



Bixby Center
for **Global**
Reproductive
Health



University of California San Francisco

Uneven Progress: Sex Education in California Public Schools

Sarah Combellick, MPH

Claire Brindis, DrPH

November 2011

Executive Summary

The state of California has an established leadership history of promoting the sexual and reproductive health of its adolescent population. It has paved the way for other states by pioneering a legislative emphasis on evidence-based, medically accurate sex education. In 2003, the State Senate passed the California Comprehensive Sexual Health and HIV/AIDS Prevention Education Act (Senate Bill [SB] 71). Prior to this legislation, the law was a conglomerate of confusing and contradictory topic-specific amendments. The passage of SB71 was a key landmark on the road towards ensuring the health of California youth, but there is much work still to be done. California's state financial crisis has eroded much of its network of valuable preventive health programs for young people, making schools one of the last strongholds for providing adolescents with comprehensive sex education. The current study was developed in order to examine the status of sex education in California public schools and to describe any changes to sex education following implementation of the requirements of SB 71. A survey was distributed in the fall and winter of 2010/2011 to a representative sample of 100 unified school districts in California; 33 surveys were completed by school district officials most knowledgeable of the district's policies and practices around sex education.

All of the school districts in this study reported providing HIV/AIDS prevention education and all but one reported providing sex education. Instruction was most often provided in the 7th (79%) and 9th (73%) grades, in a Health class (70%), and by a Health (55%) or Science teacher (36%). Over one-third (37%) of districts reported no training requirement for sex education teachers. A significant minority of districts had policies which did not comply with the California Education Code. For example, one out of every five districts (21%) had non-compliant policies that parents must sign a permission slip for their child to participate in HIV/AIDS prevention education. Additionally, one out of five districts (19%) reported that in their instruction, birth control methods were mentioned, but most of the time was spent on the benefits of abstinence. Furthermore, 16% of districts reported that they teach that *"condoms are not an effective means of preventing pregnancies and STDs/HIV"*, an inaccurate statement.

Many school districts did not cover HIV/AIDS prevention and sex education topics which are mandated by the California Department of Education. Just six out of ten districts (58%) taught about FDA-approved methods of contraception in middle and high school, and just one out of four (25%) taught about emergency contraception in both middle and high school. In comparison, eight out of ten districts (82%) taught about abstinence at the middle and high school levels.

Additionally, school districts in the study may not have been teaching HIV/AIDS prevention and sex education in the most effective ways. Several districts combined different sections of textbooks, published curricula, and self-developed curricula, often omitting parts of or adding to a curriculum. Several districts used written materials that were out-of-date.

Almost half of districts (47%) reported that their policies on HIV/AIDS prevention and sex education had been revised or changed significantly since 2004. Most districts had done so in response to the changes to the law implemented as a result of SB 71, indicating that SB 71 has helped to clarify California's sex education law. However, as findings from this study show, many schools are out of compliance with the California Education Code when it comes to teaching these important topics. Thus, many California students are not receiving the sex education which they deserve and which is required by law. Recommendations for changes are suggested for the state legislature, the California Department of Education, school districts, teachers, parents, students, and community members.

Background

In California, teenage pregnancies and births have declined significantly over the past two decades. In 2009, the birth rate among California teens reached a record low of 32.1 births per 1,000 teens. In contrast, when teen births reached their peak in California in 1991, the teen birth rate was 70.9, more than twice as high as the rate in 2009.¹ Despite California's improvements in reducing births to teens, the state's teen birth rate remains higher than the rate in many developed nations. Moreover, rates of some sexually transmitted diseases, such as Chlamydia, remain stubbornly high among California teens, particularly those of racial/ethnic minorities.²

Curriculum-based, comprehensive sexuality education, which involves instruction that includes a focus on abstinence, as well as inclusive information about contraception and sexually transmitted diseases, has been shown to delay sexual activity, improve contraceptive use among sexually active teens, and/or prevent teen pregnancy.³ No comprehensive program has been shown to hasten the initiation of sex or increase the frequency of sex, results that many people fear. Emphasizing both abstinence and protection for those who do have sex is a realistic, effective approach that does not appear to confuse young people.⁴

Middle schools and high schools present an important opportunity to provide sex education. The vast majority of adolescents attend school, where research indicates that most students receive some form of sex education.⁵ However, the type of sex education received varies considerably, with a number of schools taking an "abstinence-only" approach.⁶

Current policy framework towards sex education in California

HIV/AIDS prevention education and sex education in California public schools are governed by the California Education Code. The law requires that HIV/AIDS prevention education, defined as "instruction on the nature of HIV/AIDS, methods of transmission, strategies to reduce the risk of HIV infection, and social and public health issues related to HIV/AIDS," be taught at least once in junior high or middle school and at least once in high school. Sex education is not legally required; however, when it is taught, it must satisfy certain requirements regarding content, including taking a comprehensive rather than abstinence-only approach.

In 2003, the California legislature passed Senate Bill (SB) 71, the California Comprehensive Sexual Health and HIV/AIDS Prevention Education Act, which strengthened and clarified the Education Code requirements for sex education and HIV/AIDS Prevention Education. Now Education Code 51930-51939, it requires that instruction be age appropriate; medically accurate and objective; available on an equal basis to English language learners; appropriate for use with pupils of all races, genders, sexual orientations, and ethnic and cultural backgrounds; and appropriate for and accessible to pupils with disabilities. Instruction in grades 7-12 must include information about both abstinence and all FDA-approved methods for preventing pregnancy and sexually transmitted diseases. Abstinence-only education is not permitted.

Previous research on sexuality education in California schools

In 2003, prior to the passage of SB 71, PB Consulting conducted an assessment of sex education in California public schools.⁷ Structured telephone interviews with representatives from 153 unified school districts in California (or 47% of unified districts in the State) revealed that schools were generally not in compliance with the older Education Code sections governing sexuality and HIV/AIDS education, despite

the fact that the vast majority taught HIV/AIDS prevention education (94%) and/or sexuality education (96%). Nearly half (48%) failed to cover required topics as part of their curriculum or instruction, six in ten (58%) had no teacher training requirement for HIV/AIDS prevention instructors, and 39% had improper parental notification and consent policies in place. Most importantly, 13% were not teaching any HIV/AIDS prevention in middle or high school.

In addition to these clear violations of the laws and policies related to sexuality education, the 2003 survey also revealed other important issues that likely influenced the extent and quality of sexual health information received by California students. Many respondents described using outdated curriculum, developing their own curriculum using a combination of resources, and/or adapting existing curriculum to fit time or content constraints specific to their school and/or district. Other survey respondents noted that policies set at the district level may not correspond to the actual instruction taking place in the classroom due to local teacher or parent preferences, misinterpretation of the policy at the local level, or other factors.

Purpose of the Current Study

The current study was developed in order to conduct a second assessment of sex education in California schools several years after the passage of SB 71. The purpose of the study was to examine the current status of sex education in California public schools and describe any changes to the status of sex education following implementation of the requirements of Education Code 51930-51939. The aims of the study were to: 1) depict the proportion of school districts providing HIV/AIDS prevention education and sex education, and 2) describe the content of such instruction, how and when such education is taught, school districts’ policies regarding certain aspects of instruction, and challenges faced in implementing instruction

Survey Methodology

Survey Development

Two structured survey tools were created by the UCSF research team. The first survey was created to be answered by the school district official who was most knowledgeable of the district’s policies and practices around sex education. The tool consisted of a combination of closed and open-ended questions. Many of the questions from the 2003 survey instrument developed by PB Consulting were retained or were modified in order to allow for comparisons over time. Topics covered included:

Topics covered by Sex Education Assessment (2010-2011)				
Overall Instruction	Curriculum & Content	Delivery	Policy	
- HIV/AIDS prevention education taught?	- Topics covered/banned	- Timing of instruction	- Existence of policy on HIV/AIDS and sexuality education	
- Sexuality education taught?	- Curriculum used	- Setting of instruction	- Requirements for parental involvement	
- HIV/AIDS and sexuality	- Extent of adaptation of curriculum	- Hours devoted to instruction	- Perceived clarity	
	- Development/updates to curriculum	- Instructor/use of external organizations		

<p>education taught concurrently?</p>	<ul style="list-style-type: none"> - Training for instructors - Fidelity between policy and instruction 	<ul style="list-style-type: none"> of state and local laws and guidelines - Experienced and perceived barriers to implementation - Resources used/needed
---	---	---

The tool was pilot tested with a small sample of four school district administrators and revised for length and question understanding. The second survey tool was an adaptation of the first tool, created to be answered by middle and high school sex education instructors.

