

Health Impact Review of ESSB 5395
Concerning comprehensive sexual health education (2020 Legislative Session)

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Full review

The full Health Impact Review report is available at:

<https://sboh.wa.gov/Portals/7/Doc/HealthImpactReviews/HIR-2020-08-ESSB5395.pdf>

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Executive Summary

ESSB 5395, Concerning comprehensive sexual health education (2020 Legislative Session)

Evidence indicates that ESSB 5395 has the potential to increase provision of inclusive, comprehensive sexual health education, which will improve sexual and reproductive health outcomes for students and decrease inequities for multiple groups of students. It is unclear how the bill will impact health inequities for students that are opted-out of school-based, comprehensive sexual health education curriculum.

BILL INFORMATION

Sponsors: Senate Committee on Early Learning & K-12 Education (originally sponsored by Senators Wilson, C., Randall, Keiser, Saldaña, Takko, Mullet, Wellman, Das, Nguyen, Billig, Pedersen, Rolfes, Darneille, Dhingra, Hasegawa, Hunt, Kuderer)

Summary of Bill:

- Requires every public school (K-12) to provide comprehensive sexual health education, which is evidence-informed, medically and scientifically accurate, age-appropriate, and inclusive of all members of protected classes by September 1, 2021.
- Directs Office of Superintendent of Public Instruction (OSPI) to develop a list of comprehensive sexual health education curricula that meet state requirements and to create instructional materials review tools.
- Requires public schools to either implement a comprehensive sexual health education curriculum from the OSPI curricula list or to use the OSPI review tools when choosing curricula other than those on the list.
- Allows parents or legal guardians to excuse their child from planned instruction in comprehensive sexual health education through a written request.

HEALTH IMPACT REVIEW

Summary of Findings:

The Health Impact Review found the following evidence regarding the provisions in ESSB 5395:

- This review made the **informed assumption** that requiring every public school (K-12) in Washington to provide comprehensive sexual health education that meets state standards would result in more school districts becoming more compliant with and/or implementing evidence-informed, comprehensive, inclusive sexual health education curriculum. This assumption is based on discussions with staff at OSPI, Oregon Department of Education, and Rhode Island Department of Education.
- **Strong evidence** that implementing evidence-informed, comprehensive, inclusive sexual health education curricula in public schools would improve sexual and reproductive health outcomes for students.
- **Very strong evidence** that improving sexual and reproductive health outcomes would reduce health inequities for multiple groups of students.
- **Unclear evidence** for how ESSB 5395 will impact health inequities for students that are opted-out of school-based comprehensive sexual health education.

Introduction and Methods

A Health Impact Review is an analysis of how a proposed legislative or budgetary change will likely impact health and health disparities in Washington State ([RCW 43.20.285](#)). For the purpose of this review ‘health disparities’ have been defined as the differences in disease, death, and other adverse health conditions that exist between populations ([RCW 43.20.270](#)). This document provides summaries of the evidence analyzed by State Board of Health staff during the Health Impact Review of Engrossed Substitute Senate Bill 5395 ([ESSB 5395](#)).

Staff analyzed the content of ESSB 5395 and created a logic model depicting possible pathways leading from the provisions of the bill to health outcomes. We consulted with experts and contacted key informants about the provisions and potential impacts of the bill. We conducted an objective review of published literature for each pathway using databases including PubMed, Google Scholar, and University of Washington Libraries. More information about key informants and detailed methods are available upon request.

The following pages provide a detailed analysis of the bill including the logic model, summaries of evidence, and annotated references. The logic model is presented both in text and through a flowchart (Figure 1). The logic model includes information on the strength-of-evidence for each relationship. The strength-of-evidence has been defined using the following criteria:

- **Not well researched:** the review of literature yielded few if any studies or only yielded studies that were poorly designed or executed or had high risk of bias.
- **A fair amount of evidence:** the review of literature yielded several studies supporting the association, but a large body of evidence was not established; or the review yielded a large body of evidence but findings were inconsistent with only a slightly larger percentage of the studies supporting the association; or the research did not incorporate the most robust study designs or execution or had a higher than average risk of bias.
- **Strong evidence:** the review of literature yielded a large body of evidence on the relationship (a vast majority of which supported the association) but the body of evidence did contain some contradictory findings or studies that did not incorporate the most robust study designs or execution or had a higher than average risk of bias; or there were too few studies to reach the rigor of “very strong evidence;” or some combination of these.
- **Very strong evidence:** the review of literature yielded a very large body of robust evidence supporting the association with few if any contradictory findings. The evidence indicates that the scientific community largely accepts the existence of the association.

This review was subject to time constraints, which influenced the scope of work for this review. The annotated references are only a representation of the evidence and provide examples of current research. In some cases only a few review articles or meta-analyses are referenced. One article may cite or provide analysis of dozens of other articles. Therefore the number of references included in the bibliography does not necessarily reflect the strength-of-evidence. In addition, some articles provide evidence for more than one research question, so are referenced multiple times.

