Birkett et al., 2008). Results of the 2015 Youth Risk Behavior Survey revealed that, 15% of youth in school in Montana have reported being bullied or harassed during the past year because someone thought they were part of the sexual or gender minority youth population (Montana Office of Public Instruction, 2015). These incidences of bullying and negative social environments hurt the development of sexual and gender minority youth as they become young adults.

Conclusion

Cases of STIs and HIV have been rising in youth populations over the past 10 years (CDC, 2015; MT DPHHS, 2015). This increase can be attributed, in part, to the quality of education that youth are receiving in high school sex education courses. Topics such as STI and HIV transmission and prevention, as well as issues that specifically target sexual and gender minority youth often are not included in sex education courses – particularly in schools that endorse abstinence only sex education. Multiple studies have confirmed that comprehensive sex education; education that includes information about condom use and other forms of contraception are effective in reducing the incidence of pregnancy and STDs. Whether the majority of Montana’s schools endorse abstinence only sex education or the more effective comprehensive sex education is not known, because in Montana, guidelines for teaching sex education are deliberately vague for the purpose of allowing individual school districts to determine curricula. This study intends to gather information regarding the nature of sex education, so that policy makers, educators and public health officials can make informed decisions about sex education as it relates to the prevention of HIV and other STDs.

Chapter Three: Methods

Introduction

This study represented the first phase of a two-phase study aimed at assessing the sex education needs of sexual and gender minority youth living in Montana. Phase one consisted of gathering information regarding LGBTQ+ students' perceptions of their experiences of sexuality education in Montana's schools.

Description of Target Population

The target population for this study consisted of individuals between the ages of 18 and 24 who went to high school in Montana and identify as a part of the sexual or gender minority population. The NIH defines sexual and gender minority as: "an umbrella phrase that encompasses lesbian, gay, bisexual, and transgender populations as well as those whose sexual orientation, gender identity and expressions, or reproductive development varies from traditional, societal, cultural, or physiological norms" (2016).

It is difficult to place a number on how many youth in the United States fall under this category, because some are not "out", or have not identified themselves as part of this group to themselves or other people, and even if they are out to some, they may not be out to the world and would not identify as such in a survey. Some researchers estimate that about 2.5 percent of the youth population in high school identifies as part of the sexual and/or gender minority population, and that as many as one in ten students may be struggling to ascertain their sexual or gender identity (Santinelli, Ott, Lyon, Rogers, Summers, & Schleifer, 2005). For this study, researchers made the assumption that Montana public high schools are representative of the youth population in the United States. Given that assumption, in a rural school consisting of 200 students, approximately 25 are likely to either identify as a sexual or gender minority or are struggling with their identity.

Study Design

This study used a cross-sectional design. A cross-sectional design is one that gets a “snap shot” of an issue in current time and typically has a self-report format. These studies do not have to have a specific intervention; instead, they look at what currently exists in regard to a particular issue, and make inferences based on the data results (Barratt & Kirwan, 2009).

Cross-sectional designs have several advantages for studies such as this one. They are faster and relatively inexpensive to perform, since they are usually in a survey format and data can be collected over any amount of time the researcher needs. They can be used to describe the health situation as a whole, since researchers generally can get a large number of participants and can draw samples from the whole population. This design type also focuses on simply gathering data and observing what differences and patterns present themselves, rather than looking to employ an intervention or make a change in the subjects during the course of the study (Barratt et al., 2009).

In this study, the cross-sectional design was used to look at the subject matter that is covered in sex education classes in Montana high schools. Though cross-sectional studies do not have to be set in any particular geographic location (Barratt et al., 2009), the researchers for this study chose to limit the results to young adults who currently are attending or have graduated from a high school in Montana. Through the cross-sectional design, researchers were able to examine young adults’ perceptions of their high school sex education classes.

Questionnaire Development

Because the Montana Health Enhancement Standards do not specify, nor even recommend, topics that should be covered in regard to human sexuality in Montana’s schools, researchers relied on the National Sex Education Standards to guide them in development of the questionnaire. The National Sexuality Education Standards were developed in 2012 to address the inconsistent implementation of sexuality education

nationwide and the limited time allocated to teaching the topic. The standards provided a particularly appropriate framework for this study because they were designed to confront the challenges faced by LGBT students within the school environment (FoSE, 2012). Standards that were relevant to sexual and gender minority youth were selected for inclusion in the questionnaire (appendix A).

The questionnaire consisted of the following four sections:

- Section one included a list of sex education topics and asks respondents to indicate which topics they recall were covered in their sex education classes and how important they perceive the topic to be.
- Section two asked students to provide demographic information such as region of residence, size of school, their age, and their sexual and gender identity.
- Section three asked students to recount the greatest challenges and the greatest support in regard to their sexual health. Respondents' definitions of what it means to "have sex" and sources of information about sexual issues are requested.
- Section four examined respondents' basic knowledge about HIV transmission and prevention and also asks for information about suicide attempts and extreme sadness and depression.

Expert Review. Faculty and key informants in the sexual and gender minority community reviewed a draft of the questionnaire. Feedback from this endeavor led to questionnaire revisions and additional reviews by members of the target population using focus group methodology.

Focus Groups. Following the expert review, the questionnaire was pilot tested in two focus groups. The Gay Men's Task Force organized both focus groups. Four MSM attended the first focus group meeting and provided constructive feedback to the researchers. The questionnaire was revised and presented for review to a second focus group of sexual and gender minority young adults. This focus group consisted of 14 young adults and resulted in significant revisions to the questionnaire. A third focus

group was scheduled specifically to solicit feedback from gender minority individuals. Only one individual attended this focus group. The discussion and feedback from the participant, however, led to further refinement of the questionnaire.

Pilot Testing. The questionnaire was loaded into the Qualtrics secure survey platform and pilot tested by a small group of members of the target population. A test re-test strategy was used to determine the reliability of the instrument. The overall reliability of the questionnaire was about 80 percent. Researchers examined the questions that were most unreliable and edited the questionnaire again.

Sample Selection

Participants for this study were recruited by two methods. First, a link to the on-line survey was posted on a variety of social network websites that are frequently visited by people who identify as a sexual or gender minority (i.e. Twitter, Tumblr, Google+, Facebook, the Gender Expansion Project website (www.genderexpansionproject.org, www.genderexpansionconference.org), on the Gay Men's Task Force Website (www.mtgayhealth.org), on the Western Montana Community Center's website (www.gaymontana.org), on PinkEssence (www.pinkessence.com) and FTM Magazine (www.ftmmagazine.com). Researchers asked for assistance on posting the survey on these websites from the Gay Men's Task Force and from participants of the focus groups. Second, the snowball sampling technique was employed wherein questionnaire participants were asked to forward the questionnaire to other sexual and gender minority youth known to them who were eligible to take the survey.

Data Collection

Sexual minority individuals who clicked on either the social media link or website link were given information about the study. If they are over 17 years of age, they were asked to read an informed consent statement and indicate their wish to participate in the study by clicking "I Agree" on the informed consent and continuing on to the actual survey. The survey on average took 15 to 20 minutes to complete.

Once completed, the responses to the survey were recorded directly into the Qualtrics database. Participants' identities remained anonymous.

The survey did not require parental consent because the participants of the survey were over the age of 18, as approved by the Institutional Review Board of the University of Montana.

Data Analysis

Data from Qualtrics was downloaded into SPSS statistical package. Basic descriptive statistics were used to determine the frequency with which certain topics are included in sex education courses and how important those topics are perceived to be by participants. Barriers and facilitators of healthy sexuality, level of knowledge regarding HIV, and behaviors participants classify as "having sex" also were reported via frequency and percent.

Chi-square analysis was used to determine the relationships among variables.

Researchers also compared sexual and gender minority youths' answers to their cisgender heterosexual classmates' responses. Differences between the two groups in regard to perceptions of topics that were covered in their sex education classes and the importance of the topics were examined. Because sexual and gender minority youth are more likely to have symptoms of depression, hopelessness, and suicidal ideation than their cisgender, heterosexual classmates (Needham & Austin, 2010; Marshal et al., 2011; Birkett et al., 2008), differences between reported sadness and attempted suicide rates were examined as well.

A final written report and presentation will be prepared for MT DPHHS and the state HIV Planning Group based on these results.

Protection of Human Subjects

This study was completed in accordance with the University of Montana Institutional Review Board (IRB) guidelines for the protection of human subjects.

Chapter Four: Results

In this section, data collected by means of the online questionnaire are presented. Results are organized as they relate to the research questions posed in Chapter one.

Demographics:

While 359 participants across the state of Montana logged into the questionnaire site, 252 fell within the appropriate age range. Participation decreased gradually throughout the survey. 167 participants answered all 66 questions resulting in a 70% completion rate.