Sample Selection

Two samples were drawn for the purposes of this study, a sample of school districts and a sample of sex education instructors. Only unified school districts were selected for participation in this study. Two random samples of eligible unified school districts were selected. In order to be able to make comparisons over time, a random sample of 60 school districts were selected that had participated in the 2003 survey. A random sample of 40 districts that had not participated in the 2003 survey was also selected for a total of 100 eligible districts.

The teacher sample was a convenience sample created by asking district officials who responded to the school district survey to refer us to a sex education instructor of their choice in their district. This sampling strategy resulted in 20 eligible teachers.

Survey Administration

Data collection began in October 2010 and was completed in March 2011. District officials and teachers were contacted via phone and email and asked if they would like to participate in the study. Respondents had the choice to complete the survey over the phone by a trained telephone interviewer or to complete an online survey using the website www.zoomerang.com. Informed consent was obtained verbally for the telephone respondents and through a written information sheet for online respondents. All respondents received a small incentive (\$15 gift card) for their participation. Non-responders received up to eight follow-up phone calls and emails from a research assistant. The final samples contained responses from 33 district officials (response rate: 33%) and 7 teachers (response rate: 35%).

Data Analysis

All survey data was entered into a database in Zoomerang. Zoomerang programming performed basic descriptive statistics on the quantitative questions. Qualitative responses were analyzed by a UCSF researcher familiar with qualitative analysis techniques.

All study materials and procedures were approved by the University of California, San Francisco Committee on Human Research (CHR).

Limitations

Several limitations must be taken into consideration when interpreting the results of this study. First, the sample of both the district officials and the teachers is very small. The 33 districts for which survey data is available represent just 10% of unified school districts in the state. However, the districts surveyed do represent over 400,000 students. Second, it was difficult, even with the offer of an incentive to convince many district officials to participate in the study. Those that eventually chose to participate were particularly motivated to do so and may be qualitatively different in their policies and practices from those who did not choose to participate. Third, because of the small sample size, we were unable to make comparisons between certain types of districts (i.e., small vs. large, Northern California vs. Southern California). Significant variations in responses may exist which could only be detected by a larger sample. Thus, the results of this study should be interpreted with caution and not be used to generalize about the entire state of California.

Results of District Survey

District Profile

Among the 33 districts that responded to the survey, the largest group was located in Southern California (39%, n=13) (**Figure 1**). The Bay Area and Northern California responded at equal rates of 18% (n=6). The region with the smallest share of responses was the Sacramento/High Desert region, having only one respondent (3%).

Figure 1. Geographic Distribution of the Study Sample (N=33)		
Region	# Districts Responded	% Districts Responded
Northern	6	18%
Bay Area	6	18%
Central Valley	4	12%
Central Coast	3	9%
Sacramento/High Desert	1	3%
Southern	13	39%
<i>Total</i>	<i>33</i>	<i>100%</i>

Figure 2 shows selected characteristics of districts in the sample (responders and non-responders) compared to California unified school districts as a whole. Overall, the 33 districts that responded to the survey are similar to those districts in the sample that did not respond to the survey and to unified school districts as a whole. For example, enrollment levels are similar in all three groups when broken down into districts with: 1) less than 1,000 students, 2) 1,000-9,999 students, and 3) 10,000 students or more. Additionally, the average percent minority enrollment was very similar across groups (55 -58%), as was the average percent of student receiving free or reduced price meals (49 -53%).

Figure 2. Selected Characteristics of Sex Education Assessment Responders, Non-Responders, and California Unified Districts as a Whole, 2010-2011

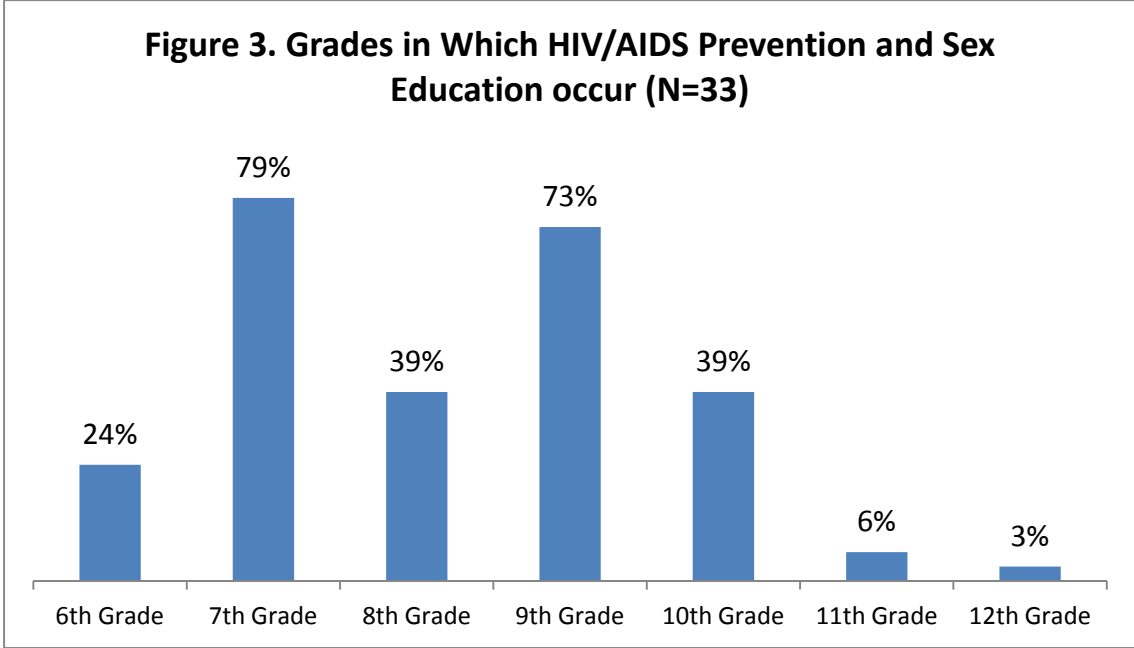
	Random Sample of Unified Districts (N=100)		All California Unified Districts (N=333)
	# Districts Responded (N=33)	# Districts Declined/Unable to Contact (N=67)	
Enrollment	Average = 14,779 students	Average = 21,996 students	Average = 13,054
≤999	5 (15%)	9 (13%)	52 (16%)
1,000-9,999	16 (49%)	33 (50%)	163 (49%)
≥10,000	12 (36%)	25 (37%)	116 (35%)
Total	33 (100%)	67 (100%)	133 (100%)
Average % Minority	55.97%	58.25%	56.71%
Average % Free or Reduced Meals	49.16%	53.74%	50.24%

