ISSUE REPORT

Furthering the Adaptation and Implementation of LGBTQ-inclusive Sexuality Education

MAY 2016

Trust for America's Health
WWW.HEALTHYAMERICANS.ORG

Acknowledgements

Trust for America's Health is a non-profit, non-partisan organization dedicated to saving lives by protecting the health of every community and working to make disease prevention a national priority.

This report was supported by a grant from the **M·A·C AIDS Fund**. The opinions expressed are those of the authors and do not necessarily reflect the views of the foundation. TFAH would like to thank M·A·C AIDS Fund for their generous support of this report.

REPORT AUTHORS

Derek Hodel
Independent Consultant

Jeffrey Levi, PhD.
Professor of Health Policy and Management
George Washington University

Anne De Biasi, MHA
Director, Policy Development
Trust for America's Health

Foreword

With support from the M·A·C AIDS Fund, Trust for America's Health (TFAH) convened a one-day consultation to consider strategies to advance the adaptation and implementation of school-based, lesbian, gay, bisexual, transgender, queer/questioning (LGBTQ)-inclusive sexuality education.

The convening followed a previous report, *Addressing the Social Determinants of Health Inequities Among Gay Men and Other Men Who Have Sex With Men in the United States*, among the recommendations of which was a call for inclusive, comprehensive sex education. Invited participants included education, sex education, and LGBTQ policy advocates; state and local education agency staff and school-based sex education providers; research scientists, and sex education curricula specialists; and federal officials, who were invited as resources and observers. After reviewing the need for LGBTQ-inclusive sex education, the state of the art for LGBTQ-inclusive sex education curricula, and the extent to which such curricula are available and accessible, the remainder of the meeting focused on identifying opportunities for enhanced federal support. Three caveats underpinned the discussion: 1) the experiences of LGBTQ youth in school, including but not limited to the uptake of sex education, are mediated by a wide range of school climate factors beyond those directly pertaining to the implementation of inclusive sex education curricula (the focus of this meeting), including anti-bullying policies, accessible role models, other inclusive curricula (history, social studies, language), school discipline policies, parental engagement, etc.; 2) many experts agree on the need for both inclusive sex-education *and* programs tailored specifically for LGBTQ youth, some of which may be best delivered outside the school setting; and 3) though promising, the evidence base to support LGBTQ-inclusive sex-education is limited, but well documented health disparities among LGBTQ youth (particularly, but not limited to HIV and violence) are sufficiently grave to warrant immediate action. As such, meeting participants were charged with articulating strategies for the federal government to advance inclusive sex-education based upon what we know now, while supporting the need for additional research. While this report reflects those conversations, the views expressed are solely those of Trust for America's Health.

Furthering the Adaptation and Implementation of LGBTQ-inclusive Sexuality Education

ISSUE REPORT

MAY 2016

Furthering the Adaptation and Implementation of LGBTQ-inclusive Sexuality Education

ISSUE REPORT

MAY 2016

Executive Summary

Many factors place LGBTQ youth at disproportionate risk for poor sexual health outcomes, including HIV. As such, the need for LGBTQ-inclusive sex education is pronounced. While the provision of adequate sex education is weak in general, most sex education in the United States either excludes LGBTQ people and experiences, or presents them in ways that demonize or marginalize them. In schools with inclusive sex education, LGB students reported fewer sexual partners, less recent sex, and less substance use before having sex.

There is broad agreement among experts that all sex education should provide factual, non-stigmatizing information on sexual orientation and gender identity, and teach respect for LGBTQ people. To be fully inclusive, sex education should anticipate the presence of LGBTQ students, and include examples of same-sex relationships in a positive light, use gender neutral pronouns, and avoid making assumptions about students' sexuality or behaviors.

LGBTQ-inclusive sex education requires an appropriate curriculum, competent instruction, and a school climate that is both safe and supportive. But schools confront barriers to implementing any effective sex education, let alone LGBTQ-inclusive programs. There is a significant need for resources and support for adapting existing curricula to be LGBTQ inclusive, and for ongoing evaluation to test how well standards, resources, programs, and curricula meet the needs of LGBTQ youth.

Professional development is critical, particularly to impart strategies for teachers to confront and manage biases exhibited by students, but also to identify and compensate for their own biases. Training is also essential for other teachers and professionals, including school administrators, counselors, nurses, psychologists, etc., to whom students may turn for advice.

For LGBTQ youth, the experience of feeling welcome or included in school is likely to affect their learning in all subjects, including sex education. But LGBTQ examples and experiences are often absent in general school curricula, and LGBTQ youth, who are disproportionately susceptible to violence, discrimination or bullying, sometimes have difficulty in identifying sympathetic adults to whom they can turn for advice or counsel.

As school policies in the U.S. are primarily established within state or local jurisdictions, policies restricting or prohibiting LGBTQ-inclusive sex education can pose a significant barrier — eight states restrict the teaching of LGBTQ-related content, while others mandate that sex education focus on monogamous heterosexual marriage. Even in states with no such prohibitions, only nine require education about sexual orientation or programs that are LGBTQ-inclusive of youth.

Overall, federal funding for sex education is limited, comprising primarily pregnancy and HIV prevention

initiatives, and few are LGBTQ-inclusive by design. For example, the Administration for Children and Families (ACF), Family and Youth Services Bureau awards up to $75 million to prevent pregnancy and sexually transmitted infections, including HIV/AIDS, among young people. The HHS Office of Adolescent Health's Teen Pregnancy Prevention Program, which supports 81 programs to implement evidence-based programs, recently required grantees to adapt them to better meet the needs of LGBTQ youth. The U.S. Centers for Disease Control and Prevention's (CDC) Division for Adolescent and School Health (DASH) funds select education agencies to support exemplary sexual health education. But two federal initiatives provide almost $85 million to support programs that expressly promote an abstinence-only-until-marriage approach, many of which implicitly marginalize LGBTQ youth and may promote homophobia.

To meet urgent public health priorities, the federal government should prioritize the consistent adaptation and implementation of LGBTQ-inclusive sex education by providing funding to develop and implement LGBTQ-inclusive sex education, and for teacher training, program evaluation and research; coordinating efforts across departments; establishing best practice and content standards; and discontinuing ineffective abstinence-only programs. While significantly more federal funding is warranted, state and local agencies may be able to take advantage of new funding mechanisms through the Every Student Succeeds Act (ESSA) or ongoing healthcare reform implementation.

Furthering the Adaptation and Implementation of LGBTQ-inclusive Sexuality Education

ISSUE REPORT

Introduction

All youth should benefit from comprehensive sex education that includes information about sexual orientation, gender identity and gender expression (see box, Understanding sex education in context). But especially for LGBTQ youth, the need for sex education that provides the knowledge and skills to reduce the risks of HIV, sexually-transmitted infections (STI), and other adverse health outcomes, is pronounced. Many factors place LGBTQ youth at disproportionate risk for poor health outcomes, including both individual behaviors and a range of school climate factors. Compared to their heterosexual peers, LGBTQ youth are more likely to begin sex at an early age and to have multiple partners,[1] are more likely to have sex while under the influence of alcohol or drugs,[2] and are less likely to report using condoms or birth control during their last sex.[3] As a result, LGBTQ youth experience a variety of adverse health consequences, including sexual health outcomes.[4,5] For example, a number of studies have shown that LGB youth are more likely to report having been or gotten someone pregnant.[6,7]

UNDERSTANDING SEX EDUCATION IN CONTEXT

Sex education advocates argue that for all students, the gold standard is ***comprehensive sexuality education*** (CSE) that starts in kindergarten and continues through 12th grade, and provides students with opportunities for developing skills as well as knowledge. CSE programs provide age-appropriate, medically accurate information on a broad set of topics related to sexuality, at minimum including human development, relationships, personal skills, sexual behavior, sexual health, and society and culture. By definition, CSE is LGBTQ-inclusive, as it includes factual, non-stigmatizing information on sexual orientation and gender identity as a part of human development and teaches respect for LGBTQ people.