Age:

18-20 – 30% (75)

21-24 – 70% (177)

Approximately 95% of the participants identified as Caucasian non-Hispanic and 5% identified as American Indian/Alaskan Native. According to the 2015 census for Montana, about 89% of the population identified as Caucasian, and about 6 % of the population identified as being American Indian/Alaskan Native. It appears, therefore, that Caucasians are slightly over-represented and American Indians/Alaskan Natives are slightly under-represented in this study (United States Census Bureau, 2015)

Table 1. Race

	%	N
Caucasian (non Hispanic)	94.4%	(167)
American Indian/Alaskan Native	5.1%	(9)
Hispanic/Latino	3.4%	(6)
African American	0.0%	(0)
Asian/Pacific Islander	1.7%	(3)
Multiracial	2.8%	(5)
Other (Please describe)	1.1%	(2)
Total #		177

Nearly one-half of the participants in this study reported attending schools with a student population of 500 or less. The most common response was attending school with over 1000 students, at approximately 36%.

Table 2. High School Size:

	%	N
Less than 100	9.3%	(16)
100 to 300	14.5%	(25)
300 to 500	21.4%	(37)
500 to 1000	17.9%	(31)
Over 1000	35.8%	(62)
Do not know	4.6%	(8)
Total #		173

Approximately one-half (48.2%) of participants graduated between 2008 and 2011, and one-half graduated between 2012 and 2015.

Table 3. Year of Graduation:

	%	N
Not graduated	2.9%	(5)
2008	2.9%	(5)
2009	8.8%	(15)
2010	17.6%	(30)
2011	15.9%	(27)
2012	15.3%	(26)
2013	14.7%	25
2014	10.6%	18
2015	11.2%	19
Total #		170

Approximately one-half of the participants reported attending high school in the Northwest region of Montana. This region includes towns such as Missoula, Kalispell, and Polson. Participants that reported attending school in the South Central region comprised about one-fourth of the questionnaire respondents. This region includes towns such as Billings and Red Lodge. Only 3% of responses came from the Eastern region of the state.

Table 4. Region

	%	N
1-Eastern	3.0%	(5)
2-North Central	6.6%	(11)
3-South Central	22.6%	(38)
4-Southwest	16.1%	(27)
5- Northwest	51.8%	(87)
Total #		168

What is your Sexual and Gender Identity?

Participants were asked to describe their sexual and gender identity. Open-ended responses to those questions were sorted and grouped into categories. People who identified as not being sure of their sexual or gender identity were included as part of the sexual and gender minority (LGBTQ) population. Responses are listed below.

Table 5. Sexual and Gender Identity

	%	N
Sexual minority	39%	(68)
Gender minority	13%	(22)
Both sexual and gender minority	14%	(24)

Sexual Minority: Of the 175 responses to the question asking for the participant's sexual identity, nearly 40% identified as something other than heterosexual, which placed

them in the sexual minority category. While nearly one-half of these participants described themselves as being “gay”, “lesbian”, or “bi-sexual”, there were many other responses. Some of these responses included pansexual (n=9), queer (n=4), and asexual (n=4). Other responses include homoromantic, Gray-Ace, bi-romantic, and two spirit.

Gender Minority: Of the 172 responses to the question asking for the participant’s gender identity, approximately one in eight (13%) identified as something other than cisgender, which placed them in the gender minority category. The most common responses were “unsure”, “transman”, and “gender-fluid” (n=13). Other less common responses included, non-binary (n=3), two spirit (n=2), and queer (n=1).

In total, nearly one-half (n=82) of the participants identified as being part of the gender or sexual identity minority. Of those 82 participants, 24 (29%) identified as being part of both.

Demographic Data Summary:

237 individuals between the ages of 18 and 24 participated in this questionnaire; 167 completed all 66 questions (70% completion rate). The vast majority of the participants were Caucasian non-Hispanic (94%) and reported graduating from a high school in the most populous regions of the state (74%); either the northwest or south central regions. Approximately half of the participants reported attending a high school with a student body of 500 or less. Over 40% of the participants identified as a sexual or gender minority; 14% identified as both a sexual and gender minority.

Sex Education Topics

The next section covers topics that could potentially be included in a sex education class. Participants were asked to rate the completeness of the topics listed below, as well as rate the importance of that topic to them. Three topics were seen as fully covered by the majority of participants, while three topics were most commonly reported as not being covered at all. Three topics also were reported as most important and three least important. There were significant relationships found between identity and the importance of the topics covered.

Table 6. Extent Topics were Covered and Importance. (n= 175-235)

Topic	How well topic was covered		How important this topic is to you?	
1. The differences between biological sex, sexual orientation, sexual behavior, and gender identity and expression	Not at all	71.1%	Not Important	11.9%
	Partially	24.2%	Somewhat Important	27.2%
	Fully	4.7%	Very Important	60.9%
2. How friends, family, media, society and culture influence the expression of gender, sexual orientation and identity	Not at all	70.2%	Not Important	12.9%
	Partially	24.9%	Somewhat Important	27.1%
	Fully	4.9%	Very Important	60.0%
3. How to advocate for school policies and programs that promote safe environments, dignity and respect for all students	Not at all	59.9%	Not Important	5.5%
	Partially	31.3%	Somewhat Important	22.6%
	Fully	8.76%	Very Important	71.9%
4. How to make decisions for various situations relating to sexual health, including condom use	Not at all	19.0%	Not Important	2.8%
	Partially	47.4%	Somewhat Important	16.3%
	Fully	33.5%	Very Important	80.9%
5. How to communicate decisions about whether or when to engage in sexual behaviors	Not at all	33.5%	Not Important	2.4%
	Partially	43.8%	Somewhat Important	14.1%
	Fully	22.6%	Very Important	83.5%
6. The effectiveness of abstinence, condoms, and other safer sex methods in preventing the spread of STDs, including HIV	Not at all	6.7%	Not Important	1.5%
	Partially	44.7%	Somewhat Important	11.6%
	Fully	48.6%	Very Important	87.0%
7. How to access and advocate for local STD and HIV testing and treatment services	Not at all	66.3%	Not Important	4.4%
	Partially	21.0%	Somewhat Important	22.4%
	Fully	12.7%	Very Important	73.1%
8. How to access medically-accurate prevention information about STDs, including HIV	Not at all	37.1%	Not Important	4.5%
	Partially	47.7%	Somewhat Important	20.1%
	Fully	15.0%	Very Important	75.3%
9. Skills to communicate with a partner about STD and HIV prevention and testing	Not at all	59.0%	Not Important	3.1%
	Partially	29.8%	Somewhat Important	25.7%
	Fully	11.1%	Very Important	70.7%

10. Individual responsibility about testing for and informing partners about STDs and HIV status	Not at all Partially Fully	44.5% 39.2% 16.2%	Not Important Somewhat Important Very Important	4.2% 16.8% 79.0%
11. Common symptoms of and treatments for STDs, including HIV	Not at all Partially Fully	18.0% 47.1% 34.9%	Not Important Somewhat Important Very Important	3.7% 23.4% 72.9%
12. The steps to using a condom correctly	Not at all Partially Fully	42.9% 24.3% 32.8%	Not Important Somewhat Important Very Important	7.9% 15.3% 76.8%
13. Ways to address being bullied, teased, harassed because someone thought you or a friend were gay, lesbian, or bisexual	Not at all Partially Fully	84.0% 11.1% 4.8%	Not Important Somewhat Important Very Important	4.3% 14.9% 80.9%
14. Sexual consent and its implications for decision making about sex	Not at all Partially Fully	38.1% 40.3% 21.5%	Not Important Somewhat Important Very Important	1.6% 7.5% 90.9%
15. The types of situations that may be considered sexual harassment, sexual abuse, sexual assault, incest, rape and dating violence	Not at all Partially Fully	33.5% 49.1% 17.3%	Not Important Somewhat Important Very Important	1.1% 9.7% 89.2%
16. How to access valid resources for help if you or someone you know is being or has been harassed, sexually abused or assaulted	Not at all Partially Fully	47.8% 40.1% 12.1%	Not Important Somewhat Important Very Important	1.7% 12.1% 86.2%
17. About the potential impacts of power differences (e.g., age, status or position) within sexual relationships)	Not at all Partially Fully	75.6% 19.4% 5.0%	Not Important Somewhat Important Very Important	4.4% 32.4% 63.1%
18. About the external influences and societal messages that impact attitudes about sexual harassment, sexual abuse, sexual assault, incest, rape and dating violence	Not at all Partially Fully	70.1% 22.9% 6.2%	Not Important Somewhat Important Very Important	4.5% 24.6% 70.1%

Extent to which Topics were Covered:

The top three topics most frequently reported as not covered were, “ways to address being bullied, teased, harassed because someone thought you or a friend were gay, lesbian, or bisexual” (84%); “the potential impacts of power differences (e.g., age, status or position) within sexual relationships” (75.6%); and “the potential impacts of power differences (e.g., age, status or position) within sexual relationships)” (70.1%).