Sexuality and HIV/AIDS Prevention Education: Overview

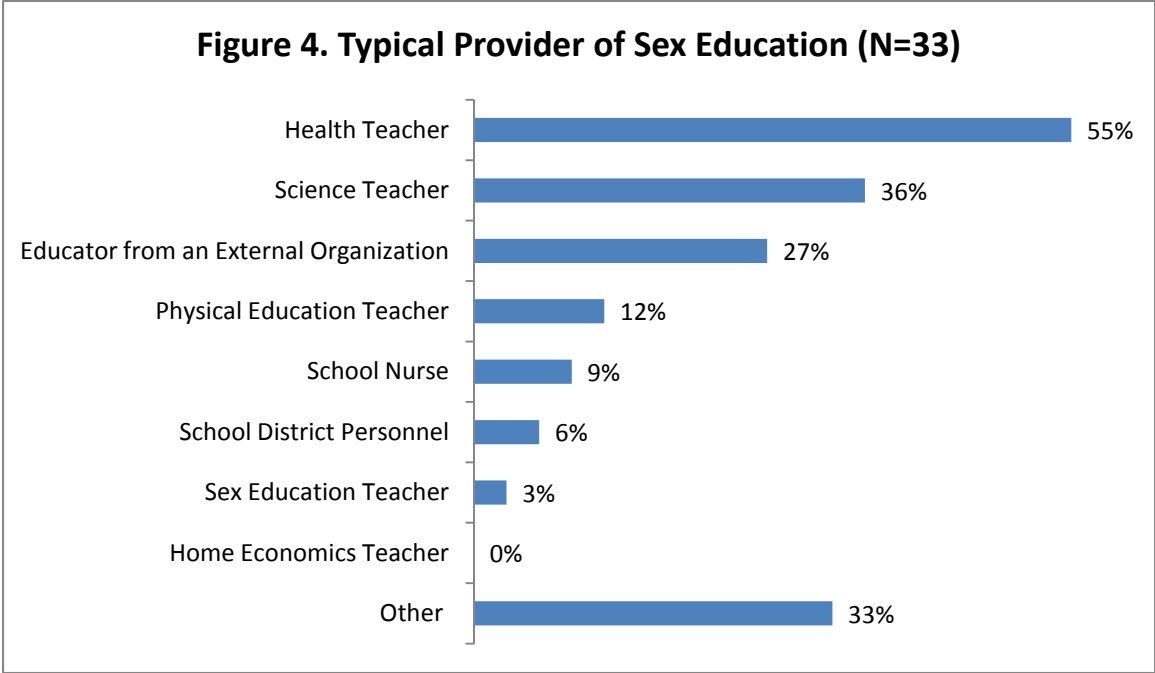
All districts (100%, n=33) reported providing HIV/AIDS prevention education and 97% (n=32) reported providing sex education in their districts. Nearly all districts had a written policy governing HIV/AIDS prevention education (94%, n=30) and sex education (90%, n=27). In the vast majority of districts (97%, n=31), HIV/AIDS prevention education and sex education were taught together (*Note: For the remainder of this report “sex education” refers to both HIV/AIDS prevention education AND sex education*).

Delivery of Sexuality and HIV/AIDS Prevention Education

Districts taught sex education most frequently in the 7th (79%, n=26) and 9th (73%, n=24) grades (**Figure 3**). More rarely it was taught in 6th grade (24%, n=8), 8th grade (39%, n=13), or 10th grade (39%, n=13). Very rarely it was taught in 11th or 12th grade. Sex education was most frequently taught in a Health class (70%, n=23). Fewer districts taught the class in a Science class (48%, n=16), State Requirements class (9%, n=3), or other class (30%, n=10; typically physical education (n=6)). In 88% of cases (n=29) the class in which sex education was taught was a required class rather than an elective.



Sex education instruction was typically provided by a Health teacher (55%, n=18), Science teacher (36%, n=12), an educator from an external organization (27%, n=9), or “Other” (33%, n=11) (Figure 4).



Use of External Organizations for Sex Education instruction

Those districts that used external organizations were asked additional questions pertaining to that experience. External organizations used were typically nonprofit, community-based organizations such as Planned Parenthood, the American Red Cross or a local medical center, though one district used a teacher from the local county health department. The amount of time the district had worked with the external organization ranged from one to 25 years, with most districts reporting relationships of 7-10 years. When asked what originally motivated the district to seek out an external organization to provide this type of instruction, respondents stated that the external organization had expertise beyond that that their teachers could provide (n=3), that they had a small staff and were unable to have their own staff members trained (n=1), or that the external organization sought out the school district first (n=2). All nine districts reported that there was a review and approval process by the district before an external organization is brought in. The process typically included review and approval by the school board (n=2), superintendent (n=1), or school principal (n=1). In two cases the review and approval process also involved teachers and parents.

Required Training and Certification

Respondents were asked if any trainings or certifications were required in order to deliver sex education at schools in their district. At least one training was required of instructors in 63% of districts (n=20). The training requirement ranged from a one-time training to re-training every one, two, three, or four years. In some cases, re-training was required on an “as needed” basis, for example, when a new curriculum was going to be offered. Thirty-six percent of districts (36%, n=12) conducted or hosted trainings for sex education teachers every year (n=4), every other year (n=2) or every four years (n=1). One district offered training just once upon hiring the instructor. Only one district required that instructors have a Health teaching credential.

Number of Hours of HIV/AIDS prevention and sex education instruction

All public schools in California are required to teach HIV/AIDS prevention education once in middle school and once in high school. The actual number of hours taught in middle school reported by respondents ranged from zero (HIV/AIDS prevention education not taught in middle school) to 30 hours, with an average of 6.5 hours. Seventeen districts (65%) taught less than ten hours of HIV/AIDS prevention education in middle school. The number of hours of HIV/AIDS prevention education reported for high school ranged from one hour to 25 hours, with an average of 7.7 hours. Eighteen districts (75%) taught less than ten hours of HIV/AIDS prevention education in high school.

Public schools in California are not required to teach sex education. Nonetheless, school districts were asked how many hours of sex education instruction students receive in middle school (*Note: sex education hours may or may not overlap with HIV/AIDS prevention education instruction*). Responses ranged from 0 (sex education not taught in middle school) to 30 hours, with an average of 9.0 hours. In high school, students received between zero and 36 hours of sex education instruction, with an average of 8.9 hours.

Written Materials used in Sexuality and HIV/AIDS Prevention Instruction

Most school districts used a combination of textbooks and written curricula for their sex education instruction. The majority of districts (58%, n=18) used a **textbook** to deliver sex education instruction. The most commonly used textbooks were Glencoe Health (n=5) and Holt Health (n=4). Other textbooks used included Prentice Hall (n=1) and Health Essentials (n=1). Nine respondents (27%) reported using a

sexuality education supplement that came with the textbook. No respondents stated that they omit parts of the textbook or supplement, but several stated that they add to the written materials with items such as videos, up-to-date statistics on birth control methods, pamphlets created by organizations such as Education, Training, and Research (ETR) Associates, and by including guest speakers.

The majority of districts (69%, n=22) also reported using a **published curriculum** to deliver sex education instruction. The most popular curriculum was Positive Prevention by the American Red Cross (n=6). Others included Teen Talk Middle School (n=1), Flash Curriculum (n=1), Health by Pierson Print Company (n=1), and Postponing Sexual Involvement by CAPSLOW (n=1). When asked about adaptations made to the curriculum, one district reported reducing the curriculum so that it would fit into the limited number of health classes offered and another district took parts of two different curricula and merged them together. Another respondent mentioned that individual teachers add to their curriculum based on their level of experience and training. Several districts added to the curriculum with more recent facts and statistics and outside speakers. One district mentioned that they had to add to their curriculum in order to be compliant with state requirements (they had received assistance from a state representative to do so).

Forty percent (40%, n=10) of districts reported using a **self-developed curriculum** to deliver sex education instruction. When prompted for what resources or materials were used to develop the curriculum, respondents cited American Red Cross HIV/AIDS resources, a peer education program, or “lots of local resources”.

Figure 5 shows the distribution of written materials used by districts in sex education instruction.