Currently, however, CSE is the exception among sex education programs in the United States. Some schools do not implement sex education *at all*, and among those that do, few implement CSE. Rather, many schools adapt or develop ***sex education curricula*** to meet their requirements, which often include significant time constraints. While some states mandate some sort of sex education, none require CSE, and there are currently no federal funds designated specifically to support CSE programs. To address the inconsistent implementation of sex education nationwide and the limited time allocated to teaching the topic, the ***National Sexuality Education Standards***, developed by the Future of Sex Education Initiative (a non-

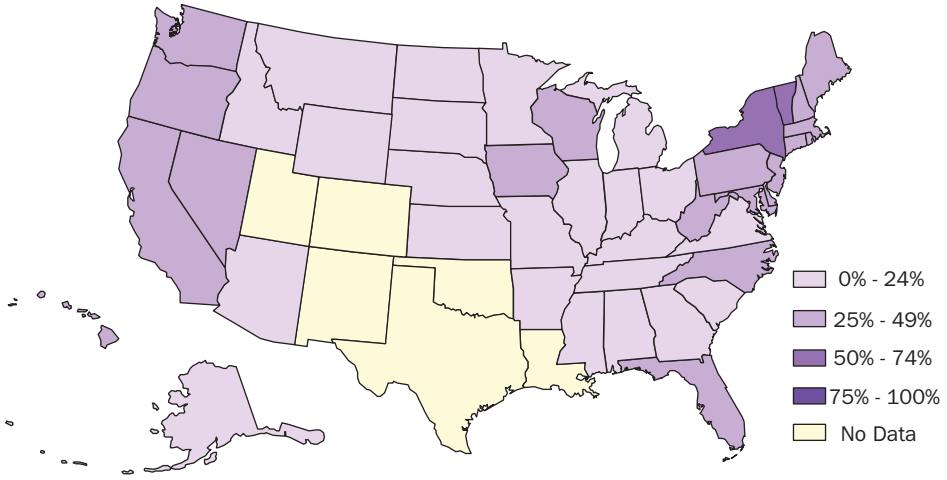
governmental partnership) establish minimum, essential core content and skills for sex education.

The limited federal funds for sex education primarily support specific, ***evidence-based*** or ***evidence-informed*** programs to reduce teen pregnancy and/or the risk for HIV/STIs. For example, the HHS Office of Adolescent Health (OAH) Teen Pregnancy Prevention Program designates and supports grantees to implement a small number of ***evidence-based programs*** (EBP) to reduce teen pregnancy, which have been demonstrated to be effective in studies that use a randomized or quasi-experimental design.* But because most EBPs focus on a specific grade level or two, they are not considered by advocates to be comprehensive, and most are not LGBTQ-inclusive by design. Moving forward, OAH has required and provided guidance to grantees to adapt EPBs to be LGBTQ-inclusive and to ensure that programs are delivered in a safe and supportive environment, and is currently evaluating other, LGBTQ-inclusive EBPs. Through the Division of Adolescent and School Health, the CDC supports a limited number of state and local agencies to implement ***evidence-informed sexuality education***, the topics, components and activities of which are based on scientific evidence about what youth need and at what stage/age to help them build healthy habits and an internal sense of agency.

** A randomly controlled trial (RCT) is a particularly rigorous method for evaluating behavioral interventions, and its use as a standard may preclude the evaluation of CSE, as such trials would require enrolling many thousands of youth over many, many years, at great expense.*

Disparities in health outcomes among LGBTQ youth are particularly evident with respect to HIV. While overall, annual HIV diagnoses in the U.S. declined by 19 percent between 2005-2014, young black gay and bisexual men ages 13-24 experienced an 87 percent increase in diagnoses — among young white men, the rate of increase was 56 percent — though between 2010 and 2014, the trend leveled off (with a 2 percent decline).[8] In 2015, the updated National HIV/AIDS Strategy for the United States called for schools to provide age- and developmentally-appropriate, culturally competent, HIV and sexually transmitted infection prevention education programs, including those designed for LGBT youth.[9]

Percentage of secondary schools that provide curricula or supplementary materials that include HIV, STD, or pregnancy prevention information that is relevant to LGBTQ youth



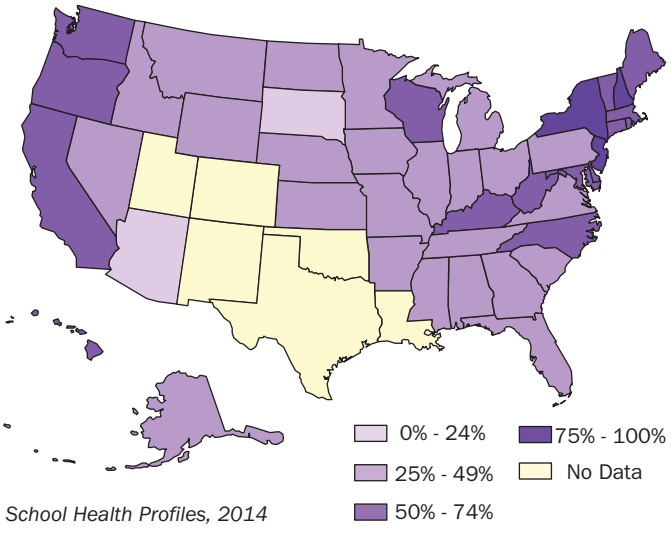
School Health Profiles, 2014

But for most LGBTQ youth, inclusive sex education is not available. In a national survey, fewer than 5percent of LGBT middle and high school students reported positive discussions of LGBT topics in their health classes.[10] According to the Centers for Disease Control, only 24.4 percent (range 11.0-56.4 percent) of schools across states, and 37.6 percent (range 5.6-85.2 percent) of schools across large urban school districts, provide curricula or supplementary materials that include HIV, STI, or pregnancy prevention information that is relevant to LGBTQ youth (e.g. that use inclusive language or terminology).[11] In recent qualitative research, LGBTQ youth reported having either no sex education in their schools or having sex education that was primarily or exclusively focused on heterosexual relationships, and pregnancy prevention within those relationships.[12]

In fact, the provision of adequate content in sex education is weak in general — in most states, fewer than half of high schools and a quarter of middle schools teach 16 critical sex education topics[13] as defined by CDC (e.g. how to create and sustain healthy and respectful relationships, how HIV and other STIs are transmitted, communication and negotiation skills related to reducing risk for HIV, other STIs, and pregnancy; etc.).[14] Moreover, sex education programs based on an abstinence-only-until-marriage (AOUM) approach remain common. While programs that include discussions of both abstinence and risk reduction (e.g. condoms) show a protective effect,[15] AOUM programs rarely provide information on even the most basic topics in human sexuality such as birth control,[16,17] and have not been shown effective in preventing pregnancy,[18] or reducing HIV.[19]

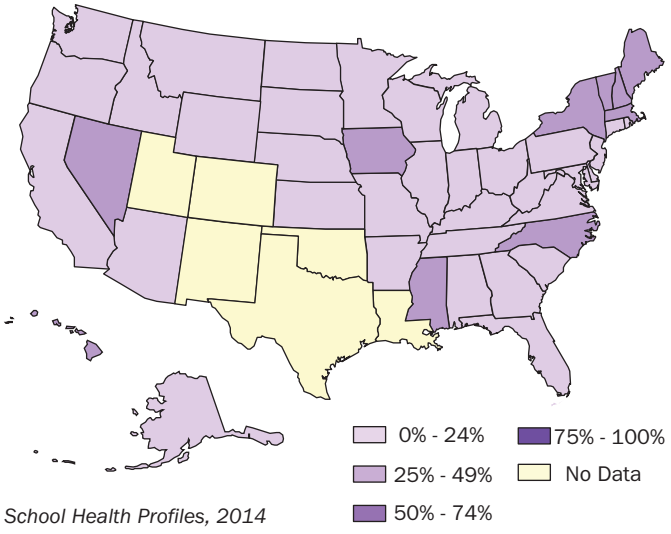
Most sex education in the United States, far from being inclusive, either excludes LGBTQ people and experiences, or presents them in ways that demonize or marginalize them — and even curricula that affirmatively include LGB people often exclude the experiences of transgender people.[20]

High Schools: Teach All 16 Sex Ed Topics



School Health Profiles, 2014

Middle Schools: Teach All 16 Sex Ed Topics



School Health Profiles, 2014

FOCUS GROUPS AND INTERVIEWS AMONG 92 LGBTQ YOUTH (15-19) FROM ACROSS THE UNITED STATES

Protection is something you need, blah, blah, blah, but it's always taught with straight sex, so I think a lot of gay teens get a little confused or they get a little like, "Oh, well, I'm not going to get that."