Topics most frequently reported as being fully covered were, “the effectiveness of abstinence, condoms, and other safer sex methods in preventing the spread of STDs, including HIV” (86%); “common symptoms of and treatments for STDs, including HIV”

(34.9%); and “how to make decisions for various situations relating to sexual health, including condom use” (33.5%).

Chi Square analyses were performed to determine the relationship between sexual orientation/gender identity (LGBTQ) and perceptions of the extent to which topics were covered. No significant relationships were found between the individuals who identified as LGBTQ and those who did not and their perception of the extent to which topics were covered.

One topic area approached significance:

Out of the 172 participants who responded to this question, the topic concerning sexual harassment, abuse, rape, and dating violence was almost significant with a p value of .062. This means that out of all the participants who answered this question, people who identify as part of the sexual and gender minority population appeared to consider this topic as fully covered more often than heterosexual and cisgender peers.

The types of situations that may be considered sexual harassment, sexual abuse, sexual assault, incest, rape and dating violence. $\chi^2 (2, N = 172)$
 $p = .062$.

Importance of Topics:

60.0% of participants perceived all of the topics to be very important. The three topics perceived as very important by the greatest percentage of participants were “sexual consent and its implications for decision making about sex” (90.9%); “the types of situations that may be considered sexual harassment, sexual abuse, sexual assault, incest, rape and dating violence” (89.2%); and “the effectiveness of abstinence, condoms, and other safer sex methods in preventing the spread of STDs, including HIV” (87.0%).

The three topics considered least important (12.9%) were, “how friends, family, media, society and culture influence the expression of gender, sexual orientation and identity” (12.9%); “the differences between biological sex, sexual orientation, sexual behavior, and gender identity and expression” (11.9%); and “the steps to using a condom correctly” (7.9%).

Chi Square analyses were performed to determine the relationship between sexual orientation/gender identity and perceptions of the importance of the topics.

A significant relationship was observed in the following areas:

1. The differences between biological sex, sexual orientation, sexual behavior, and gender identity and expression. $\chi^2 (2, N = 172) p=.010$
2. How friends, family, media, society and culture influence the expression of gender, sexual orientation and identity. $\chi^2 (2, N = 172) p=.005$
3. Ways to address being bullied, teased, harassed because someone thought you or a friend were gay, lesbian or bisexual. $\chi^2 (2, N = 172) p=.016$.

These p values show that participants who identify as part of the sexual and gender minority population were more likely to view these topics as important than their heterosexual cisgender peers.

Approaching Significance:

The following topics were considered important, but the relationship between identity and the reported importance of the topics was not strong enough to be considered significant.

4. About the potential impacts of power differences (e.g., age, status or position) within sexual relationships. $\chi^2 (2, N = 172) p=.077$.
5. About the external influences and societal messages that impact attitudes about sexual harassment, sexual abuse, sexual assault, incest, rape and dating violence. $\chi^2 (2, N = 172) p=.056$

Other topics

Participants were provided the opportunity to write in responses to the question, “What other topics would you have liked to learn about during sex education class.” 82

participants responded. The most common themes are listed below:

- Issues relating to the sexual and gender minority community (35%),
- Birth control and abortion options and resources (26%),
- Anatomy and biology (such as more information about how sexually-transmitted infections affect the body) (13%).

Other themes that were less reported included information related to communication and sexual consent and healthy relationships. Two participants stated that they did not receive sex education and would have wanted to learn about all of these subjects during their high school years.




Physical Education or gym class (74%) was the most common subject taught in addition to sex education. Other subjects mentioned, but taught less frequently, were science, history, English, or coached a sport such as basketball or wrestling.

Table 7. Does/Did your health teacher teach other subjects?

	%	N
Yes	63.6%	(110)
No	22.5%	(39)
Unsure	14.5%	(25)
Total #		173





Approximately one-half of the participants (n=87) believed their teachers were somewhat comfortable or very comfortable teaching sex education.

Chart 1. How comfortable did your teacher seem when talking about sex education?

#	Answer	Bar	Response	%
1	Very uncomfortable		27	15.61%
2	Somewhat uncomfortable		59	34.10%
3	Somewhat comfortable		57	32.95%
4	Very comfortable		30	17.34%
	Total		173	100.00%

Approximately three-quarters of the participants reported that their sex education was somewhat useless or very useless. The remaining one-quarter of participants said that their sex education was somewhat useful or very useful to them in high school. Only 3% reported sex education as being very useful.

Chart 2. How useful was the sex education you received in high school to you personally.

#	Answer	Bar	Response	%
1	Very useful		6	3.37%
2	Somewhat useful		40	22.47%
3	Somewhat useless		72	40.45%
4	Very useless		60	33.71%
	Total		178	100.00%

The LGBTQ community, internet/websites and health classes were identified as the best way for LGBTQ youth to access sexuality information.

Table 8. What is the best way for LGBTQ+ youth to access sexuality information?

	%	N
Internet/Websites	62.9%	(107)
Health classes	40.9%	(70)
Parents	27.5%	(47)
Friends	30.4%	(52)
LGBTQI+ Community	81.3%	(139)
Social Media	25.1%	(43)
Spiritual/Religious Leader	7.6%	(13)
Total #		171

Over 50% of participants said that they did not experience any challenges in high school. Almost 31% of participants said that their main challenge was keeping their sexual and/or gender minority identity a secret from friends or family.

Table 9. What is/was your biggest challenge in high school in regard to your sexuality?

	%	N
No challenges	52.1%	88
Not knowing why I was different	12.9%	22
Keeping my sexual orientation and/or gender identity a secret from friends	12.3%	21
Keeping my sexual orientation and/or gender identity a secret from family	15.2%	26
Being bullied or harassed because of my sexual orientation and/or gender expression	8.2%	14
Not having anyone to date	15.2%	26
Not being able to accept myself	18.7%	32
Not having anyone else to relate to (e.g. other queer friends)	21.1%	36
Not identifying with a specific label	14.0%	24
Other challenges:	15.8%	27
	Total #	171

Participants were provided the opportunity to write in regarding other challenges they have faced. Of the 27 responses to this question, the three most common themes revolved around not yet knowing or realizing that that they identified as part of the sexual or gender minority and thus not knowing it was a challenge for them; dealing with homophobic comments from people on a daily basis at school, whether or not they were out; and not knowing it was okay to be abstinent from sex or not want to have sex in high school.

The majority of answers (47%) indicated that the Internet was the most helpful resource to high school students. The next most useful resource for high school students who identified as part of the LGBTQ population was a friend or a parent. Very few participants (less than 7%) said that a school counselor or school-based student group was the most helpful resource in regard to sexual health.

Table 10. What was most helpful, in regard to your sexual health as a high school student?

	%	N
Nothing was helpful	13.6%	23
One of my teachers	7.1%	12
School counselors	3.0%	5
A friend	39.3%	66
My parents/guardians	31.6%	53
Online support system (social media)	14.3%	24
A school-based student group like Gay Straight Alliances, Gay Student Associations, or Diversity Clubs	3.6%	6
Finding Information on the Internet	47.6%	80
Please describe other things or people that were helpful	9.5%	16
	Total #	169

Researchers also provided a write-in option if there were any other resources that were not listed. Out of the 15 responses, 3 responses mentioned Planned Parenthood programs that were designed to provide education and outreach for sexual health. One person said going to college was the most helpful for him or her.

The majority of all the respondents considered vaginal/penile sex, anal sex and oral sex as “having sex.” Other ways of defining “having sex” such as digital sex and masturbation were endorsed by one-third or less of the respondents.

Chart 3. What is your definition of "having sex"?

#	Answer	Bar	Response	%
1	Kissing (making out)		2	1.18%
2	Touching someone's intimate areas		35	20.59%
3	Vaginal/penile sex		164	96.47%
4	Anal sex		144	84.71%
5	Oral sex (using your mouth only)		112	65.88%
6	Digital sex (using hands and fingers only)		58	34.12%
7	Dry humping		11	6.47%
8	Masturbating with your partner		45	26.47%
9	Masturbating alone		13	7.65%
10	Other actions you consider to be sex:		7	4.12%
	Total		591	100.00%

The majority of participants (88%) said that there is not a cure for HIV, which almost 12% either said that there was a cure, or that they were not sure of the correct answer.

Table 11: Is there a cure for HIV?

	%	N
Yes	3.6%	6
No	88.2%	149
Unsure	8.2%	14
Total #		169

Approximately 44% of questionnaire respondents said that there were no drugs available that can prevent HIV. Almost 37% of respondents said that there were drugs available, and approximately 20% of participants were unsure.

Table 12: Are there drugs available that can prevent HIV?

	%	N
Yes	36.7%	62
No	43.8%	74
Unsure	19.5%	33
Total #		169

Approximately 87% of participants said that there were drugs available that can treat HIV and related symptoms. About 13% of respondents were either unsure or said that there were no drugs available.