Figure 5. Distribution of Written Materials Used for Sex Education (N=33)		
Curriculum Type	# of Schools	% of schools
Textbook Only	4	12%
Published Curriculum Only	7	21%
Self-Developed Curriculum Only	4	12%
Textbook and Published Curriculum	10	30%
Textbook and Self-Developed Curriculum	1	3%
Published and Self-Developed Curricula	2	6%
Textbook, Published and Self-Developed Curricula	3	9%
None	2	6%

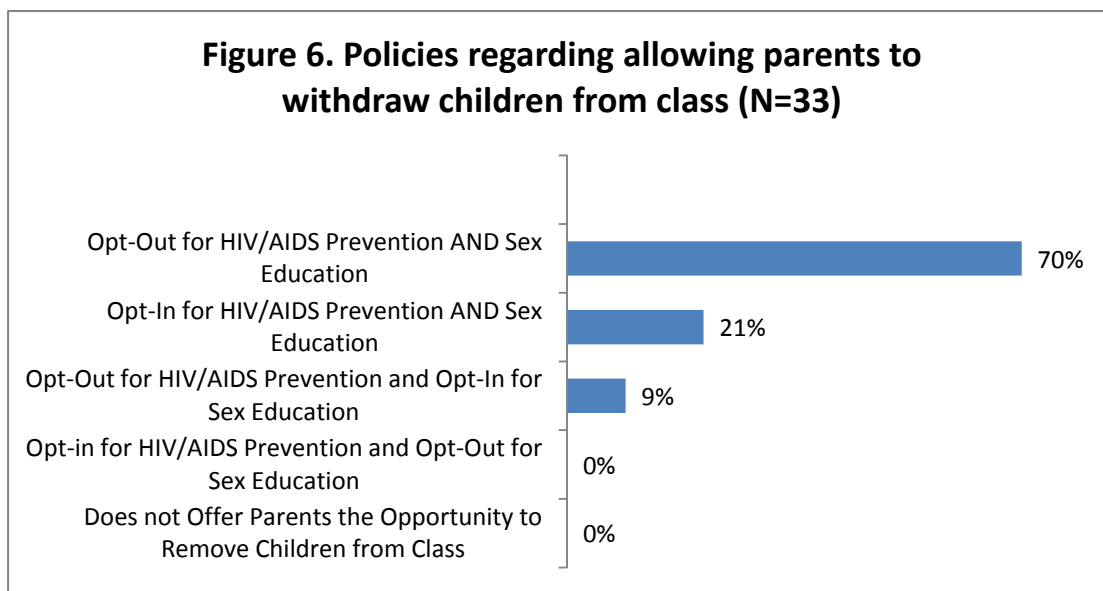
Respondents were asked how often they updated their instructional materials. Five districts did so on an annual basis, two did so when “new materials become available” and one stated that their instructional materials had not been updated since the 1990s (*Note: most respondents chose not to answer this*

question). When asked who was responsible for reviewing and updating instructional materials, 11 respondents mentioned a district administrator, six reported individual teachers, 5 reported a committee, 4 reported an external organization, 3 reported a superintendent or vice-superintendent, 3 reported a curriculum department, and one reported a district nurse.

Current Policies Regarding Sexuality and HIV/AIDS Prevention Education

Policies Regarding Withdrawal of Child from Class

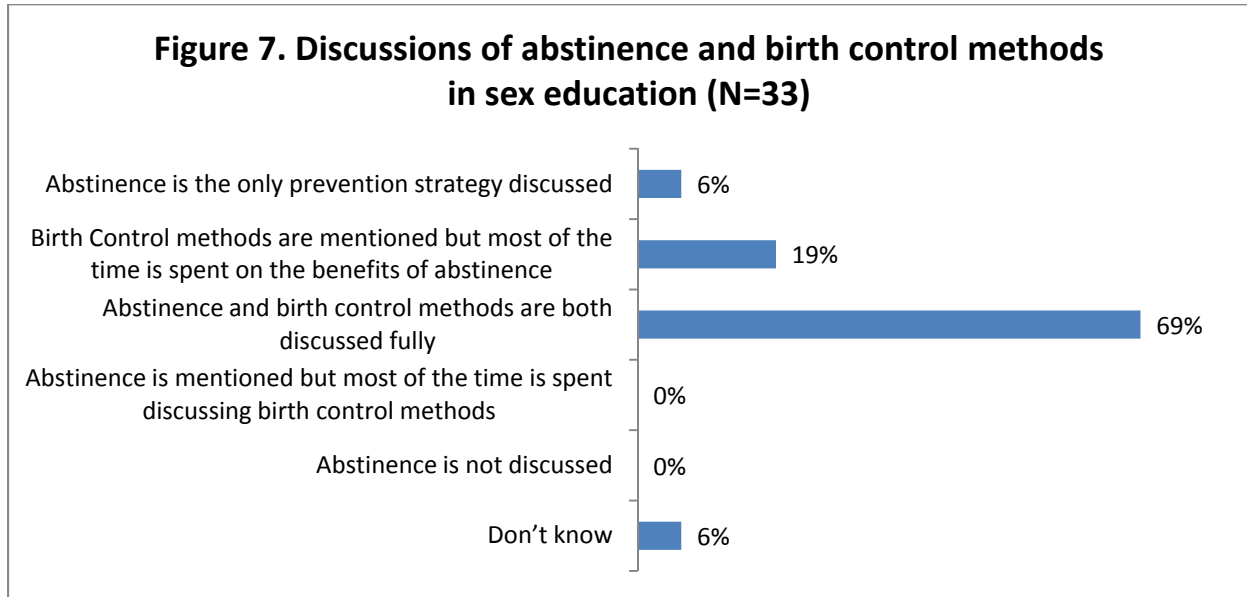
SB 71 was written with a section dictating that districts must have an “opt-out” policy allowing parents to withdraw their children from sex education and HIV/AIDS prevention education classes. This means that a parent or guardian must write or sign a letter only if they DO NOT want their child to participate in instruction. “Opt-in” policies, in which parents must write or sign a letter in order for their child to participate in instruction, were prohibited. However, when the California Department of Education (CDE) became responsible for implementing the new law, they interpreted it slightly differently – stating that “opt-in” policies were acceptable for sex education but not for HIV/AIDS prevention education. Respondents were asked about their current policies; the results are shown in **Figure 6**. Seventy percent (70%, n=23) of districts followed the law the way it was originally intended, in that they had an opt-out policy for both sex education AND HIV/AIDS prevention education. One out of every five districts (21%, n=7) were out of compliance in that they had an opt-in policy for both types of instruction. Three districts (9%) followed CDE’s interpretation of the law – opt-out for HIV/AIDS prevention and opt-in for sex education. Thirty percent (30%, n=9) of respondents indicated that their policy had changed since 2004. In five cases, the policy had changed from opt-in to opt-out, in one case it had changed from opt-out to opt-in, and three respondents were not sure how it had changed.



Policies Regarding Teaching about Abstinence

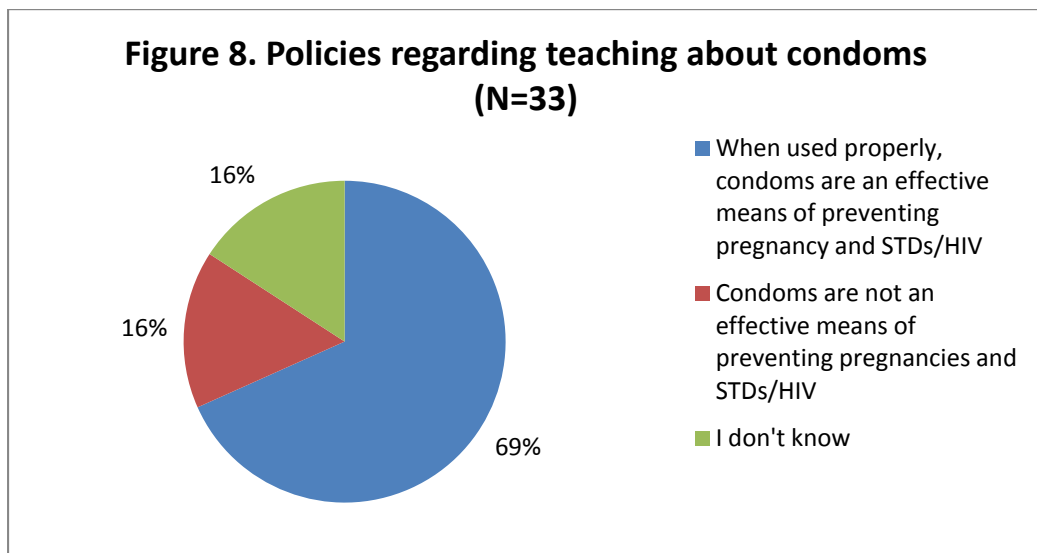
Figure 7 shows respondents’ answers to a question which asked: “**Which of the following best describes the overall approach of your district toward abstinence?**” More than two-thirds of districts (69%, n=22) reported that “*when discussing pregnancy and sexually transmitted diseases, abstinence and birth control methods are both discussed fully*”. One out of five districts (19%, n=6) reported that birth control