Participant 5 (Urban Delaware)

I went to a progressive high school. We had comprehensive sexual education. The only issue was they talked about gay men briefly. Then, when it came to queer female sex, that did not come up at all.

Participant 21 (Small City Virginia)

There's absolutely no mention of transgender health in health classes. I feel like trans youth have an even more of a deficit of information and support than LGB youth.

Participant 81 (Urban Washington)

SOURCE: Levine DS, Kantor LM, Steinke J, Root-Bowman M, Estabrook S. New findings on the needs of LGBTQ youth [poster]. Presented at the meeting of the American Public Health Association, Chicago, IL, November 2015.

Meanwhile, there is general support among adults in the United States for sex education in schools.[21] There is also support for LGBTQ-inclusive sex education, both among the public and scientific experts — in a 2015 poll, 85 percent of parents surveyed favored discussion of sexual orientation as part of sex education in high school, while 78 percent favored it in middle school.[22]

Leading national health and education organizations support LGBTQ-inclusive sex education, including the American Academy of Pediatrics, American Association for Health Education, American Medical Association, American Psychological Association, American Public Health Association, American School Health Association, National Education Association, Society for Adolescent Health and Medicine, and Society of State Leaders of Health and Physical Education.

Though relatively rare, LGBTQ-inclusive sex education programs make a difference for LGBTQ youth. In a study among LGB students, those in schools with inclusive sex education reported fewer sexual partners, less recent sex, and less substance use before having sex than those in other schools.[23]

Facilitators of and Barriers to LGBTQ-Inclusive Sex Education

To be effective, LGBTQ-inclusive sex education requires: a curriculum that includes appropriate content and teaches necessary skills to promote healthy behaviors; competent instruction that enables students to learn to the best of their ability; and a school climate that is both *safe*, allowing students to focus on learning what they need to learn, and *supportive*, encouraging them to do so. While implementing LGBTQ sex education poses specific challenges, schools often confront significant barriers to implementing any effective sex education curricula due to severe limitations on time available for health and sex education. In some instances, school districts have eliminated health education classes entirely. In other settings, schools must juggle multiple worthy health education mandates (e.g. dating violence, nutrition, tobacco use). As such, even schools willing to use evidence-based sex education curricula frequently adapt them to meet their needs, in the process sometimes eliminating time-intensive skills building sessions known to be critical for behavior change. Meeting participants described a wide range of factors that impact the adaptation and implementation of each of these components of LGBTQ-inclusive sex education.

Need for LGBTQ-Inclusive Sex Education Curricula.

While some resources are available to aid educators, there is an ongoing need for additional resources and support for adapting curricula to be fully LGBTQ-inclusive while maintaining their integrity. Examples of fully LGBTQ-inclusive curricula are few, and more research is needed to further delineate sex education content for all students related to sexual orientation, gender identity and expression, and to understand the optimal approaches for reaching LGBTQ youth. Notwithstanding the need for additional research, however, there is broad consensus among experts in the field and advocates on the general characteristics of an LGBTQ-inclusive curriculum.

WHAT DOES LGBTQ-INCLUSIVE SEX EDUCATION LOOK LIKE?

LGBTQ-inclusive sex education should provide factual, non-stigmatizing information on sexual orientation and gender identity as a part of human development and teach respect for LGBTQ people. At minimum, LGBTQ-inclusive sex education should:

- Include information for all students about sexual orientation and gender identity that is medically accurate and age-appropriate
- Be designed with the needs of LGBTQ students in mind and be implemented with awareness that all classes are likely to have some LGBTQ students
- Include depictions of LGBTQ people and same-sex relationships in a positive light in stories and role-plays
- Use gender-neutral terms such as "they/them" and "partner" whenever possible
- Ensure that prevention messages related to condom and birth control use are not relayed in a way that suggests only heterosexual youth or cisgender* male/female couples need to be concerned about unintended pregnancy and STI prevention
- Avoid making assumptions about students' sexual orientation or gender identity

** Cisgender — people whose gender identity matches their sex assigned at birth.*

SOURCE: Advocates for Youth, Answer, GLSEN, Human Rights Campaign, Planned Parenthood Federation of America, SIECUS. A Call to Action: LGBTQ Youth Need Inclusive Sex Education. Available at: https://www.plannedparenthood.org/files/1014/4906/8078/Inclusive_Sex_Education.pdf (accessed February 26, 2016).

To address the inconsistent implementation of sex education nationwide and the limited time allocated to teaching the topic, the National Sexuality Education Standards† establish minimum, essential core content and skills for sex education programs that is developmentally and age-appropriate for students in grades K–12, including concepts related to sexual orientation, gender expression and identity (see box).[24]

† The National Sexuality Education Standards were developed by the Future of Sex Education Initiative (see http://www.futureofsexeducation.org), a non-governmental coalition comprising Advocates for Youth, Answer and the Sexuality Information and Education Council of the U.S. (SIECUS), in partnership with the American School Health Association, the American Association for Health Education, the National Education Association, and the Society of State Leaders of Health and Physical Education.

IDENTITY							
Core Concepts CC	**Analyzing Influences INF**	**Accessing Information AI**	**Interpersonal Communication IC**	**Decision-Making DM**	**Goal Setting GS**	**Self-Management SM**	**Advocacy ADV**
BY THE END OF THE 2ND GRADE, STUDENTS SHOULD BE ABLE TO :							
Describe differences and similarities in how boys and girls may be expected to act **ID.2.CC.1**	Provide examples of how friends, family, media, society and culture influence ways in which boys and girls think they should act **ID.2.INF.1**						
BY THE END OF THE 5TH GRADE, STUDENTS SHOULD BE ABLE TO :							
Define sexual orientation as romantic attraction to an individual of the same gender or of a different gender **ID.5.CC.1**		Identify parents or other trusted adults to whom they can ask questions about sexual orientation **ID.5.AI.1**				Demonstrate ways to treat others with dignity and respect **ID.5.SM.1**	Demonstrate ways students can work together to promote dignity and respect for all people **ID.5.ADV.1**
BY THE END OF THE 8TH GRADE, STUDENTS SHOULD BE ABLE TO :							
Differentiate between gender identity, gender expression and sexual orientation **ID.8.CC.1**	Analyze external influences that have an impact on one's attitudes about gender, sexual orientation and gender identity **ID.8.INF.1**	Access accurate information about gender identity, gender expression and sexual orientation **ID.8.AI.1**	Communicate respectfully with and about people of all gender identities, gender expressions and sexual orientations **ID.8.IC.1**				Develop a plan to promote dignity and respect for all people in the school community **ID.8.ADV.1**
Explain the range of gender roles **ID.8.CC.2**							
BY THE END OF THE 12TH GRADE, STUDENTS SHOULD BE ABLE TO :							
Differentiate between biological sex, sexual orientation, and gender identity and expression **ID.12.CC.1**	Analyze the influence of peers, media, family, society, religion and culture on the expression of gender, sexual orientation and identity **ID.12.INF.1**					Explain how to promote safety, respect, awareness and acceptance **ID.12.SM.1**	Advocate for school policies and programs that promote dignity and respect for all **ID.12.ADV.1**
Distinguish between sexual orientation, sexual behavior and sexual identity **ID.12.CC.2**							

Figure 2: SOURCE — Future of Sex Education Initiative. National Sexuality Education Standards: Core Content and Skills, K-12 [a special publication of the Journal of School Health], 2012.