Table 13: Are there drugs available that treat HIV?

	%	N
Yes	86.9%	146
No	7.1%	12
Unsure	6.0%	10
Total #		168

Body fluids and HIV

Participants were asked to list as many body fluids as they knew that are able to transmit HIV to another person. The four main fluids researchers were looking for were blood, semen, vaginal fluids, and breast milk. Researchers categorized these answers into five sections. A categorization of “1” meant that the respondent did not correctly identify any of the four fluids. A “2” meant that the participant correctly identified one of the body fluids that can transmit HIV, “3” meant that two body fluids, and up to 5, identified, which indicated to researchers that all four body fluids were correctly identified. Out of the 155 responses, almost 15% of respondents were categorized at a 5, while 16% of respondents scored a 1 or 2. The rest of the respondents could identify at least 2 correct body fluids.

Other fluids that were incorrect that were listed as being able to transmit HIV were saliva, urine, and “all of them”, because the participant was not told which fluids specifically can transmit HIV.

Activities leading to HIV transmission

Researchers also wanted to know participants’ knowledge about what activities can lead to HIV transmission to get an idea of what is being covered in class. Essentially, researchers wanted to know if the majority of people knew that HIV can be transmitted through blood to blood contact and through exposure to body fluids such as semen and vaginal fluids. The same categories listed above were used with this question. Well over 90% of participants said that having (unprotected) sex, whether oral, vaginal, or anal, could lead to HIV transmission. Participants also acknowledged that having blood-to-blood contact through activities like sharing needles, exposure to wounds, or contaminated blood transfusions could lead to HIV transmission. Seven participants listed activities such as playing football, kissing, and sharing a drink, which were incorrect for HIV transmission.

A chi-square test was performed and a significant relationship was observed between sexual orientation/gender identity and reported experience of sadness while in high school, $\chi^2 (1, N = 169) p = .001$. Gender and sexual minority participants were significantly more likely to report experiencing sadness while in high school.

Table 14: When you were in school, do you remember experiencing extreme sadness for two or more weeks that caused you to stop doing your normal activities?

	%	N
Yes	54.4%	92
No	45.6%	77
Total #		169

A chi-square test was performed and a significant relationship was observed between sexual orientation/gender identity and reported experience of sadness during the past 12 months, $\chi^2 (1, N = 164) p = .048$. Gender and sexual minority participants were significantly more likely to report experiencing sadness during the past 12 months.

Table 15: During the past 12 months, do you remember experiencing extreme sadness for two or more weeks that caused you to stop doing your normal activities?

	%	N
Yes	42.6%	72
No	57.4%	97
Total #		169

A chi-square test was performed and a significant relationship was observed between sexual orientation/gender identity and attempted suicide as a high school student, $\chi^2 (1, N = 169) p = .001$. Gender and sexual minority participants were significantly more likely to report attempting suicide at least once as a high school student.

Table 16: As a high school student, how many times have you attempted suicide?

	%	N
0 times	82.3%	139
1 time	11.2%	19
2-3 times	4.1%	7
4-5 times	0.6%	1
6 or more	1.8%	3
Total #		169

A chi-square test was performed and no relationship was observed between sexual orientation/gender identity and attempted suicide at least once since graduating from or leaving high school, $\chi^2 (2, N = 164) p = .189$. Significance for this relationship was found to be weak, so people of all identities seemed to be just as likely to report attempting suicide after high school.

Table 17: Since graduating from high school, how many times have you attempted suicide?

	%	N
I am still in high school	1.8%	3
0 times	89.9%	152
1 time	5.3%	9
2-3 times	1.8%	3
4-5 times	0.6%	1
Total#		169

Chapter Five: Discussion

The purpose of this study was to explore the sex education needs of Montana's sexual and gender minority youth (LGBTQ). Specifically, this study examined the perceptions of young adults in regard to the extent specific topics were covered in their high school sex education classes and the importance of those topics. Additionally, study participants were asked to report the challenges they faced in regard to sexual health while in high school, and to answer questions regarding depression, suicide attempts and knowledge about HIV transmission and prevention. Differences in responses between LGBTQ participants and participants who described themselves as heterosexual/cisgender were explored.

Data was collected by means of an electronic survey on a confidential web server. The survey was developed through expert review and revised through focus groups. It was distributed through email, social media sites, and websites that sexual and gender minority youth were more likely to visit, such as the Gay Men's Task Force. The most common way participants viewed and completed the survey was through a Facebook page developed specifically for the project, where researchers posted a link.

From the results of this study, researchers saw the need for consistent sexual health education throughout the state. Results for the extent of topics covered varied widely, as did the HIV knowledge questions. For topics covered, anywhere from just over 6% to over 70% of participants said certain topics were not at all covered. With more consistent education with more descriptive guidelines, more students would be receiving the same knowledge. With this consistency, more students would be practicing healthy sexual behavior, and STI infection rates would decrease instead of increasing as they are now.

Two hundred and thirty-seven individuals between the ages of 18 and 24 participated in the survey. Approximately 70% completed the entire survey. According to the 2015

census for Montana, about 89% of the population identified as Caucasian, and about 6 % of the population identified as being American Indian/Alaskan Native. It appears, therefore that in this study Caucasians (94%) are slightly over-represented and American Indians/Alaskan Natives (5%) are slightly under-represented (United States Census Bureau, 2015).

A goal of this study was to determine young adults' perceptions of the extent to which a variety of topics were taught in their sex education classes. Participants were asked to rate topics as being "fully covered," "partially covered" or "not at all covered." Not surprisingly, sex education specifically related to LGBTQ issues were reported as covered to a lesser extent than topics deemed more general in nature. Specifically, topics such as abstinence, safer sex methods and prevention of STDs were reported as being partially or fully covered by over 90% of respondents, whereas topics such as being bullied, teased, harassed because someone thought you or a friend were gay, lesbian, or bisexual, were reported as being fully or partially covered by only 16% of the respondents. Somewhat surprisingly, there were no statistically significant differences in the ratings of coverage of topics between the LGBTQ and heterosexual/cisgender respondents.

Researchers asked about the participant's perceptions of the teacher's comfort level while talking about the sex education curriculum. Approximately half of all participants reported that they perceived their teacher to be "somewhat" or "very uncomfortable" teaching the subject. While this sounds like a positive thing, it also means that about half of all participants said that they perceived that their teacher was at least somewhat uncomfortable teaching about sex education during health class. The difference in what teachers are expected to cover and the experiential knowledge that youth want are different. According to Vavrus (2009), many teachers in the United States report that they experienced a "lack of preparation" to engage in educational conversations with their students about sex. Students are looking for more social learning-based education

and put importance on their peer group, while the educators are instructed how to teach the fundamentals and the technical terms involved with sex education (p. 384).

At the end of the content questions, participants were asked to name any other topics that they would have wanted to be covered during sex education. Eighty-two participants responded to this question and several themes presented themselves in the write-in answers. The most common themes for subject topics were issues relating to the sexual and gender minority, birth control and abortion options and resources, and anatomy and biology-related questions such as how STIs affect the body. These results coincide with the theme found through this survey that many of the participants of the study received an abstinence-based curriculum during their sex education class.

Resources and Challenges

Survey participants were asked to identify personal challenges faced in high school in regard to sexuality. Over half of participants reported that they did not face any challenges in high school, and approximately 23% of participants who identify as LGBTQ reported not facing any challenges in high school. This could be because they did not identify as part of the sexual and gender minority during their high school years, or simply did not have any challenges. The second-highest response for challenges was not having anyone else to relate to in high school, such as not having or not knowing of having any sexual and gender minority friends. Participants also reported not being able to accept themselves as part of the sexual and gender minority population. Participants also were given the opportunity to write in the challenges they faced. Of the 27 responses, the most common themes involved not knowing that the participant was part of the sexual and gender minority population, coping with homophobic comments from people at school, and not knowing it was okay to not want to have sex in high school.

Participants were asked where sexual and gender minority youth can best access information about sexuality. The most common response at over 80% was to get

sexuality information from members of the LGBTQ population in the community. Participants also reported using the Internet and various websites (63%), as well as getting information from health class (41%). Fewer participants said that spiritual and religious leaders were the best way for sexual and gender minority students to access sexuality information.

Finally, study participants were asked to identify any helpful sexual health resources that they had while they were in high school. Participants were able to select more than one answer for this question. The most common response was finding information on the Internet, which can be quite inaccurate, depending on from where the information came. The next most common resource was a friend. The least common resources reported were a school counselor, a school-based group like Gay-Straight Alliances or Diversity clubs, and one of the teachers. This finding indicates that instead of getting sex education information from class, most students are getting their sex education outside the classroom, where information is not always tracked for accuracy.