methods are mentioned, but most of the time is spent on the benefits of abstinence. Two districts (6%) reported that abstinence was the only prevention strategy discussed.



Policies Regarding Teaching about Condoms

Figure 8 shows responses to a question which asked: *“Which of the following best describes the way you teach about condoms in your HIV/AIDS prevention/sex education program?”* More than two-thirds of districts (69%) chose the option: *“When used properly, condoms are an effective means of preventing Pregnancies and STDs/HIV”*. Five respondents (16%) chose the option, *“Condoms are not an effective means of preventing pregnancies and STDs/HIV”*. Another 16% (n=5) did not know their district’s policy toward teaching about condoms.



Topics Covered in Sexuality and HIV/AIDS Prevention Education

A wide range of topics were covered as part of districts' sex education instruction. **Figure 9** shows the proportion of districts teaching selected topics in middle school and high school. The most common topics taught in middle and high school were reproductive anatomy and physiology (82%, n=27), abstinence (82%, n=27), decision making (76%, n=25), how STDs/HIV are transmitted (73%, n=24), and how to prevent STDs/HIV (73%, n=24). Just over half of districts reporting teaching about contraception related topics such as FDA-approved contraceptive methods (58%, n=19), success rates of different contraceptive methods (55%, n=18), and failure rates of different contraceptive methods (55%, n=18).

Many districts covered interpersonal topics, such as decision-making (76%, n=25) and healthy relationships (67%, n=22) in both middle and high school. Less than one-third of districts covered topics such as gender roles (30%, n=10) and sexual orientation (30%, n=10) in both middle and high school. The least talked about topic was emergency contraception, which was covered only 25% of the time in both middle and high school (n=8).

Figure 9. Topics covered as part of HIV/AIDS prevention and sex education instruction (N=33)

	No	Yes, in middle & high school	Yes, in middle school only	Yes, in high school only	Don't know
Decision-making	3% (n=1)	76% (n=25)	0% (n=0)	6% (n=2)	15% (n=5)
How to talk to parents about sex	18% (n=6)	39% (n=13)	9% (n=3)	6% (n=2)	27% (n=9)
Abstinence	0% (n=0)	82% (n=27)	0% (n=0)	6% (n=2)	12% (n=4)
FDA approved contraceptive methods	3% (n=1)	58% (n=19)	6% (n=2)	15% (n=5)	18% (n=6)
Success rates of different contraceptive methods	6% (n=2)	55% (n=18)	6% (n=2)	21% (n=7)	12% (n=4)
Failure rates of different contraceptive methods	3% (n=1)	55% (n=18)	3% (n=1)	27% (n=9)	12% (n=4)
Emergency contraception	25% (n=8)	25% (n=8)	6% (n=2)	28% (n=9)	16% (n=5)
How STDs/HIV are transmitted	0% (n=0)	73% (n=24)	3% (n=1)	15% (n=5)	9% (n=3)
How to prevent STDs/HIV	0% (n=0)	73% (n=24)	3% (n=1)	15% (n=5)	9% (n=3)
STD/HIV symptoms	0% (n=0)	67% (n=22)	3% (n=1)	18% (n=6)	12% (n=4)
Condom effectiveness for STD/HIV prevention	0% (n=0)	61% (n=20)	3% (n=1)	21% (n=7)	15% (n=5)
Respect for marriage and committed relationships	0% (n=0)	67% (n=22)	3% (n=1)	9% (n=3)	21% (n=7)
Reproductive anatomy and physiology	0% (n=0)	82% (n=27)	3% (n=1)	6% (n=2)	9% (n=3)
Strategies for communicating with partners	9% (n=3)	36% (n=12)	6% (n=2)	21% (n=7)	27% (n=9)
Societal views/stereotypes for people living with HIV/AIDS	6% (n=2)	48% (n=16)	3% (n=1)	21% (n=7)	21% (n=7)
Local resources for sexual health care (e.g., testing, contraception)	3% (n=1)	61% (n=20)	3% (n=1)	18% (n=6)	15% (n=5)
Healthy relationships	6% (n=2)	67% (n=22)	3% (n=1)	15% (n=5)	9% (n=3)
Sexual orientation	24% (n=8)	30% (n=10)	9% (n=3)	15% (n=5)	21% (n=7)
Body image	12% (n=4)	52% (n=17)	12% (n=4)	9% (n=3)	15% (n=5)
Gender roles	21% (n=7)	30% (n=10)	6% (n=2)	15% (n=5)	27% (n=9)
Sex under the influence of drugs or alcohol	12% (n=4)	45% (n=15)	3% (n=1)	18% (n=6)	21% (n=7)

Special Populations Reached in Sexuality and HIV/AIDS Prevention Education

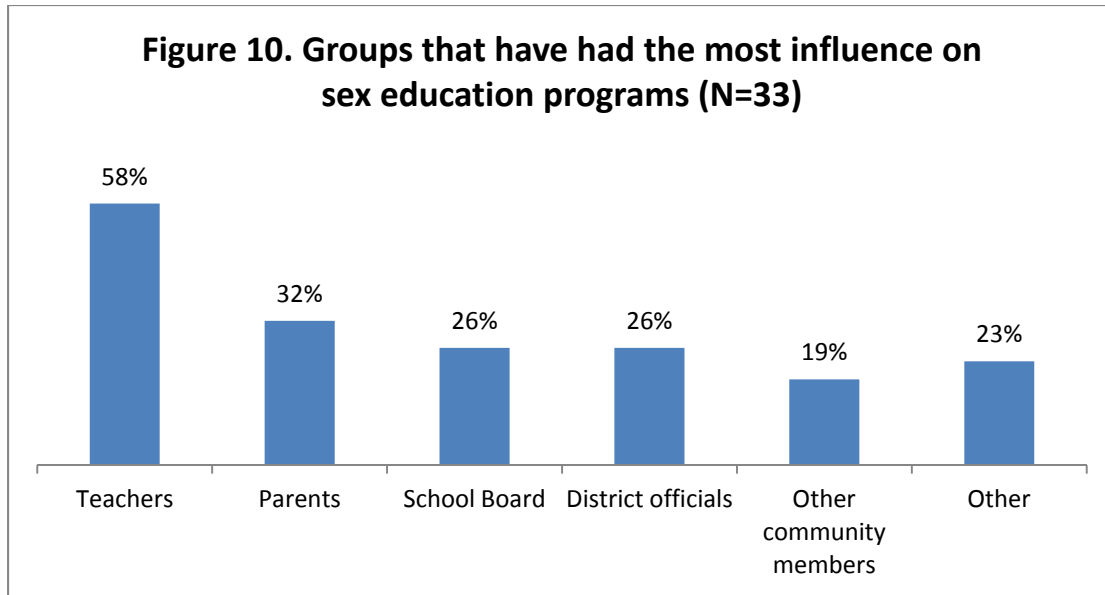
The majority of districts responded “Yes” (73%, n=22) to a question about whether instructional materials were offered in modified formats for students with disabilities. However, when asked to elaborate, some districts simply stated that materials could be “modified if necessary” (n=8). Four districts mentioned that instructional materials were available in large print and Braille and one district reported they had instruction available through sign language and lip reading.