LGBTQ-INCLUSIVE vs. LGBTQ-SPECIFIC

It is important to teach all students respect for differences in sexual orientation, gender identity, and gender expression, to acknowledge the likelihood that there are LGBTQ students in almost any classroom, and to address the needs and questions of students for whom sexual orientation or gender identity and/or expression remain fluid. Fully LGBTQ-inclusive programs must also find appropriate ways to address the needs and experiences of LGBTQ-identified youth. For example, while it is important to address pregnancy prevention in an LGBTQ-inclusive way, for sexually-active gay youth, it is also important to discuss anal sex, which without proper protection increases the risk for HIV and other STIs — and which also occurs among sexually active straight youth. Even when not feasible to cover specific health-related topics in a classroom setting, sex educators must find other ways of providing information, such as through referrals to youth-friendly community health centers or web resources. Moreover, even "LGBTQ-inclusive" curricula are often more responsive to the needs and experiences of lesbian and gay students than they are to bisexual, transgender, or queer/questioning students.

EVALUATION OF LGBTQ-INCLUSIVE SEX EDUCATION

While the broad contours of LGBTQ-inclusive sex education have been articulated, meeting participants emphasized the need for ongoing evaluation to rigorously test how well standards, resources, programs, and curricula meet the sex education needs of all students, but particularly LGBTQ youth, including but not limited to pregnancy and HIV/STI prevention. Given the dearth of research on LGBTQ-inclusive approaches, it is also important to consider the extent to which current evaluation results may inadvertently discourage LGBTQ-inclusive sex education. Specifically:

- Evidence-based programs. Among the 37 evidence-based programs that the HHS Office of Adolescent Health recognizes as having been shown to be effective in reducing sexual risk behaviors that lead to teen pregnancies or STIs,‡ almost none are purposefully LGBTQ-inclusive (*Get Real* is one exception). In part, critics argue that this is because both evaluations to date, as well as HHS criteria for their review, have defined *effectiveness* too narrowly. For example, EBPs must be demonstrated through randomized or quasi-experimental evaluations to be effective in preventing teen pregnancies, reducing STIs, or reducing rates of sexual risk behaviors. By failing to consider other factors demonstrated in research on sexual orientation, gender identity and expression to play a role in LGBTQ adolescent sexual health, such evaluations may incentivize programs that focus on pregnancy or disease prevention rather than promoting overall sexual health. Moreover, because evaluation takes so long, many LGBTQ-inclusive programs have yet to be evaluated (although OAH's 2015 five-year evaluation grants include several inclusive programs). As a consequence, the current list of EBPs focuses primarily on disease and pregnancy prevention rather than taking a holistic approach to adolescent sexual health.[25] Moreover, some EBPs expressly promote an abstinence-only-until-marriage approach, which implicitly marginalizes LGBTQ youth and may promote homophobia.[26]
- Other LGBTQ-inclusive curricula, including *Family Life and Sexual Health (FLASH),* developed by Public Health Seattle-King County, and *Rights, Respect, Responsibility,* recently developed by Advocates for Youth, were designed to align with National Sexuality Education Standards and are considered by advocates to be comprehensive, but have not yet been rigorously evaluated. (*High School FLASH* is among the interventions that received a five-year OAH Tier 2B award in 2015 for rigorous evaluation of new or innovative approaches to prevent teen pregnancy.)

‡ The Department of Health and Human Services (HHS) Office of the Assistant Secretary for Planning and Evaluation (ASPE) conducts a Teen Pregnancy Prevention Evidence Review that uses a systematic process for reviewing evaluation studies against a rigorous standard in order to identify programs shown effective at preventing teen pregnancies, sexually transmitted infections, or sexual risk behaviors in schools, clinics, and other community settings.

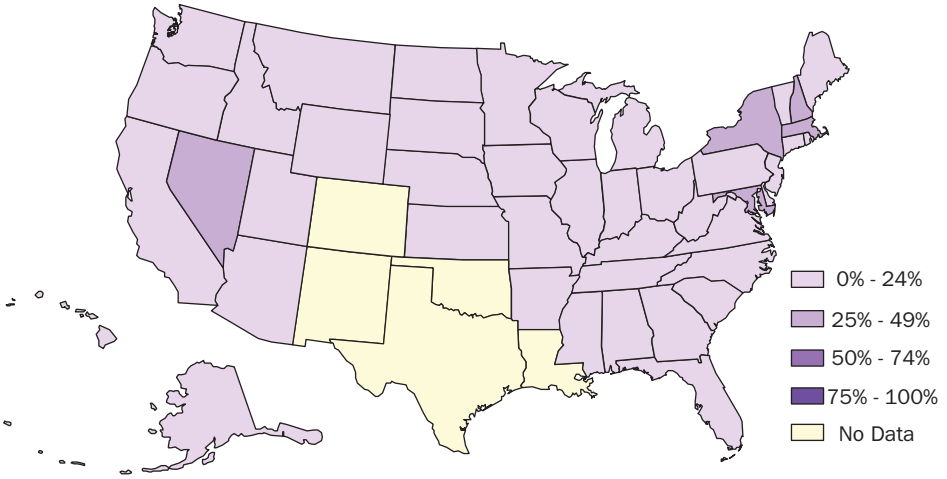
PROFESSIONAL DEVELOPMENT

While LGBTQ-inclusive content is essential, it is only the first step towards inclusive sex education. Professional development — including pre-service as well as continuing education and training — is critical to ensure that sex education teachers are able to actively engage students and help them master important health information and skills. Among lead health education teachers surveyed, a majority (medians 56 percent across states and 75 percent in large urban school districts) expressed interest in receiving professional development on teaching students of different sexual orientations or gender identities.[27] Particularly for science, physical education, or other teachers — who may be tasked with teaching sex education even without specific qualifications — comfort with LGBTQ-inclusive terms and concepts (gender identity and expression, sexual identity, attraction, and behavior, etc.) is crucial.

To encourage pre-service sex education training for health- and physical-education teachers, the National Teacher Preparation Standards for Sexuality identify seven basic areas of competence educators should master to effectively teach sexuality education, including diversity and equity, which focuses on educators' ability to be inclusive and affirming and emphasizes the need to be LGBTQ-inclusive.[28] Other considerations for professional development include:

- Given the pervasiveness of LGBTQ stigma and discrimination, teachers need strategies not only to confront and manage biases exhibited by students, but also to identify and compensate for their own biases.
- While professional development and training is critical for health educators, it is also essential for other teachers and professionals, including school administrators, counselors, nurses, psychologists, etc., to whom students may turn for advice.
- Quality control is a key component of professional training to ensure standards and consistency. Even well-meaning educators (sometimes including even lesbian- or gay-identified teachers) may overestimate their competence in managing complex situations — for example, in talking with young people about trans issues, or the fact that young people may identify as straight, lesbian or gay, but engage in sexual behaviors with either gender.

Percentage of secondary schools in which the lead health education teacher received professional development during the 2 years before the survey on teaching students of different sexual orientations or gender identities



School Health Profiles, 2014

SCHOOL CLIMATE

Because sex education happens in the context of a broader school environment, multiple factors relating to school climate, beyond the health education classroom, impact the implementation and uptake of LGBTQ-inclusive curricula. For LGBTQ youth, the experience of feeling welcome or included in school is likely to affect their learning in all subjects. LGBTQ examples and experiences are often absent in general school curricula, including language, history and social studies, math and sciences — fewer than 20 percent of LGBTQ students report being taught any LGBT-related topics in any classroom.[29] LGBTQ youth sometimes have difficulty in identifying sympathetic adults to whom they can turn for advice or counsel. The disproportionate susceptibility of LGBTQ youth to violence, discrimination or bullying is well documented.[30]

Conversely, in a recent study, students at schools with LGBTQ-inclusive education were less likely to report bullying based on sexual orientation or gender expression, and more likely to feel safe.[31] But while a commitment to achieving a welcoming school environment is important, it is essential not to over-simplify what that means — e.g. while a Gay Straight Alliance (GSA) or an anti-bullying policy are desirable, they are not necessarily sufficient to achieve a welcoming school environment. Achieving a welcoming school environment for all youth requires a continuous effort to adapt to evolving challenges.