Rates of Sadness and Suicide Attempts

Because there is a higher percentage of students who identify as part of the sexual and gender minority population that report feelings of extreme sadness and suicide attempts researchers wanted to know if participants had ever experienced extreme sadness or attempted suicide while in high school. According to the Youth Risk Behavior Survey, about 60% of LGBTQ students reported feeling sad, compared to about 26% of heterosexual students, and about 31% of LGBTQ students reported attempting suicide compared with approximately 6% of heterosexual students (OPI, 2016, p. 21). When asked about experiencing extreme sadness for two or more weeks, over 67% of participants who identified as being part of the LGBTQ population reported experiencing this, while 41% of straight and cisgender participants reported the same. Reported rates of sadness in this study correspond closely with the 2016 YRBS data where 39% of high school students reported feeling sad. About 28% of LGBTQ participants reported

attempting suicide at least once while in high school, compared to about 8% of straight cisgender participants. Again, this percent is in keeping with Montana's 2016 YRBS, which reported a 9% total suicide attempt rate (OPI, 2016).

HIV Knowledge

The survey included questions related to HIV transmission and prevention, as well as the participant's opinion of what it means to have sex. When asked what it means to have sex, participants were given a list of different sexual activities and asked to choose which actions they thought were considered "sex". Researchers wanted to determine if sexual acts that could lead to HIV transmission were considered having sex by youth, thus it was more likely that protective measures would be used during the act. In both sexual and gender minority and straight cisgender participants, over 95% of participants considered vaginal penetration to be sex. What was interesting was that only about 85% of participants considered anal penetration to be sex, and only about two thirds of participants said that oral stimulation was considered sex. However, oral stimulation, and most notably anal penetration, are also acts that can lead to HIV transmission.

Participants were also asked if there was a cure for HIV, and if drugs are available that can treat or cure HIV. The large majority (over 80%) knew that there is no cure for HIV, but almost 20% of participants were unsure if there were drugs available that could prevent HIV transmission. More than 10% of the population also did not know that there were drugs available to treat HIV after diagnosis. These gaps in knowledge could contribute to the increase in HIV diagnoses in the past few years in the MSM population.

When asked what body fluids transmit HIV, researchers were looking for the answer "semen, blood, vaginal fluids, and breast milk", or any combination of those four answers. Only 15% of participants listed all four fluids that transmit the virus, but the majority was able to identify the three sources that are more prevalent (blood, semen,

vaginal fluids). Another concern was that many people believed fluids other than the four listed could transmit the virus. Many participants answered that urine or saliva can transmit the virus when research demonstrates that they cannot, unless another one of the fluids (such as blood) are also involved. Researchers also wanted to know if the majority of participants knew the behaviors that can lead to HIV transmission. Well over 90% of participants identified that unprotected sex and sharing needles or coming in contact with contaminated blood can lead to transmission. Overall knowledge about HIV was accurate, but there were some inconsistencies that, if corrected, can help protect this vulnerable population.

Limitations

The primary limitation to this study is the format of participant recall since the majority of participants were no longer in high school when they completed the survey.

Participants had to recall the content covered in their sex education class, which could potentially lead to some discrepancies between what participants recall and what was actually covered. Some participants may have also been absent for one or more days during their sex education class, which would mean that some knowledge would have been missed. Some schools also teach sex education in middle school, so the participants had to differentiate what they learned in high school from what information they may have gotten in middle school.

Second, while the Internet is widely used, there are people who may have not been able to have access to the Internet in order to take the survey since the primary method of distribution was through social media and websites that cater to the sexual and gender minority population in Montana. More participants may have been recruited if other methods such as paper copies were available.

Finally, the sample size was relatively small for the number of students who went to high school in Montana who fit the age range. This small sample made it more difficult to make generalizations about the communities, as well as perform statistical analyses. A larger sample size would have produced more accurate results for this population.

Recommendations

The following recommendations were provided to the Montana Department of Public Health and Human Services with the hope that by increasing the general knowledge of what is being covered in sex education classes, public health workers can work with the community and schools to provide a comprehensive education that will help prevent the spread of STIs and HIV.

Researchers recommended that comprehensive sex education become the standard for sex education in the state of Montana. According to the studies cited in this research, comprehensive sex education curricula helps delay the initiation of sexual activity, and increases the chance that students will use contraceptives to keep themselves safe from STIs and pregnancy (Waxman, 2004). Abstinence-only curricula has not proven to be successful in reducing sexual intercourse interactions in students, and students were less likely to use any form of protection against STIs or pregnancy during sexual intercourse (Santelli et al., 2006).

Researchers also recommended talking with the Office of Public Instruction to create sex education standards that each school district needs to follow to ensure that students across Montana are getting the same level of education about sex before they graduate from high school. The variation in sexual health knowledge, particularly about HIV, was concerning. Even with this variation in what participants knew, health teachers are still abiding by the state guidelines for health education, since the guidelines are so vague. To promote unity and consistency in students' education, sex education standards approved by the Office of Public Instruction should promote healthy sexual

behaviors and information about contraceptives and STIs and be the same across the entire state.

Conclusions

This study represented one of the first attempts to gather information about the curricula for sexuality education in high schools across the state of Montana. This is particularly important in understanding what knowledge is being shared in high school for Montana students because there are no clear guide lines about the content that must be covered over the course of a student's high school education. The sample size for this study was small, which made it difficult to form overall assumptions about relationships between the sexual and gender minority student population in Montana and the content of sex education. However, some important issues regarding sex education knowledge are worth examining.

Over 80% of participants did not know all of the basic information about HIV transmission and prevention, such as how the virus is transmitted and whether or not there are drugs available to cure HIV. This is especially concerning when the research shows that one particular part of the sexual and gender minority population, young MSM, have seen a 22% increased rates of HIV transmission in the past few years (CDC, 2015). Acceptance of oneself was the most frequently reported challenge in high school in regard to sexuality, though about one-quarter of sexual and gender minority participants reported that they did not experience any challenges with sexuality in high school. The most reported helpful resource for high school students to find out information about sexuality was to turn to the Internet or a friend. Over 50% of participants reported feeling extreme sadness at least once while they were in high school, and sexual and gender minority students were significantly more likely to report sadness than straight cisgender peers at 67% versus 41%. Suicide attempts during high school reached to about 28% of LGBTQ participants, which is quite high.

According to the results, many topics relating to sexual and gender minority students are missing from sex education in high school. The YRBS states that about 12% of the population identifies as part of the LGBTQ community (2016), which would equate to approximately 10,450 people. Given the high rates of how many students identify as part of the sexual and gender minority population, sex education is an important topic to improve in the public high school systems in Montana.

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Appendix A: Survey Questions

Sex Ed in Schools

Q1 You are invited to participate in a research project about assessing the sex education curriculum that is offered in Montana public high schools. This online survey should take about 15-20 minutes to complete. Participation is entirely voluntary, and responses are completely anonymous. You have the option to not respond to any questions that you choose. Participation or nonparticipation will not impact your relationship with the University of Montana. Submission of the survey will be interpreted as your informed consent to participate and that you affirm that you are at least 15 years of age. If you have any questions about the research, please contact the Principle Investigator, Dr. Annie Sondag, phone (406) 243-5215 or via email at annie.sondag@umontana.edu. If you have any questions regarding your rights as a research subject, contact the UM Institutional Review Board (IRB) at (406) 243-6672. Please print or save a copy of this page for your records. * I have read the above information and agree to participate in this research project.

☐ Yes (1)

☐ No (2)

If No Is Selected, Then Skip To End of Survey

Q2 What is your age?

☐ 14 years or younger (1)

☐ 15-17 (2)

☐ 18-20 (3)

☐ 21-24 (4)

☐ 25 years or older (5)

If 14 years or younger Is Selected, Then Skip To End of Survey
If 25 years or older Is Selected, Then Skip To End of Survey

Q3 Were you taught about the following topics in your high school sex education or health classes?