Half of districts (52%, n=17) offered instructional materials in a language other than English. Languages included Spanish (n=16) and Chinese (n=1). Among those respondents whose districts did not offer instructional materials in non-English languages, four reported that there was a need to do so in Spanish.

Challenges and Influences in Implementing Sexuality and HIV/AIDS Prevention Education

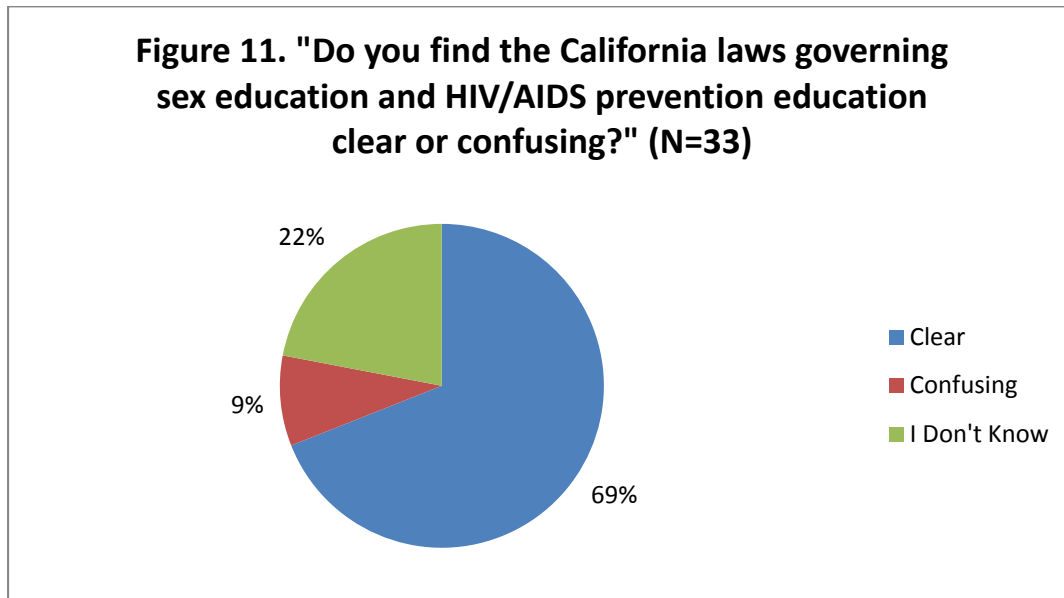
One-third of districts (34%, n=11) reported having faced challenges in implementing HIV/AIDS prevention and sex education in their schools. Challenges included being confronted by conservative members of the community that opposed the curriculum (n=4), monetary challenges (being able to pay for instructors or to have staff trained) (n=2), time constraints (the instructional day “eaten up” by other subjects) (n=1), keeping up-to-date on resources (n=1), and lack of communication (n=1). One district with an “opt-in” policy for HIV/AIDS prevention and sex education mentioned how challenging it was to make sure every child turns in their permission slip.

Respondents note several groups that influenced aspects of their HIV/AIDS prevention and sex education programs (**Figure 10**). Teachers were noted to have the most influence (58%, n=18), followed by parents (32%, n=10), the school board (26%, n=8), district officials (26%, n=8), other community members (19%, n=6), and “Other” (23%, n=7), which included the California State Office of Education (n=2), students (n=1), the HIV/STD County Office of Education Coordinator (n=1), or administrators (n=1). One out of five districts (19%, n=6), reported feeling pressured by one or more of these groups to change their current program. Four districts had been pressured by parents, community members, or the school board to teach abstinence-only sex education. Two districts were pressured (one successfully) to stop using Planned Parenthood as an external organization. One district had been pressured (“*not in a bad way*”) to start discussing contraception in their instruction.



Impact of Changes in California Law

Respondents were asked if they found the California law governing sex education and HIV/AIDS prevention education clear or confusing. Their responses are shown in **Figure 11**. More than two-thirds (69%, n=22) reported that they found the law to be clear.



Almost half of districts (47%, n=14) reported that their policies on HIV/AIDS prevention and sex education had been revised or changed significantly since 2004. Some respondents maintained they had changed policies in order to be in compliance with the new California Educational Code by adding discussion of HIV prevention (n=1) and contraceptive methods (n=1), changing from opt-in to opt-out (n=1), adopting a new curriculum (n=1), or generally "*staying in line*" with state requirements (n=2).

Among the districts surveyed, 28% (n=9) reported that the California Department of Education had conducted a Categorical Program Monitoring Review of their HIV/AIDS prevention instruction. It should be noted that 28% (n=9) of respondents did not know the answer to this question.

Differences between District and Teacher Surveys

Note: Because of the very small number of teacher surveys completed (n=7), results of the teacher survey should be interpreted with caution.

The results of the teacher surveys and the district surveys were very similar, suggesting that there is a high level of consistency between the policies at the district level and the actual instruction on the ground level. There were two cases, however, where there were notably inconsistent results. When asked about their policy regarding parents' ability to remove their children from class, no districts indicated that they do not allow parents the opportunity to remove children from class. However, one teacher surveyed indicated that at his/her school, parents were not given this opportunity, a clear violation of the law. The second case involved the question: ***"Do you find the California laws governing sex education and HIV/AIDS prevention education clear or confusing?"*** While 70% of district officials found the laws to be clear, just 3 out of 7 teachers did. Four out of 7 teachers responded "I don't know" to this question, suggesting a lack of familiarity with the law at the instructor level.

Conclusions and Recommendations

Sex education in California schools is nearly universal and has improved since the passage of the California Comprehensive Sexual Health and HIV/AIDS Prevention Education Act.

The vast majority of school districts provide HIV/AIDS prevention and sex education instruction.

All of the school districts in this study reported providing HIV/AIDS prevention education and all but one reported providing sex education. Instruction was most often provided in the 7th and 9th grades, in a health class, by a health or science teacher. Almost half of districts (47%) reported that their policies on HIV/AIDS prevention and sex education had been revised or changed significantly since 2004. Most districts had done so in response to the changes to the law implemented as a result of SB 71. Additionally, more than two-thirds of school districts (69%) now state that the law governing sex education is clear.

Since the law was passed in 2003, California schools have provided more instruction on required sex education topics and enhanced their teacher training. Middle schools have increased their instruction on contraception and condom effectiveness by more than 15 percentage points since 2003, while teacher training requirements have increased by more than 20 percentage points.⁸

Despite progress, sex education in many schools still does not comply with the California Education Code.

A significant minority of districts have policies that do not comply with the California Education Code.