Recognizing the importance of LGBTQ-inclusivity and the need for sex educators to adapt both the content and setting of existing programs, in its current funding round the HHS Office of Adolescent Health required grantees to ensure that Teen Pregnancy Prevention Programs are LGBTQ-inclusive, both in terms of language and content, as well as the setting in which programs are delivered. To facilitate efforts to adapt existing curricula and programs, OAH developed a guide for assessing LGBTQ-inclusivity of Teen Pregnancy Prevention Programs.[32] The guide defines inclusivity on a spectrum from inclusive (i.e. a program that has made efforts to include LGBTQ youth) to affirming (i.e. a program that validates, supports, respects, and values the identities of all youth). Based on a consensus among field experts, the guide assesses inclusivity among six constructs related to both setting and content (see box), many of which would also apply to school-based sex education.

SIX LGBTQ INCLUSIVITY CONSTRUCTS FOR TEEN PREGNANCY PREVENTION PROGRAMS:

Organizational policies and practices: the extent to which program participants, facilitators, and other staff are held responsible for their actions and statements regarding LGBTQ individuals

Points of entry: the avenues and means by which youth reach a program, including recruitment strategies (e.g., outreach materials), as well as the manner in which youth are greeted upon arrival

Physical space: the characteristics of the room(s) and building(s) in which a program takes place

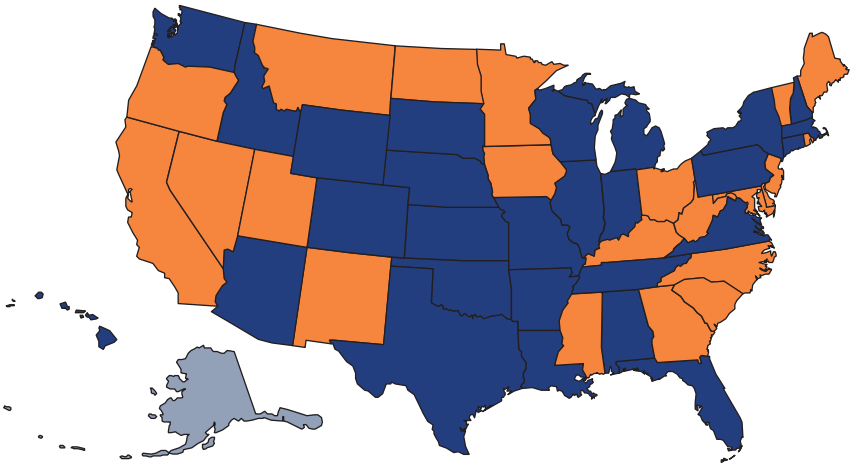
Staff competency: a reflection of the cultural competence of the program facilitator(s) and other staff related to working with LGBTQ youth

Language: the terminology used both in program materials and by the program facilitator(s)

Content: the accuracy and applicability of a program's material or subject matter to LGBTQ youth

SOURCE: Office of Adolescent Health, U.S. Department of Health and Human Services. A Guide for Assessing LGBTQ Inclusivity of Teen Pregnancy Prevention Programs, 2015. Available at: http://www.hhs.gov/ash/oah/oah-initiatives/assets/tpp-grantee-orientation/guide-for-lgbtq-inclusivity.pdf.

General Requirements, Sex Education and HIV Education: 24 states and the District of Columbia mandate sex education



Guttmacher Institute, State Laws and Policies as of May 1, 2016

STATE AND LOCAL POLICIES

Meeting participants noted the urgent need to reform state policies restricting or prohibiting LGBTQ-inclusive sex education, which pose a significant barrier. School policies in the United States are primarily established within state or local jurisdictions, and most states have policies requiring sex education and/or HIV education — 34 mandate HIV education, while 24 and the District of Columbia mandate sex education (22 states and DC mandate both). But laws and policies related to sex education across the country vary dramatically. Eight states restrict the teaching of LGBTQ-related content: Alabama, Arizona, Louisiana, Mississippi, Oklahoma, South Carolina, Texas, and Utah. Arizona specifically prohibits instruction that "promotes a homosexual life-style" or portrays homosexuality in a positive manner, while Alabama requires teachers to "emphasize […] that homosexuality is not a lifestyle acceptable to the general public and that homosexual conduct is a criminal offense under the laws of the state." Other states, such as Florida and North Carolina, mandate that sex education focus on "monogamous heterosexual marriage."[33,34]

While many states have no such prohibitions, few require education about sexual orientation or programs that are inclusive of LGBTQ youth — only nine states§ and the District of Columbia specifically require sex education to be inclusive of LGBTQ youth. Only 13 states require that sexual orientation be discussed at all.[35] Because the content of sex education is typically decided on a local level by school boards, advisory committees or even individual teachers — too often the result is not only the exclusion of LGBTQ youth, but also a failure to provide information about sexual orientation and gender identity to all youth.

In jurisdictions with progressive state policies (such as California, Massachusetts, and the District of Columbia), sex educators emphasized their importance in facilitating implementation of inclusive programs at the local level. Similarly, in making the case for inclusive sex education, educators in several states noted the value of national endorsements, position papers, and policy statements.

§ California, Colorado, Delaware, Iowa, New Jersey, New Mexico, Oregon, Rhode Island, Washington

FUNDING

Overall funding designated for sex education is very limited, contributing to highly uneven coverage across the United States. School-based sex education is funded through a variety of mechanisms, though often exclusively with locally controlled education funds. In some instances, this diversity in funding provides flexibility — but it can also make the implementation of sex education programs more challenging, with distinct application, program delivery, and reporting requirements. Federally, three HHS divisions support pregnancy and HIV prevention programs, including sex education (see box). While the Department of Education does not directly fund sex education, it does award grants to improve school climate. The recently passed Every Student Succeeds Act contains a variety of provisions that prioritize school climate and safety, and includes school climate factors such as incidents of bullying or harassment among the indicators that can be used to measure school quality and school success.

FY16 FEDERAL FUNDING FOR SEX EDUCATION

- In 2015, the HHS Office of Adolescent Health's Teen Pregnancy Prevention Program, currently funded at $101 million annually, awarded five-year cooperative agreements to 81 community organizations and local governments to implement evidence-based programs, and to develop and evaluate new and innovative approaches, to prevent teen pregnancy.
- Through the State Personal Responsibility Education Program (PREP), the HHS Administration for Children and Families, Family and Youth Services Bureau awards up to $75 million annually to states, local organizations and agencies, and tribal authorities to educate young people on both abstinence and contraception to prevent pregnancy and sexually transmitted infections, including HIV/AIDS. The program targets youth ages 10-19 who are homeless, in foster care, live in rural areas or in geographic areas with high teen birth rates, or come from racial or ethnic minority groups. The program also supports pregnant and parenting youth.
- The CDC Division for Adolescent and School Health, currently funded at $33.1 million annually, provides funding to select local (17) and state (19) education agencies to support exemplary sexual health education, increase adolescent access to sexual health services, and establish safe and supportive school environments. Meeting participants noted that for those agencies that receive awards, DASH funding has been pivotal in the implementation of sex education that is consistent with the science and best practices of effective health education, and in professional development and technical assistance to teachers and administrators.
- Finally, two federal initiatives support abstinence-only-until-marriage programs: 1) the Competitive Abstinence Education Grant program (recently replaced by a new "sexual risk avoidance" program to encourage "voluntarily refraining from non-marital sexual activity"),* administered by ACF, provides up to $10 million annually in two-year grants to community and faith-based organizations (22 organizations in 17 states and 1 territory); and 2) the Title V Abstinence-only-until-marriage program, also administered by ACF, provides up to $75 million annually to 36 states and 3 territories (which must provide $3 in matching funds or in-kind resources for every $4 in federal funds).