	How important is this topic to you?			How well was this topic covered in class?		
	Not Important (1)	Somewhat Important (2)	Very Important (3)	Not at all (1)	Partially (2)	Fully (3)
1. The differences between biological sex, sexual orientation, sexual behavior, and gender identity and expression? (1)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. The influence of friends, family, media, society and culture on the expression of gender, sexual orientation and identity (2)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. How to advocate for school policies and programs that promote safe environments, dignity and respect for all students (3)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. How to make decisions for various situations relating to sexual health,	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

including condom use (4)						
5. What influences that may have an impact on deciding whether or when to engage in sexual behaviors (5)	○	○	○	○	○	○
6. How to communicate decisions about whether or when to engage in sexual behaviors (6)	○	○	○	○	○	○
7. The effectiveness of abstinence, condoms, and other safer sex methods in preventing the spread of STDs, including HIV (7)	○	○	○	○	○	○
8. How to access and advocate for local STD and HIV testing and treatment services (8)	○	○	○	○	○	○
9. Access medically-accurate prevention information about STDs, including HIV (9)	○	○	○	○	○	○

10. Demonstrate skills to communicate with a partner about STD and HIV prevention and testing (10)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
11. Understand individual responsibility about testing for and informing partners about STDs and HIV status (11)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
12. Describe common symptoms of and treatments for STDs, including HIV (12)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
13. Describe the steps to using a condom correctly (13)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
14. Ways to address being bullied, teased, harassed because someone thought you or a friend were gay, lesbian, or bisexual (14)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
15. Students not going to	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

<p>school because of feeling unsafe at school or on the way to/from school because someone thought they were gay, lesbian, or bisexual (15)</p>						
<p>16. Define sexual consent and explain its implications for decision making about sex (16)</p>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<p>17. Know the differences between situations and behaviors that may constitute sexual harassment, sexual abuse, sexual assault, incest, rape and dating violence (17)</p>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<p>18. Access valid resources for help if you or someone you know is being or has been harassed, sexually abused or assaulted (18)</p>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<p>19. Describe potential</p>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

<p>impacts of power differences (e.g., age, status or position) within sexual relationships (19)</p> <p>20. Analyze the external influences and societal messages that impact attitudes about sexual harassment, sexual abuse, sexual assault, incest, rape and dating violence (20)</p>	○	○	○	○	○	○
--	---	---	---	---	---	---

Q4 What is your sexual identity? (Some examples of sexual identity include straight, heterosexual, two-spirit, gay, bi-sexual, questioning, etc.)

Q5 If you are unsure, check this box.

☐ Unsure (1)

Q6 What is your gender identity? (Some examples of gender identity include cisgender (my gender identity matches the sex I was assigned at birth), transgender, gender fluid, gender queer, two-spirit, etc.)

Q7 If you are unsure, check this box.

☐ Unsure (1)

Q8 About how many students attend/attended your high school?

☐ Less than 100 (1)

☐ 100 to 300 (2)

☐ 300 to 500 (3)

☐ 500 to 1000 (4)

☐ Over 1000 (5)

☐ Do not know (6)

Q9 What grade are you in?

☐ 8th grade (1)

☐ 9th grade (2)

☐ 10th grade (3)

☐ 11th grade (4)

☐ 12th grade (5)

☐ graduated high school (6)

Q10 In what region is/was your school located?

☐ 1-Eastern (green) (1)

☐ 2-North Central (white) (2)

☐ 3-South Central (light blue) (3)

☐ 4-Southwest (purple) (4)

☐ 5- Northwest (dark blue) (5)

Q11 Did your health teacher teach other subjects?

☐ Yes (what other subject?) (1) _____

☐ No (2)

☐ Unsure (3)

Q12 What is the best way that LGBT+ youth can obtain sexuality information?

- ☐ Online (1)
- ☐ Health classes (2)
- ☐ Parents (3)
- ☐ Friends (4)
- ☐ LGBT+ Community (5)
- ☐ Other ways to obtain information about sex: (6) _____

Q13 What was your biggest challenge in high school in regard to your sexuality?
(check all that apply)

- ☐ Not knowing why I was different (1)
- ☐ Keeping my sexual orientation and/or gender identity a secret from friends (2)
- ☐ Keeping my sexual orientation and/or gender identity a secret from family (3)
- ☐ Being bullied or harassed because of my sexual orientation and/or gender expression (4)
- ☐ Not having anyone to date (5)
- ☐ Not being able to accept difference myself (self-acceptance) (6)
- ☐ Not having anyone else to relate to (e.g. other queer friends) (7)
- ☐ Not identifying with a specific label (8)
- ☐ No challenges (9)
- ☐ Other challenges: (10) _____

Q14 What was most helpful, in regard to your sexual health as a high school student? (check all that apply)

- ☐ One of my teachers (1)
- ☐ School counselors (2)
- ☐ A friend (3)
- ☐ My parents/guardians (4)
- ☐ Online support system (social media) (5)
- ☐ A school-based student group like Gay Straight Alliances, Gay Student Associations, or Diversity Clubs (6)
- ☐ Other things or people that were helpful (7) _____
- ☐ Nothing was helpful (8)

Q15 What is your definition of "having sex"? (Check all that apply)

- ☐ Kissing (making out) (1)
- ☐ Touching someone's intimate areas (2)
- ☐ Vaginal/penile sex (3)
- ☐ Anal sex (4)
- ☐ Oral sex (using your mouth only) (5)
- ☐ Digital sex (using hands and fingers only) (6)
- ☐ Dry humping (7)
- ☐ Masturbating with your partner (8)
- ☐ Masturbating alone (9)
- ☐ Other actions you consider to be sex: (10) _____

Q16 What do you know about HIV/AIDS?

Q17 Is there a cure for HIV?

- ☐ Yes (1)
- ☐ No (2)
- ☐ Unsure (3)

Q18 Are there drugs that can prevent HIV?

- ☐ Yes (1)
- ☐ No (2)
- ☐ Unsure (3)

Q19 In which body fluids is the virus that causes HIV found? List as many as you can.

Q20 What are some activities that could lead to HIV transmission? List as many as you can up to 5.

- Activity 1 (1)
- Activity 2 (2)
- Activity 3 (3)
- Activity 4 (4)
- Activity 5 (5)

Q21 During the last 12 months have you experienced extreme sadness for two or more weeks that caused you to stop doing your normal activities?

- ☐ Yes (1)
- ☐ No (2)

Q22 During the last 12 months have you seriously considered suicide?

- ☐ Yes (1)
- ☐ No (2)

Q23 During the last 12 months, how many times have you attempted suicide?

- ☐ 0 times (1)
- ☐ 1 time (2)
- ☐ 2-3 times (3)
- ☐ 4-5 times (4)
- ☐ 6 or more times (5)

Q24 Here is a list of resources for you, if any of the questions made you feel uncomfortable or triggered any negative memories or feelings. Thank you so much for being part of this survey. Your answers will help make a difference in future generations of students.

National Suicide Prevention hotline: 1-800-273-8255

The Trevor Project: 1-866-488-7386

The GLBT National Help Center Youth Talk line: 1-800-246-7743

Appendix B: IRB Approval Form



INSTITUTIONAL REVIEW BOARD for the Protection of Human Subjects in Research

FWA 00000078

Research & Creative Scholarship

University Hall 116

University of Montana

Missoula, MT 59812

Phone 406-243-6672 | Fax 406-243-6330

Date: October 9, 2015

To: Dr. Annie Sondag, Health and Human Performance

From: Paula A. Baker, IRB Chair and Manager

A handwritten signature in blue ink, appearing to read "Paula A. Baker", written over a horizontal line.

RE: IRB #224-15: "Sex Education in Montana's High Schools: Project Phase 1"

Your IRB proposal cited above has been **APPROVED** under **expedited review** by the Institutional Review Board in accordance with the Code of Federal Regulations, Part 46, section 110. Expedited approval refers to research activities that (1) present no more than minimal risk to human subjects, and (2) fit within the following category for expedited review as authorized by 45 CFR 46.110 and 21 CFR 56.110:

7. Research on individual or group characteristics or behavior (including, but not limited to, research on perception, cognition, motivation, identity, language, communication, cultural beliefs or practices, and social behavior) or research employing survey, interview, oral history, focus group, program evaluation, human factors evaluation, or quality assurance methodologies.

Focus Groups: A waiver for the obtainment of written informed consent is granted for this project, as verbal consent will be obtained and the following conditions apply:

1. Participation involves no more than minimal risk to the subjects; and
2. The only record linking the subject and the research would be the consent document and the principal risk would be potential harm resulting from a breach of confidentiality.

Amendments: Any changes to the originally-approved protocol must be reviewed and approved by the IRB **before** being made (unless extremely minor). Requests must be submitted using [Form RA-110](#).

Unanticipated or Adverse Events: You are required to timely notify the IRB if any unanticipated or adverse events occur during the study, if you experience an increased risk to the participants, or if you have participants withdraw from the study or register complaints about the study. Use [Form RA-111](#).

Continuation: Federal and University of Montana IRB policy requires you to file an annual Continuation Report ([Form RA-109](#)) for expedited studies. You must file the report within 30 days **prior** to the expiration date, which is **October 8, 2016**. *Tip: Put a reminder on your calendar now.* A study that has expired is no longer in compliance with federal or University IRB policy, and all project work must cease immediately.

Study Completion or Closure: Finally, you are also required to file a Closure Report ([Form RA-109](#)) when the study is completed or if the study is abandoned. See the directions on the form.

Please contact the IRB office with any questions at (406) 243-6672 or email irb@umontana.edu.



THE UNIVERSITY OF MONTANA-MISSOULA
Institutional Review Board (IRB)
for the Protection of Human Subjects in Research
CHECKLIST / APPLICATION

IRB Protocol No.:

224-15

At the University of Montana (UM), the Institutional Review Board (IRB) is the institutional review body responsible for oversight of all research activities involving human subjects outlined in the U.S. Department of Health and Human Services' Office of Human Research Protection and the National Institutes of Health, Inclusion of Children Policy Implementation.