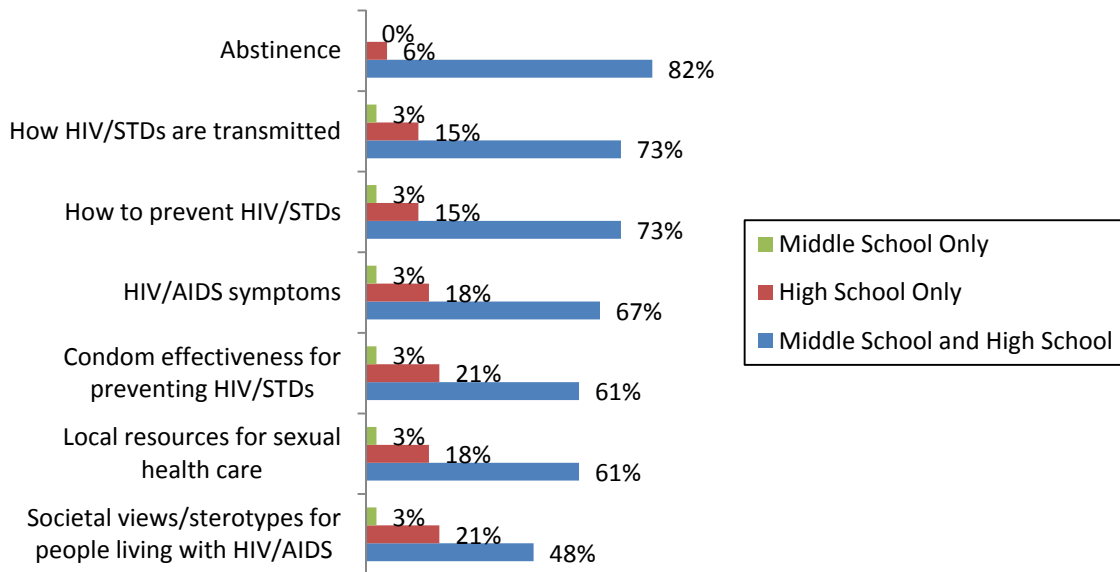
A concerning number of districts were out of compliance with the policies of the California Comprehensive Sexual Health and HIV/AIDS Prevention Education Act (Education Code 51930-51939).

- **Policies regarding withdrawing children from class.** Nearly one out of three districts (30%) had some sort of opt-in policy regarding parents withdrawing their children from class. This goes against the way the law was written and places a burden on teachers, parents and students. It may also result in fewer students being included in HIV/AIDS prevention and sex education instruction. As one district administrator who was out of compliance commented, “[the] challenge is to make sure everyone turns in their [permission] slips”.
- **Policies regarding abstinence-only versus comprehensive sex education.** One out of every four districts surveyed (25%) either provided abstinence-only education or emphasized abstinence over other forms of contraception in their instruction. Past research indicates that sex education programs that only cover abstinence are not effective in delaying sexual activity, increasing contraceptive use among sexually active youth, or preventing teenage pregnancy or births.⁹
- **Policies regarding training of instructors.** Over one-third (37%) of districts reported no training requirement for sex education teachers. The Education Code requires that instructors are trained in the appropriate courses, defined as “knowledge of the most recent medically accurate research on human sexuality, pregnancy, and sexually transmitted diseases”.

Many school districts do not cover HIV/AIDS prevention and sex education topics which are mandated by the California Department of Education.

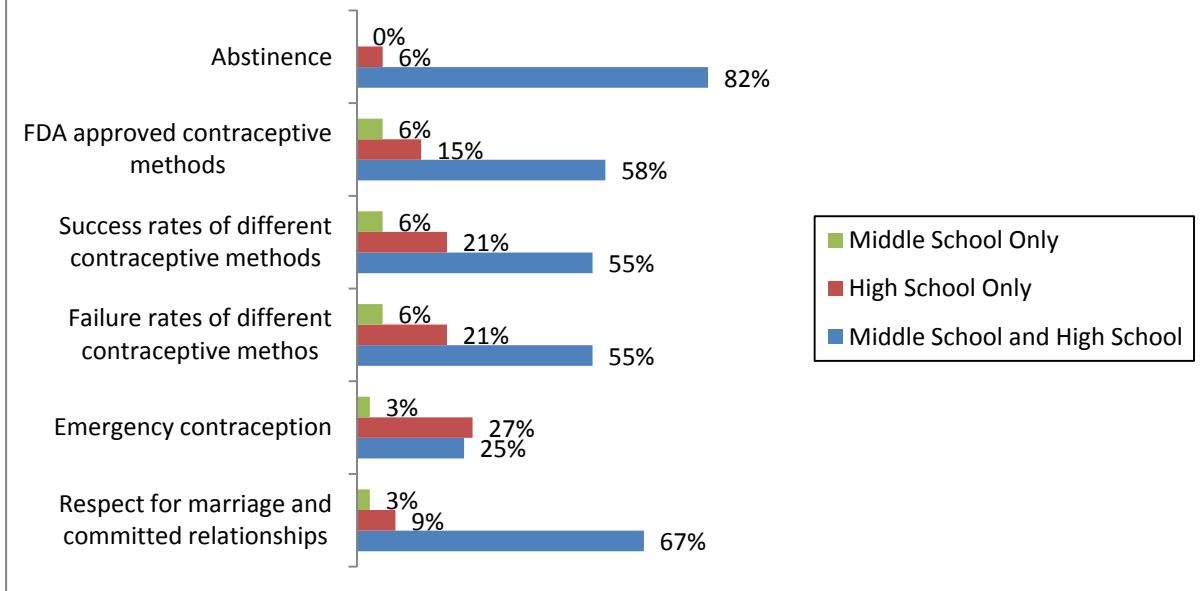
- **HIV/AIDS prevention education topics.** The Education Code requires that certain topics be covered in HIV/AIDS prevention education, including abstinence, how HIV is transmitted, how to prevent HIV, HIV/AIDS symptoms, condom effectiveness for preventing HIV, societal views and stereotypes for people living with HIV/AIDS, and local resources for HIV testing and medical care. While 82% of districts covered the topic of abstinence in both middle school and high school, less than three-fourths of districts covered other mandatory HIV/AIDS prevention education topics (**Figure 12**).

Figure 12. Coverage of Mandatory HIV/AIDS Prevention Education Topics (N=33)



- **Comprehensive sex education topics.** While teaching sex education beyond HIV/AIDS prevention is not mandatory in California districts, if it is taught, certain topics must be covered. These topics include abstinence, respect for marriage and committed relationships, and effectiveness and safety of all FDA-approved methods of contraception including emergency contraception. **Figure 13** shows the extent to which these topics were covered in middle and high school among survey respondents. Just six out of ten districts (58%) taught about FDA-approved methods of contraception in middle and high school and fewer taught about success/failure rates of different methods. These numbers conflict with an earlier question in the survey in which 69% of respondents reported that “birth control methods are discussed fully” in their districts. More work is needed to ensure that students are taught about the full scope of contraceptive methods available to them.
- **Emergency Contraception.** Just one out of four districts (25%) taught about emergency contraception in both middle and high school; another 28% taught emergency contraception at the high school level only (**Figure 13**). The Education Code singles out emergency contraception as a method that must be covered. In view of its potential for preventing unwanted pregnancy among teenagers, it is disturbing that so few districts are teaching about it.

Figure 13. Coverage of Mandatory Sex Education Topics (N=33)



- **Policies regarding teaching about condoms.** A small, but significant, number of districts (16%) taught students that condoms are not an effective way to prevent pregnancy or STDs/HIV. The California Education Code requires that sex education taught in California public schools be “medically accurate”. The US Centers for Disease Control and Prevention states that “consistent and correct use of latex condoms reduces the risk” for many STDs and are “highly effective” in preventing HIV.¹⁰ School districts that taught otherwise were out of compliance with the Education Code.
- **Sexual orientation.** The Legislature passed the Act in part “to encourage a pupil to develop healthy attitudes concerning adolescent growth and development, body image, gender roles, sexual orientation, dating, marriage, and family.” The law additionally requires that school-based sex education be appropriate for students of all genders and sexual orientations. Instruction that omits mention of sexual orientation or assumes that all students in the class are heterosexual does not meet the standards of the law. Addressing sexual orientation in a medically accurate and age-appropriate manner provides an opportunity to dispel bias and develop healthier attitudes among all students. It is therefore troubling that only 30% of schools reported covering sexual orientation as part of both their middle and high school curricula.

A significant minority of districts do not offer instructional materials in modified formats for students with disabilities and non-English speaking students.