** The President's FY17 budget proposes eliminating this program.*

COMMUNITY SUPPORT

Community support — especially from parents — can be crucial to the success of sex education in general and LGBTQ-inclusive sex education in particular. With parental support, school administrators can gain confidence to pursue programming that meets the needs of all youth, and sometimes, to deflect opposition. Many successful programs find ways to foster and leverage community buy-in.

Sex education programs may also benefit from the support of the LGBTQ community. While LGBTQ-inclusive programs should strive to meet the needs of all students, some students may benefit from additional, external resources, and many jurisdictions establish successful partnerships with community organizations to which they can refer students. For example, Washington, D.C. public schools partners with Supporting and Mentoring Youth Advocate Leaders (SMYAL), which supports Gay-Straight Alliances in high schools and middle schools in the Washington DC metro area, providing LGBTQ youth with a much-needed safe space to process their identities and experiences.

SPOTLIGHT: PLANNED PARENTHOOD LOS ANGELES LGBT FAMILY ACCEPTANCE PROGRAM

Parental support can be key for students, as well, when parents support LGBTQ-inclusive sex education in schools, and reinforce the messages students learn. In Los Angeles, the Planned Parenthood affiliate developed an LGBT Family Acceptance Program using the Promotoras Comunitarias model, which trains Latina women who are knowledgeable and respected in the community to provide reproductive health information to other Latinas. In the LGBT Family Acceptance program, parents learn about challenges LGBT people face as a result of institutional discrimination and family rejection, with an emphasis on the unique experience of LGBT Latinos. They also learn about the vulnerability of LGBT youth of color within hostile school environments. The program aims specifically to dispel myths and increase knowledge related to LGBT issues, increase willingness to support LGBT family members, empathy for LGBT people's experience of discrimination, and participant's willingness to be a LGBT ally. Among 154 parents surveyed before and after completing the four-session curriculum, there was a significant increase among parents who disagreed with the statements "teasing is not a big deal" (41 percent to 87 percent), "I don't think about LGBT safety" (50 percent to 65 percent), and "they bring harassment onto themselves" (53 percent to 87 percent).

Recommendations

Insofar as most education laws, policies, and regulations are developed and implemented at the state or local level, there is an urgent need for state and local policymakers to remove restrictions and require LGBTQ-inclusive sex education. Policymakers should also support funding to develop and implement LGBTQ-inclusive sex education, and for teacher training, program evaluation and research.

While it cannot set education policy at the state or local level, the federal government can exert significant influence via the development of resources and tools, best practice standards, etc., as well as by supporting research, and as appropriate, providing conditional funding. In this context, the federal government's role should be to provide resources and incentives that are sufficiently flexible to allow for innovative approaches, while setting standards for LGBTQ inclusivity and continuous quality improvement. Specifically, the federal government should:

- Establish a federal coordinating mechanism. A single federal authority should be charged with ensuring that relevant agencies and departments are collaborating effectively, and that all federally funded programs that seek to improve sexual health, including those to reduce unintended pregnancy, STIs and HIV, are consistently LGBTQ-inclusive, by promulgating, for example:
  - **Common language and requirements defining LGBTQ-inclusivity standards across funding opportunity announcements, with compliance a condition of award.**
  - **Uniform guidance provisions that allow for funding non-governmental organizations when state/local agencies decline to adopt LGBTQ-inclusivity standards.**
  - **A common approach to civil rights concerns.** HHS and ED Offices of Civil Rights should explore enforcement approaches to ensure that programs are LGBTQ-inclusive.

At least three existing mechanisms could potentially fulfill this role: the Office of National AIDS Policy (ONAP), consistent with the call for HIV/STI prevention education in the National HIV/AIDS Strategy; the Interagency Working Group on Youth Programs (IWGYP), comprised of 18 federal agencies that support programs and services focusing on youth; or the National Prevention Council (NPC), which is charged with implementing the National Prevention Strategy, one priority of which is sexual and reproductive health.

- **Ensure that evidence-based program reviews consider scientific evidence from a broad range of disciplines, including social, behavioral, medical and public health sciences.** An exclusive focus on disease and pregnancy prevention often omits factors related to sexual orientation, gender identity and gender expression, which for all adolescents, but especially for LGBTQ youth, may shape their sexual agency and relationships and are essential for adolescent health. For example, as those factors are not considered in ASPE reviews to designate evidence-based programs, most EBPs are not inclusive. Moreover, when programs are not intentionally LGBTQ-inclusive, they may promulgate or reinforce harmful stereotypes and biases. Because OAH now requires that implemented programs be LGBTQ-inclusive, this requires grantees to adapt existing EPBs. Moving forward:
  - **Content guidelines.** In collaboration with scientific and health professional associations, the federal government should develop and disseminate content guidelines for federally funded sex education across programs to ensure medical accuracy and LGBTQ-inclusiveness.
  - **Decertify abstinence-only-until-marriage programs.** Sex education programs that rely on an abstinence-only-until-marriage approach, and which ignore or marginalize LGBTQ youth, should be removed from approved lists.
- **Leverage existing federal funding mechanisms.** While some federal programs are providing critical support for LGBTQ-inclusive sex education and supporting innovation, their scope is limited. These efforts should be expanded, as follows:
  - **DASH funding should be expanded and made available to qualifying agencies nationwide.** The CDC Division of Adolescent and School Health currently has HIV, STI, and Unintended Pregnancy Prevention cooperative agreements with 17 local and 19 state education agencies to support exemplary sexual health education, increase adolescent access to sexual health services, and establish safe and supportive school environments for all youth, including LGBTQ adolescents. Increasing funding to local education agencies in large urban areas, where HIV/STI rates among youth are especially high, is a particularly effective way to reach young African-American and Latino men-who-have-sex-with men, who are at disproportionate risk for HIV. Additional funding should also support demonstration sites to implement evidence-informed best practices with intensive technical assistance, state agencies for surveillance and monitoring, and local agencies for guidance development, dissemination of evidence-based tools, and professional development for administrators and school staff.
  - **Department of Education funding for safe and supportive school environments should support evidence-informed strategies to implement LGBTQ-inclusive sex education and professional development.** Ultimately, LGBTQ youth's uptake of even highly inclusive sex education programs will be mediated by multiple school climate factors. As such, the Department of Education should support the integration of LGBTQ-inclusive sex education as an important component of an LGBTQ-inclusive, safe and welcoming school environment.

- **The federal government should support a mechanism to facilitate local braiding of distinct funding streams.** "Braiding" is a strategy for using separate categorical funding streams together to support a range of programs that address local priorities — each source of funding that is braided retains its separate requirements and restrictions.** In some instances, braiding of private funds can further leverage public funds and encourage multisectoral partnerships — e.g. health care, public health, philanthropy, and social services. With federal investment in local infrastructure, multiple existing funding streams — such as the CDC's Division of Adolescent and School Health program or the OAH Teen Pregnancy Prevention Program — could be utilized more effectively to support LBGTQ-inclusive sex education and welcoming school environments.