Instructions: A separate application must be submitted for each project. IRB proposals are approved for no longer than one year and must be continued annually (unless Exempt). Faculty and students may email the completed form as a Word document to IRB@umontana.edu or submit a hardcopy (no staples) to the Office of the Vice President for Research in University Hall 116. Student applications must be accompanied by email authorization by the supervising faculty member or a signed hard copy. *All fields must be completed. If an item does not apply to this project, write in: N/A. Questions? Call the IRB office at 243-6672.*

1. Administrative Information

Project Title: Sex Education in Montana's High Schools: Project Phase 1	
Principal Investigator: Annie Sondag	UM Position: Professor
Department: Health and Human Performance	Office location: McGill 205
Work Phone: 5215	Cell Phone:

2. Human Subjects Protection Training *(All researchers, including faculty supervisors for student projects, must have completed a self-study course on protection of human research subjects within the last three years and be able to supply the "Certificate(s) of Completion" upon request. If you need to add rows for more people, use the Additional Researchers Addendum.)*

All Research Team Members (list yourself first)	PI	CO-PI	Faculty Supervisor	Research Assistant	DATE COMPLETED Human Subjects Protection Course
Name: Annie Sondag Email: annie.sondag@umontana.edu	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	11/18/2012 → Re-new
Name: Elizabeth Redinger Email: elizabeth.redinger@umontana.edu	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	8/11/2015
Name: Email:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Name: Email:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

3. Project Funding *(If federally funded, you must submit a copy of the abstract or Statement of Work.)*

Is grant application currently under review at a grant funding agency? <input checked="" type="checkbox"/> Yes <i>(If yes, cite sponsor on ICF if applicable)</i> <input type="checkbox"/> No			Has grant proposal received approval and funding? <input checked="" type="checkbox"/> Yes <i>(If yes, cite sponsor on ICF if applicable)</i> <input type="checkbox"/> No		
Agency	Grant No.	Start Date	End Date	PI on grant	
MTDPHHS		1-15-15	12-31-15	K. "Annie" Sondag	

For UM-IRB Use Only

IRB Determination:

- ☐ Not Human Subjects Research
☒ Approved by Exempt Review, Category # _____ *(see memo)*
☒ Approved by Expedited Review, Category # 7 *(see Note to PI)*
☐ Full IRB Determination *with Waiver*
☐ Approved *(see Note to PI)*
☐ Conditional Approval *(see memo)* - IRB Chair Signature/Date: _____
☐ Conditions Met *(see Note to PI)*
☐ Resubmit Proposal *(see memo)*
☐ Disapproved *(see memo)*

Note to PI: Non-exempt studies are approved for one year only. Use any attached IRB-approved forms (signed/dated) as "masters" when preparing copies. If continuing beyond the expiration date, a continuation report must be submitted. Notify the IRB if any significant changes or unanticipated events occur. When the study is completed, a closure report must be submitted. Failure to follow these directions constitutes non-compliance with UM policy.

Risk Level: Minimal

Final Approval by IRB Chair/Manager: [Signature] Date: 10/9/2015 Expires: 10/8/2016

SUBJECT INFORMATION AND INFORMED CONSENT

Study Title: An Assessment of the HIV/STD Prevention Needs of Montana's Sexual Minority Youth: Phase One

Sponsor: Montana Department of Health and Human Services

Investigator(s):

Dr. Annie Sondag, Professor, Health and Human Performance, McGill Hall
Beth Redinger, Graduate Student, HHP Community Health and Prevention Sciences, McGill Hall

Special Instructions:

This consent form may contain words that are new to you. If you read any words that are not clear to you, please ask the person who gave you this form to explain them to you.

Inclusion Criteria:

- Male-identified sexual minority
- Between the ages of 18-25

Purpose:

You have been invited to participate in this focus group because your insights and opinions are important to us. We would like to hear your ideas about the best way we can collect information about the experiences of students enrolled in sex education classes in Montana's public high schools. We are particularly interested in the experiences of individuals who identify as a member of a sexual minority.

Procedures:

If you agree to take part in this research study, you will be participating in a focus group. Dr. Sondag and I will ask a series of questions, and we hope that you answer as honestly as possible. This session will last for approximately 60 to 90 minutes.

Payment for Participation:

For your time today, at the beginning of the focus group, each of you will receive \$25.00 cash. You may keep the incentive money even if you decide you do not want to answer focus group questions or decide you would like to discontinue your participation at any time.

Risks/Discomforts:

There is no anticipated discomfort for those contributing to this study, so risk to participants is minimal. However, answering the questions may cause you to think about feelings/experiences that make you sad or upset.

Benefits:

Your participation in this study may help the Montana Department of PublicHealth and Human Services create a strong argument for improving the sex education requirements in Montana's public schools.

The University of Montana IRB	
Expiration Date	<u>10-8-2016</u>
Date Approved	<u>10-9-2015</u>
Chair/Admin	<u>Shirley L. DeBruin</u>

Confidentiality:

Your records will be kept confidential and will not be released without your consent except as required by law. If the results of this study are written in a scientific journal or presented at a scientific meeting, your name will not be used. Your identity will be kept private. The audio-recording will be transcribed without any information that could identify you. The recording will then be erased.

Voluntary Participation/Withdrawal:

Your decision to take part in this research study is entirely voluntary.

You may refuse to take part in, or you may withdraw from the study at any time without penalty.

You may be asked to leave the study for any of the following reasons:

1. Failure to follow the Project Director's instructions;
2. A serious adverse reaction which may require evaluation;
3. The Project Director thinks it is in the best interest of your health and welfare; or
4. The study is terminated.

Questions:

If you have any questions about the research now or during the study, please contact: Annie Sondag: annie.sondag@umontana.edu; phone 406-243-5215.

If you have any questions regarding your rights as a research subject, you may contact the UM Institutional Review Board (IRB) at (406) 243-6672.

Statement of Your Consent:

I have read the above description of this research study. I have been informed of the risks and benefits involved, and all my questions have been answered to my satisfaction. Furthermore, I have been assured that any future questions I may have will also be answered by a member of the research team. I voluntarily agree to take part in this study. I understand I will receive a copy of this consent form.

(verbal consent)

Statement of Consent to be Audiotaped

- o I understand that audio recordings may be taken during the study.
- o I consent to being audio recorded
- o I consent to use of information from my audio recording in presentations related to this study.
- o I understand that if information from the audio recordings are used for presentations of any kind, names or other identifying information will not be associated with them.
- o I understand that audio recordings will be destroyed following transcription, and that no identifying information will be included in the transcription.

(verbal consent)

The University of Montana IRB	
Expiration Date	<u>10-8-2016</u>
Date Approved	<u>10-9-2015</u>
Chair/Admin	<u>[Signature]</u>

Appendix C: Social Media Invitation

Online Script:

I have been asked to invite my LBGTQI+ friends, to take a survey asking about their perceptions of high school sex education classes in Montana. The University of Montana and the Montana state public health department are interested in whether sex education classes are providing LBGTQI+ (sexual and gender minority) students with the information and skills they need to stay safe and healthy.

If you consider yourself to be part of the sexual and/or gender minority community, are between the ages of 18 and 24, and attended a high school in Montana we need your input.

Click on this link https://umt.co1.qualtrics.com/SE/?SID=SV_a3La6F7oXfOgFIH to take an ANONYMOUS 10-15 minute survey and have the opportunity to contribute to the movement for inclusive, comprehensive sex education in Montana and put your name in a drawing for one of TEN \$25 Amazon gift cards.

This is an equal opportunity survey, so If you do not identify as a member of the sexual and/or gender minority community, but are between the ages of 18 and 24 and attended high school in Montana, we welcome your participation as well.

Appendix D: Email Invitation for Participation

Greetings, (names of emailed contacts),

My name is Beth Redinger, and I am Dr. Annie Sondag's graduate research assistant at the University of Montana in Community Health and Prevention Sciences.

We are interested in what young adults remember about their sex education classes in high school. Specifically, we want to know if sex education classes are meeting the needs of LBGT+ students.

We developed an electronic survey for 18 to 24 year old Montanans. The survey is completely anonymous, and will take about 10 to 15 minutes to complete. The survey has been approved by the University's institutional review board for research involving human subjects.

We are hoping you'd be willing to post the link to the survey on your organization's website or Facebook page in order to attract more participants. If you are over 24 years of age and would like to review the survey before posting the link, please simply click through the questions without answering them. Here is the link: https://umt.co1.qualtrics.com/SE/?SID=SV_a3La6F7oXfOgFIH

We hope to share the results of the survey with policy makers throughout the state and ultimately make a positive impact on sex education curricula. If you have any questions or concerns, please do not hesitate to email me at this address: elizabeth.redinger@umontana.edu.