The Education Code states that HIV/AIDS prevention and sex education must be available on an equal basis to English Language Learners and that instruction and materials are to be accessible to and appropriate for pupils with disabilities. Most respondents could not explain in detail their districts’ procedures for making sex education accessible for students with disabilities. Moreover, one out of four districts (27%) reported that instructional materials were not available for students with disabilities in their district. Thirty-nine percent (39%) of districts did not offer instructional materials in a language other than English, though several mentioned the need to develop materials in Spanish. These

responses indicate a gap in services to special populations of California youth that may be at risk of pregnancy and sexually transmitted diseases.

Even when they are in compliance with the law, school districts struggle to provide the quality sex education that their students need.

Written materials and curricula used by school districts are often fragmented, outdated, and presented without fidelity or a sufficient amount of instructional time.

Research indicates that in order to be most effective, sex education curricula should be taught with fidelity to the original source material.¹¹ Districts in this study tended to mix together different parts of textbooks, published curricula, and self-developed curricula. They often omitted parts of or added to a curriculum. Many districts used materials that were out-of-date or did not update their materials often enough. Additionally, most instructors were not given the opportunity to attend trainings on a regular basis, in order to become familiar with the most recent scientific evidence available.

Furthermore, districts ranged considerably in how many hours of instruction were given to students. Previous research suggests that, typically, at least fourteen hours of instruction are needed in order for a sex education program to show positive behavioral or health outcomes.¹² California's state-funded Teen Pregnancy Prevention programs require a minimum of eight hours of prevention education instruction. Many of the districts in this study provided far fewer hours of instruction. For example, in grades 9-12, 13 districts (39%) provided less than eight hours of sex education instruction, some offering only 1-2 hours total. There may be many reasons for the low number of hours, including lack of interest in teaching sex education, time constraints, and schools' focus on academic subjects in order to keep up with rigorous testing requirements. Additionally, 12% of districts offered sex education in an elective, rather than required, class, indicating that HIV/AIDS prevention education was not mandatory under these circumstances.

One-third of districts (34%) reported having faced challenges in implementing HIV/AIDS prevention and sex education in their schools.

Challenges faced included responding to the demands of conservative members of a community, time and resource constraints, and confusion about the laws governing HIV/AIDS prevention and sex education in California. Schools and school districts could benefit from support in facing these challenges in the form of training and additional funding.

One-quarter of districts (27%) relied on external organizations to provide HIV/AIDS prevention and sex education in their schools.

Though not documented in this study, many of the external organizations that are used by school districts to provide instruction are funded through the California Department of Public Health, Office of Family Planning, specifically its Community Challenge Grant (CCG) program. The entire \$20 million CCG program was cut in the FY 2011-2012 state budget, making it unlikely that many organizations will be able to keep providing these services to schools. Several survey respondents mentioned that they currently use external organizations because they do not have the resources or training to provide HIV/AIDS prevention and sex education in-house. In a survey of past CCG grantees, many participants commented that the elimination of the program would result in their local schools being unable to continue to meet Education Code requirements.¹³

Recommendations

1. The State Legislature should mandate combined sex education and HIV/AIDS prevention education, preferably within a mandatory health class, so that every student in California has an opportunity to receive important information about sexual health.
2. The State Legislature should increase funding both to school districts for the implementation of comprehensive sex education and to programs, including the Community Challenge Grant (CCG) and Information and Education (I&E) programs, that support outside organizations in providing school-based instruction. It should also increase funding for programs that serve special populations of students, such as incarcerated, homeless, and other marginalized groups.
3. The California Department of Education (CDE) should continue to monitor school-based HIV/AIDS and sex education programs and to bring them into compliance with the Education Code as necessary. More resources should be given to CDE to increase the number of reviews they conduct and increase the capacity to carry them out.
4. CDE should provide guidance and support to schools and school districts on adapting instructional materials for students with disabilities and English-Language Learners, as well as keeping educational materials up to date.
5. CDE should further clarify the opt-in/opt-out process and implement and monitor the law in the way it was originally intended: Prohibiting opt-in policies and mandating opt-out policies for both HIV/AIDS prevention and sex education classes.
6. School districts and teachers should become familiar with the provisions of the California Education Code that govern HIV/AIDS prevention and sex education. Resources are available at <http://www.cde.ca.gov/ls/he/se/>.
7. School districts should adopt evidence-based sex education curricula for their classrooms. Teachers should implement these curricula with fidelity (not omitting or changing any sections of the written curriculum, although some modifications, such as up-to-date language and pictures shown of adolescents' current fashions, are acceptable). Resources are available at <http://www.californiahealthykids.org/c/@u7o9xrqaYkvTw/Pages/sexualhealthevaluations.html>.
8. School districts should, at a minimum, provide annual training for sex education and HIV/AIDS prevention instructors.
9. Teachers should be sure to provide medically accurate instruction that includes all topics mandated by the Education Code. Specific topics that need more attention include sexual orientation, condoms, contraception, and emergency contraception.
10. Parents, students, and community members should educate themselves about California law regarding sex education in public schools and advocate for full implementation of comprehensive sex education, using checklists and other user-friendly materials developed by the American Civil Liberties Union of Northern California, Bay Area Communities for Health Education, and other sources. Resources are available at http://www.aclunc.org/sex_ed and <http://www.bacheinfo.org>.

Acknowledgements

The authors wish to thank Lauren Ralph, MPH, for assistance with the development of the survey, Noushin Berdjis for assistance with data collection, and Christina Jeffery for assistance with the creation of this report.

This study was commissioned by the American Civil Liberties Union of Northern California with the generous support of the Wallace Alexander Gerbode Foundation, the David B. Gold Foundation, the Richard and Rhoda Goldman Fund, the William and Flora Hewlett Foundation, the David and Lucile Packard Foundation, and the Mary Wohlford Foundation. All analysis, interpretations, and conclusions reached are those of UCSF, not the American Civil Liberties Union.

¹ California Department of Public Health. California Teen Births Continue Decline. February 2011. Available at: <http://www.cdph.ca.gov/Pages/NR11-008.aspx>, accessed April 13, 2011.

² California Adolescent Sexual Health Working Group. 2008 Data for California Births, AIDS, STD. July 2010. Available at: http://www.californiateenhealth.org/download/ASHWG_Integrated_Data_Tables.pdf, accessed April 13, 2011.

³ Kirby D. Emerging Answers 2007: Research Findings on Programs to Reduce Teen pregnancy and Sexually Transmitted Diseases. November 2007. Washington, DC: The National Campaign to Prevent Teen Pregnancy.

⁴ Ibid.

⁵ Landry DJ, Darroch JE, Singh S, Higgins J. Factors Associated with the Content of Sex Education In U.S. Public Secondary Schools. *Perspectives on Sexual and Reproductive Health*, 2003; 35(6):261–269.

⁶ Darroch JE, Landry DJ, Singh S. Changing Emphases in Sexuality Education in U.S. Public Secondary Schools, 1988–1999. *Family Planning Perspectives*, 2000; 32(5):204–211 & 265.

⁷ Burlingame P. Sex Education in California Public Schools: Are Students Learning What they Need to Know? August 2003. San Francisco, CA: PB Consulting.

⁸ Burlingame, P. Sex Education in California Public Schools, op. cit.

⁹ Kirby D, Emerging Answers 2007, op. cit.; Manlove J, Romano-Papillo A, Ikramullah E. Not Yet: Programs to Delay First Sex among Teens. Washington, DC: National Campaign to Prevent Teen Pregnancy, 2004.

¹⁰ United States Centers for Disease Control and Prevention. Condom Fact Sheet in Brief. April 2011. Available at: <http://www.cdc.gov/condomeffectiveness/brief.html>, accessed April 20, 2011.

¹¹ Kirby D, Laris BA, Roller L. Sex and HIV Education Programs for Youth: Their Impact and Important Characteristics. May 2006. Research Triangle Park, NC: Family Health International.

¹² Kirby D, Emerging Answers 2007, op. cit.

¹³ TeenNow California. “Community Challenge Grants in our Schools.” Survey. *SurveyMonkey*. Web. March, 2011.