- **Redirect funding for abstinence-only-until-marriage programs.** Both the Title V abstinence-only-until-marriage program, and the discretionary competitive abstinence education grant program (recently supplanted by a new "sexual risk avoidance" program) should be discontinued, with the resources from both programs redirected to support LGBTQ-inclusive sex education that is based on existing evidence and best practices. Not only do the significant resources currently supporting these ineffective programs waste money, but there is evidence to suggest that they do more harm than good. For example, LTBTQ youth who reported receiving abstinence-only based sex education were less likely to feel safe at school, more likely to miss school because they felt unsafe, and less likely to be able to identify LGBTQ-sympathetic personnel, or to discuss LGBTQ issues with any school personnel.[36]

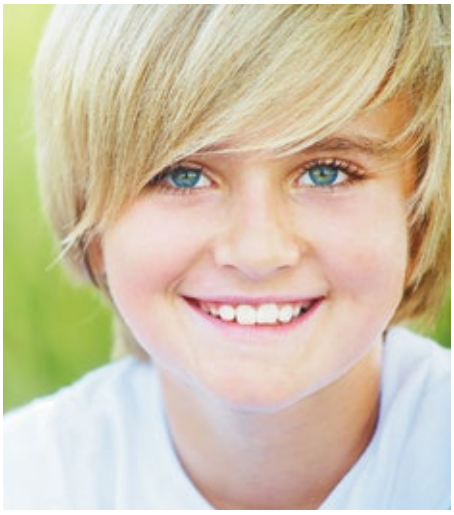
- **Leverage opportunities in the transformation of healthcare delivery and financing systems.** With the ongoing implementation of healthcare reform, there may be new opportunities to incorporate sex education within the healthcare delivery system. For example:

  - Healthcare reform increasingly employs value-based purchasing, where providers are paid for the value of their services (improved health outcomes and lower costs for a population), as opposed to their volume (fee-for-service). As such, Accountable Care Organizations (ACOs) and Managed Care Organizations (MCOs), both of which are paid to manage the health of a population, have an incentive to provide prevention services — such as LGBTQ-inclusive sex education as part of a strategy to reduce the risks of HIV, STIs and unplanned pregnancy. States can further incentivize Medicaid MCOs to invest in prevention strategies by including relevant quality measures in managed care contracts .[37]

  - New Medicaid authorities may also provide opportunities for sustainable financing for sex education:

    - Under the preventive services rule change, states can opt to reimburse for preventive services delivered by non-licensed providers, such as in the ***LGBT Family Acceptance Program*** described above.

    - Due to a reversal of what was known as the "free care policy," states can opt to expand the provision of Medicaid services in schools, a key venue for delivering sex education.



*** There are a few Federal initiatives designed to encourage braiding and blending of Federal funding streams, such as the Now is the Time, Performance Partnership Pilots for Disconnected Youth, Partnership for Sustainable Communities, Neighborhood Revitalization Initiative, Strong Cities, Strong Communities (SC2) and Promise Zones. In addition, community health improvement initiatives often blend public and private funding sources. For examples, see: http://www.nemours.org/content/dam/nemours/wwwv2/filebox/about/2013casestudies.pdf http://healthyamericans.org/health-issues/prevention_story/registry-colorado*

Albert Russ / Shutterstock.com

- States have the option of creating Medicaid Health Homes to improve care coordination and care management for Medicaid enrollees with complex needs. Medicaid Health Homes can be structured to target populations with one chronic condition and at risk for another. For example, a health home could target enrollees with a substance use disorder who are at risk for HIV and payment could support sex education as a health promotion service.
- Medicaid Targeted Case Management (TCM) is another optional state service that supports health promotion and care coordination, which could incorporate sex education. For example, the Rhode Island Medicaid program intends to cover TCM services for individuals who are deemed to be at risk of HIV infection, including men who have sex with men, bisexual men and women and transgender individuals.[38]
- Delivery System Incentive Reform Payments (DSRIPs) are a type of Medicaid waiver that allows states to test new delivery system and payment models. In Houston, DSRIP funds support the Department of Health's HIV service linkage program. The linkage program could connect patients to sex education programs.[39]

- In exchange for substantial tax advantages, non-profit hospitals are required to conduct, and to implement programming that responds to the findings of community health needs assessments. Sex education is a strategy hospitals could support to lower the risk of HIV and other STIs and improve the overall health of LGBTQ persons in their community.
- School-based health centers provide a range of sexual and reproductive health services for adolescents and are a key venue for delivery of evidence-informed, LGBTQ inclusive sexual health education. Many currently offer programs on sexual orientation and gender identity.[40]

- **State and local agencies should take advantage of provisions in the Every Student Succeeds Act to support school health and sex education.** ESSA, the recent- reauthorization of federal elementary and secondary school programs, may provide opportunities to support quality sex education in order to promote health, as a strategy for improving school and student success. Because most programming and spending decisions will be made at the state and local level, it will be up to schools to think proactively. For example, a variety of ESSA provisions prioritize school climate and safety, and include incidents of bullying, harassment, and dating violence — all of which might be partially addressed in sex education — among the indicators that can be used to measure school quality and school success. ESSA also includes health among subjects that comprise a well-rounded education, and provides funding to implement "well-rounded program(s) of instruction," which could include sex education. Specifically:
  - Funding is available to Title I schools (i.e. those in which at least 40 percent of students are low-income) that conduct a comprehensive needs assessment (with a particular emphasis on high-risk students) and develop a plan to address the academic achievement gap to implement "well-rounded programs of instruction."
  - Title II supports professional development and training services, for which new, broader criteria could include health and sex educators and related support personnel.
  - Title IV funding, for student support and academic enrichment grants and *21st Century Community Learning Centers,* may be used by states and local education agencies (LEAs) to develop, implement and evaluate programs that foster safe, healthy, supportive and drug-free environments, and to support their implementation by training school personnel. If funded, LEAs that receive more than $30,000 are required to spend 20 percent on at least one activity to help students be safe and healthy — since sex education programs support an active, healthy lifestyle, these grants could support their implementation. To qualify, LEAs must conduct a comprehensive needs assessment every three years
  - Several different ESSA provisions make funding contingent on state and local school needs assessments, which may be an opportunity for education partners to link with hospital community benefit needs assessments referenced above, as well assessments conducted by local public health agencies.
  - ESSA contains a variety of provisions that prioritize school climate and safety, and includes school climate factors such as incidents of bullying, harassment, and dating violence among the indicators that can be used to measure school quality and school success.

Conclusion

Well-designed and -implemented sex education has been shown to be effective in reducing the sexual risk behaviors among youth that can lead to HIV, STI, and teen pregnancy.[41] The knowledge and skills provided through sex education may be especially important for LGBTQ youth, who are at disproportionate risk for a variety of adverse mental, physical and sexual health outcomes, including but not limited to HIV. As such, all programs that aim to reduce unintended pregnancy, HIV or STIs, or to promote sexual health should be LGBTQ-inclusive — i.e. help all youth understand sexual orientation and gender identity; incorporate positive examples of LGBTQ individuals, romantic relationships and families; emphasize the need for protection during all kinds of sex among all kinds of people; and dispel common myths and stereotypes. To meet urgent public health priorities, the federal government should prioritize the consistent adaptation and implementation of LGBTQ-inclusive sex education.

Endnotes

1 Tornello SL, Riskind RG, Patterson CJ. Sexual orientation and sexual and reproductive health among adolescent young women in the United States. *J Adolescent Health,* 2014;54:160-168.

2 Herrick AL, Marshal MP, Smith HA, Sucato G, Stall RD. Sex while intoxicated: a meta-analysis comparing heterosexual and sexual minority youth. *J Adolescent Health,* 2011;48:306-309.

3 Kann L, Olsen EO, McManus T et al. Sexual identity, sex of sexual contacts, and health-risk behaviors among students in grades 9-12. Youth Risk Behavior Surveillance, selected sites, United States, 2001-2009. *MMWR Surveillance Summaries,* 2011;60(SS-7):1-134.

4 Remafedi G. "Health disparities for homosexual youth" [chapter] in: Wolitski RJ, Stall R, Valdiserri RO (eds). *Unequal Opportunity: Health Disparities Affecting Gay and Bisexual Men in the United States.* New York: Oxford University Press, 2008.

5 Institute of Medicine. "Childhood/Adolescence" [chapter] in: *The Health of Lesbian, Gay, Bisexual and Transgender People: Building a Foundation for Better Understanding.* Washington, DC: The National Academy Press, 2011: 153-157.

6 Saewyc E, Poon C, Wang N et al. (2007). *Not Yet Equal: The Health of Lesbian, Gay, & Bisexual Youth in British Colombia.* Vancouver, BC: McCreary Centre Society, 2007.