Recruitment scripts that have been approved by the university's institutional review board are attached. Include a script with the survey link if possible.

(Although we are particularly interested in the needs of LBGT+ students, we invite all Montanans between the ages of 18 and 24 to take the survey. There will be an opportunity at the end to enter a drawing for one of 10 \$25 Amazon.com gift cards)

Have a great day!

Sincerely,

Beth Redinger

Appendix E: National Standards for Sex Education

Curriculum Mapping Tool Alignment with National Sexuality Education Standards Grades 9-12 Strands 1-7

Note: The complete National Sex Ed Standards is available online at www.futureofsexeducation.org

Curriculum Title:
Author & Publisher:
Publication date:

By end of 12th Grade

STRAND 1: ANATOMY & PHYSIOLOGY

National Standards Core Concepts	<i>Rubric score for how completely standard is addressed</i> <i>Key: 0= not at all; 1=partially; 2=fully</i>	<i>Included at another grade level and/or in a different content area? If so, where?</i>	<i>Lesson title and page number that applies</i>
AP.12.CC.1 Describe the human sexual response cycle, including the role hormones play			

STRAND 2: PUBERTY & ADOLESCENT DEVELOPMENT

National Standards Core Concepts	<i>Rubric score for how completely standard is addressed</i> <i>Key: 0= not at all; 1=partially; 2=fully</i>	<i>Included at another grade level and/or in a different content area? If so, where?</i>	<i>Lesson title and page number that applies</i>
PD.12.CC.1 Analyze how brain development has an impact on cognitive, social and emotional changes of adolescence and early adulthood			
PD.12.INF.1 Analyze how friends, family, media, society and culture can influence self-concept and body			

image			
PD.12.DM.1 Apply a decision- making model to various situations relating to sexual health			

STRAND 3: IDENTITY

National Standards Core Concepts	<i>Rubric score for how completely standard is addressed</i> <i>Key: 0= not at all; 1=partially; 2=fully</i>	<i>Included at another grade level and/or in a different content area? If so, where?</i>	
ID.12.CC.1 Differentiate between biological sex, sexual orientation, and gender identity and expression			
ID.12.CC.2 Distinguish between sexual orientation, sexual behavior and sexual identity			
ID.12.INF.1 Analyze the influence of friends, family, media, society and culture on the expression of gender, sexual orientation and identity			
ID.12.SM.1 Explain how to promote safety, respect, awareness and acceptance			

ID.12. ADV.1 Advocate for school policies and programs that promote dignity and respect for all			
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STRAND 4: PREGNANCY AND REPRODUCTION

National Standards Core Concepts	<i>Rubric score for how completely standard is addressed</i> <i>Key: 0= not at all; 1=partially; 2=fully</i>	<i>Included at another grade level and/or in a different content area? If so, where?</i>	
PR .12.CC.1 Compare and contrast the advantages and disadvantages of abstinence and other contraceptive methods, including condoms			
PR .12.CC.2 Define emergency contraception and describe its			

mechanism of action			
PR .12.CC.3 Identify the laws related to reproductive and sexual health care services (i.e., contraception, pregnancy options, safe surrender policies, prenatal care)			
PR .12.CC.4 Describe the signs of pregnancy			
PR .12.CC.5 Describe prenatal practices that can contribute to or threaten a healthy pregnancy			
PR .12.CC.6 Compare and contrast the laws relating to pregnancy, adoption, abortion and parenting			
PR .12.INF.1 Analyze influences that may have an impact on deciding whether or when to engage in sexual behaviors			
PR .12.INF.2 Analyze internal and external influences on decisions about pregnancy options			
PR .12.INF.3 Analyze factors that influence decisions about whether and when to become a parent			
PR .12. AI.1 Access medically-accurate information about contraceptive methods, including abstinence and condoms			
PR .12. AI.2 Access medically-accurate information and resources about emergency contraception			
PR .12. AI.3 Access medically-accurate information about pregnancy and pregnancy options			
PR .12. AI.4 Access medically-accurate information about prenatal care services			
PR .12.IC.1 Demonstrate ways to communicate decisions about whether or when to engage in sexual behaviors			
PR .12.DM.1 Apply a decision-making model to choices about contraception, including abstinence and condoms			
PR .12.DM.2 Assess the skills and resources needed to become a parent			
PR .12.SM.1 Describe the steps to using a condom correctly			

STRAND 5: SEXUALLY TRANSMITTED DISEASES & HIV

National Standards Core Concepts	<i>Rubric score for how completely standard is addressed</i> <i>Key: 0= not at all; 1=partially; 2=fully</i>	<i>Included at another grade level and/or in a different content area? If so, where?</i>	<i>Lesson title and page number that applies</i>
SH.12.CC.1 Describe common symptoms of and treatments for STDs, including HIV			
SH.12.CC.2 Evaluate the effectiveness of abstinence, condoms, and other safer sex methods in preventing the spread of STDs, including HIV			
SH.12.CC.3 Describe the laws related to sexual health care services, including STD and HIV testing and treatment			
SH.12.INF.1 Analyze factors that may influence condom use and other safer sex decisions			
SH.12.AI.1 Explain how to access local STD and HIV testing and treatment services			
SH.12.AI.2 Access medically-accurate prevention information about STDs, including HIV			
SH.12.IC.1 Demonstrate skills to communicate with a partner about STD and HIV prevention and testing			
SH.12.DM.1 Apply a decision-making model to choices about safer sex practices, including abstinence and condoms			
SH.12.GS.1 Develop a plan to eliminate or reduce risk for STDs, including HIV			
SH.12.SM.1 Analyze individual responsibility			

about testing for and informing partners about STDs and HIV status			
SH.12.SM.2 Describe the steps to using a condom correctly			
SH.12.ADV.1 Advocate for sexually active youth to get STD/HIV testing and treatment			

STRAND 6: HEALTHY RELATIONSHIPS

National Standards Core Concepts	<i>Rubric score for how completely standard is addressed</i> <i>Key: 0= not at all; 1=partially; 2=fully</i>	<i>Included at another grade level and/or in a different content area? If so, where?</i>	<i>Lesson title and page number that applies</i>
HR.12.CC.1 Describe Characteristics of healthy and unhealthy romantic and/or sexual relationships			
HR.12.CC.2 Describe a range of ways to express affection within healthy relationships			
HR.12.CC.3 Define sexual consent and explain its implications for sexual decision making			
HR.12.CC.4 Evaluate the potentially positive and negative roles of technology and social media in relationships			
HR.12.INF.1 Explain how media can influence one's beliefs about what constitutes a healthy sexual relationship			
HR.12.INF.2 Analyze factors, including alcohol and other substances, that can affect the ability to give or perceive the provision of consent to sexual activity			
HR.12.AI.1 Demonstrate how to access valid information and resources			

to help deal with relationships			
HR.12.IC.1 Demonstrate effective strategies to avoid or end an unhealthy relationship			
HR.12.IC.2 Demonstrate effective ways to communicate personal boundaries as they relate to intimacy and sexual behavior			
HR.12.SM.1 Demonstrate respect for the boundaries of others as they relate to intimacy and sexual behavior			
HR.12.SM.2 Describe strategies to use social media safely, legally and respectfully			

STRAND 7: PERSONAL SAFETY

National Standards Core Concepts	<i>Rubric score for how completely standard is addressed Key: 0= not at all; 1=partially; 2=fully</i>	<i>Included at another grade level and/or in a different content area? If so, where?</i>	<i>Lesson title and page number that applies</i>
PS.12.CC.1 Compare and contrast situations and behaviors that may constitute bullying, sexual harassment, sexual abuse, sexual assault, incest, rape and dating violence			
PS.12.AI.1 Access valid resources for help if they or someone they know are being bullied or harassed, or have been sexually abused or assaulted			
PS.12.IC.1 Demonstrate effective ways to communicate with trusted adults about bullying, harassment, abuse or assault			
PS.12.ADV.1 Advocate for safe environments that encourage dignified and respectful treatment of everyone			
PS.12.CC.2 Analyze the laws related to bullying, sexual			

harassment, sexual abuse, sexual assault, incest, rape and dating violence			
PS.12.INF.1 Describe potential impacts of power differences (e.g., age, status or position) within sexual relationships			
PS.12.AI.2 Demonstrate ways to access accurate information and resources for survivors of sexual abuse, incest, rape, sexual harassment, sexual assault and dating violence			
PS.12.IC.2 Identify ways in which they could respond when someone else is being bullied or harassed			
PS.12.CC.3 Explain why using tricks, threats or coercion in relationships is wrong			
PS.12.INF.2 Analyze the external influences and societal messages that impact attitudes about bullying, sexual harassment, sexual abuse, sexual assault, incest, rape and dating violence			
PS.12.CC.4 Explain why a person who has been raped or sexually assaulted is not at fault			