7 Blake SM, Ledsky R, Lehman T, Goodenow C, Sawyer R, Hack T. Preventing sexual risk behaviors among gay, lesbian, and bisexual adolescents: The benefits of gay-sensitive HIV instruction in schools. *AJPH,* 2001; 91: 940-946.

8 CDC Factsheet: Trends in U.S. HIV Diagnoses, 2005-2014. December 2015. Available at: http://www.cdc.gov/nchhstp/newsroom/docs/factsheets/hiv-data-trends-fact-sheet-508.pdf (accessed on February 26, 2016).

9 White House Office of National AIDS Policy. National HIV/AIDS Strategy for the United States: updated to 2020. Available at: https://www.aids.gov/federal-resources/national-hiv-aids-strategy/overview/ (accessed February 26, 2016).

10 GLSEN. *The 2013 National School Climate Survey: The experiences of lesbian, gay, bisexual and transgender youth in our nation's schools. 2014.* Available at: http://www.glsen.org/article/2013-national-school-climate-survey (accessed February 26, 2016).

11 Demissie Z, Brener ND, McManus T, Shanklin SL, Hawkins J, Kann L. *School Health Profiles 2014: Characteristics of Health Programs Among Secondary Schools.* Atlanta: Centers for Disease Control and Prevention, 2015.

12 Levine DS, Kantor LM, Steinke J, Root-Bowman M, Estabrook S. New findings on the needs of LGBTQ youth [poster]. Presented at the meeting of the American Public Health Association, Chicago, IL, November 2015.

13 CDC. *16 Critical Sexual Education Topics.* Available at: http://www.cdc.gov/healthyyouth/data/profiles/pdf/16_criteria.pdf (accessed March 10, 2016).

14 Ibid. Demissie Z et al.

15 Chin HB, Sipe TA, Elder RW et al, Community Preventive Services Task Force. The effectiveness of group-based comprehensive risk-reduction and abstinence education interventions to prevent or reduce the risk of adolescent pregnancy, Human Immunodeficiency Virus, and sexually transmitted infections: two systematic reviews for the Guide to Community Preventive Services. *Am J Prev Med* 2012;42(3):272-94.

16 Santelli, J, Ott MA, Lyon M, Rogers J, Summers D. Abstinence-only education policies and programs: A position paper of the Society for Adolescent Medicine. *J Adolescent Health,* 2006; 38: 83-87.

17 Advocates for Youth. *Abstinence-Only-Until-Marriage Programs: Ineffective, Unethical, and Poor Public Health.* Available at: http://www.advocatesforyouth.org/storage/advfy/documents/pbabonly.pdf (accessed February 26, 2016).

18 Stanger-Hall KF, Hall DW. Abstinence-Only Education and Teen Pregnancy Rates: Why We Need Comprehensive Sex Education in the U.S. *PLoS ONE,* 2007; 6(10): e24658. doi:10.1371/journal.pone.0024658

19 Underhill K, Montgomery P, Operario D. Sexual abstinence only programmes to prevent HIV infection in high income countries: systematic review. *BMJ,* 2007;335:448.

20 Greytak EA, Kosciw JG. "Responsive classroom curriculum for lesbian, gay, bisexual, transgender, and questioning students" [chapter] in: Fisher ES, Komosa-Hawkins, K [eds]. *Creating Safe and Supportive Learning Environments: A Guide for Working with Lesbian, Gay, Bisexual, Transgender, and Questioning Youth and Families.* New York: Routledge, 2013.

21 Herrman JW, Solano P, Stotz L, McDuffie MJ. Comprehensive sexuality education: A historical and comparative analysis of public opinion. *American Journal of Sexuality Education,* 2013;8:140-159.

22 Let's Talk Poll. New York: Planned Parenthood Federation of America and Center for Latino Adolescent and Family Health, 2015.

23 Ibid. Blake SM et al.

24 Future of Sex Education Initiative. *National Sexuality Education Standards: Core Content and Skills, K-12 [a special publication of the Journal of School Health],* 2012. Available at: http://www.futureofsexeducation.org/documents/josh-fose-standards-web.pdf (accessed on March 10, 2016).

25 Schalet AT, Santelli JS, Russell ST, et al. Broadening the evidence for adolescent sexual and reproductive health and education in the United States. *J Youth Adolescence,* 2014;43:1595-1610.

26 Schroeder E, Hauser D, Rodriguez M. "He-men, virginity pledges, and bridal dreams: Obama administration quietly endorses ab-only curriculum." Available at: http://rhrealitycheck.org/article/2012/05/01/he-men-virginity-pledges-and-bridal-dreams-an-hhs-endorsed-curriculum/ (accessed March 11, 2016).

27 Ibid. Demissie Z et al.

28 Future of Sex Education Initiative. National teacher preparation standards for sexuality education. Available at: http://www.futureofsexed.org/documents/teacher-standards.pdf (accessed April 5, 2016).

29 GLSEN. The 2013 National School Climate Survey: *The experiences of lesbian, gay, bisexual and transgender youth in our nation's schools. 2014.* Available at: http://www.glsen.org/article/2013-national-school-climate-survey (accessed February 26, 2016).

30 Birkett M, Espelage DL, Koenig B. LGB and questioning students in schools: the moderating effects of homophobic bullying and school climate on negative outcomes. *J Youth Adolescence,* 2009;38:989-1000.

31 Snapp SD , McGuire JK, Sinclair KO, Gabrion K, Russell ST. LGBTQ-inclusive curricula: why supportive curricula matter. *Sex Education,* 2015; 15: 580-596.

32 Office of Adolescent Health, U.S. Department of Health and Human Services. *A Guide for Assessing LGBTQ Inclusivity of Teen Pregnancy Prevention Programs, 2015.* Available at: http://www.hhs.gov/ash/oah/oah-initiatives/assets/tpp-grantee-orientation/guide-for-lgbtq-inclusivity.pdf (accessed March 9, 2016).

33 Advocates for Youth, ANSWER, GLSEN, Human Rights Campaign, Planned Parenthood Federation of America, SIECUS. *A Call to Action: LGBTQ Youth Need Inclusive Sex Education.* Available at: http://www.hrc.org/resources/a-call-to-action-lgbtq-youth-need-inclusive-sex-education (accessed February 26, 2016).

34 Guttmacher Institute. "State Policies in Brief: Sex and HIV Education, as of May 1, 2016." Available at: https://www.guttmacher.org/state-policy/explore/sex-and-hiv-education.

35 Ibid. Guttmacher Institute.

36 Kosciw JG, Diaz EM, Greytak EA. *The 2007 National School Climate Survey: The experiences of lesbian, gay, bisexual and transgender youth in our nation's schools, 2008.* Available at: http://www.glsen.org/sites/default/files/2007%20National%20School%20Climate%20Survey%20Full%20Report.pdf (accessed March 15, 2016).

37 National Alliance of State and Territorial AIDS Directors. *Financing HIV prevention services: Collaboration and innovation between public health and Medicaid Agencies,* February 9, 2016. Available at: https://www.nastad.org/Financing-HIV-Prevention (accessed April 14, 2016).

38 Ibid. National Alliance of State and Territorial AIDS Directors.

39 Ibid. National Alliance of State and Territorial AIDS Directors.

40 Boonstra HD. Meeting the sexual and reproductive health needs of adolescents in school-based health centers. *Guttmacher Policy Review,* 2015;18:21-26.

41 Chin HB, Sipe TA, Elder RW et al, Community Preventive Services Task Force. The effectiveness of group-based comprehensive risk-reduction and abstinence education interventions to prevent or reduce the risk of adolescent pregnancy, Human Immunodeficiency Virus, and sexually transmitted infections: two systematic reviews for the Guide to Community Preventive Services. *Am J Prev Med* 2012;42(3):272-94.

1730 M Street, NW, Suite 900
Washington, DC 20036
(t) 202-223-9870
(f) 202-223-9871