Analysis of ESSB 5395 and the Scientific Evidence

Summary of relevant background information

- Sexual health education instructional materials must meet the Washington State requirements detailed in the AIDS Omnibus Act (1994), Healthy Youth Act (2007), and the rules and guidelines pertaining to the prohibition of discrimination in instructional materials (2010).
- The AIDS Omnibus Act (RCW [28A.230.070](#)) requires that public schools in Washington State provide annual instruction for students in 5th through 12th grades about human immunodeficiency virus (HIV).¹ The chosen curriculum must be scientifically and medically accurate, teach which behaviors put a person at risk of infection, and discuss methods to avoid risk.¹ Parents and guardians have the right to preview the educational materials and may excuse their child(ren) by submitting an objection to participation in writing.¹
- The State Healthy Youth Act (RCW [28A.300.475](#)) requires that every public school that offers sexual health education must assure that instruction is medically and scientifically accurate; age-appropriate; appropriate for students regardless of gender, race, disability status, or sexual orientation; and includes information about abstinence and other methods of preventing unintended pregnancy and sexually transmitted diseases (STDs).² The act allows a parent or legal guardian to excuse their child(ren) from planned instruction in sexual health education by written request.²
 - The Act also directs Office of Superintendent of Public Instruction (OSPI) to annually review HIV prevention and sexual health education curricula to assess consistency with state law. OSPI conducts reviews biennially of both comprehensive and supplemental instructional materials. Reviews are conducted in collaboration with Department of Health (DOH) to ensure medical accuracy.³ The review considers other factors, including curriculum design and whether curricula is evidence-informed (e.g., based on health behavior change theory) or evidence-based (i.e., proven effective through rigorous evaluation) (OSPI, personal communication, June 2019). OSPI publishes the list of reviewed curricula on the agency's website for schools and school districts to use when considering which curriculum to adopt.⁴ While OSPI does not approve or endorse curriculum, its "2015-17 Reviewed HIV/Sexual Health Instructional Materials" identifies which curricula meet state requirements, which require some modification to meet requirements, and which are not consistent with state requirements or are consistent only with major modifications.⁵
- The K-12 Education – Prohibition of Discrimination (RCW [28A.642.020](#)) requires OSPI to develop rules and guidelines to eliminate discrimination in Washington public schools as it applies to various elements, including textbooks and instructional materials used by students.⁶ Prohibited discrimination includes that "on the basis of race, creed, religion, color, national origin, honorably discharged veteran or military status, sexual orientation including gender expression or identity, the presence of any sensory, mental, or physical disability, or the use of a trained dog guide or service animal by a person with a disability."⁶

- In 2016, OSPI adopted the Washington State Health & Physical Education K-12 Learning Standards, which includes sexual health education.⁷ The sexual health education grade-level outcomes were developed using, “research on what kind of health education is needed to keep students safe and healthy; and guidelines from organizations such as the American Academy of Pediatrics and the Centers for Disease Control and Prevention (CDC) that recommend when students need information.”⁸ Topics are phased in as developmentally appropriate. For example:
 - Elementary school—Healthy relationships are discussed in every grade level. In kindergarten, students “recognize ways to express feelings” and “recognize people have the right to refuse giving or receiving unwanted touch.”⁷ By Grade 4, students are expected to “explain [the] importance of communicating with trusted adults about relationships.”⁷ The topic of reproduction begins in Grade 2, at which point students are expected to “understand living things can reproduce.”⁷ In Grade 5, students are expected to “recognize puberty prepares the body for reproduction.”⁷
 - Middle school—Puberty and development are discussed at every grade level. In Grade 6, students are expected to “identify physical, social, mental, and emotional changes that occur during puberty.”⁷ By Grade 8, students will be able to “describe the physical, social, mental and emotional changes that occur during adolescence.” Self-identity is also discussed. In Grade 6, students should “understand the range of gender roles, identity, and expression across culture.”⁷ By Grade 8, students should “recognize external influences that shape attitudes about gender identity, gender expression, and sexual orientation.”⁷
 - High school—Prevention is addressed at all grade levels, and students are expected to “evaluate the effectiveness of abstinence, condoms, and other contraceptives in preventing pregnancy and STDs/HIV” and “use a decision-making model to make a sexual health-related decision.”⁷ Specific to healthy relationships, students are expected to “demonstrate effective ways to communicate with a partner about healthy sexual decisions and consent” and “analyze factors that can affect the ability to give or recognize consent to sexual activity.”⁷
- In federal fiscal year 2017, federal funding for sexual health education totaled \$299 million dollars.⁹ There are currently three main federal funding programs for abstinence-based education and two for comprehensive sexual health education.⁹
 - *Abstinence-based*: Federal funding for sexual health education in the form of abstinence-only-until-marriage began in 1981 as a result of the Adolescent Family Life Act.¹⁰ Title V of the 1996 Social Security Act (Title V, Section 510) reaffirmed this funding and stipulated that abstinence-only-until-marriage education, “has as its exclusive purpose, teaching the social, psychological, and health gains to be realized by abstaining from sexual activity.”¹⁰ The definition of abstinence specified eight points (A-H), and prohibits teaching about condoms or contraception except to emphasize failure rates.⁹ The program was affirmed again in 2010 by the Patient Protection and Affordable Care Act (ACA).⁹ In 2012,

Congress created the “Sexual Risk Avoidance Education” program, which bypassed state authority and provided grants directly to community organizations.⁹ The purpose of this program is to promote “‘voluntarily refraining from non-marital sexual activity’ and teaching the benefits ‘associated with self-regulation.’”¹⁰ Federal funding for abstinence-only programs in 2017 totaled \$90 million dollars across these two federal funding programs, including \$75 million dollars for the Title V Abstinence-Only-Until-Marriage program and \$15 million dollars for Sexual-Risk Avoidance Education.⁹ Approximately half of states refuse federal Title V funding,^{9,10} including Washington State.¹¹ In 2018, Congress increased funding for sexual-risk avoidance programs by 67%.⁹ Teen-Aid Inc., located in Spokane, Washington, received Sexual-Risk Avoidance Education funding in 2018.¹¹ Teen-Aid Inc. is a non-profit organization founded in 1981 to develop an alternative approach to sexual health education.¹² The organization notes that, “the purpose of this corporation is to encourage premarital abstinence as a life-style among teens and foster virtuous character development...by promoting effective parent-teen communication, increasing fertility awareness and respect for the power to create life, and embracing the standard of parenting within wedlock thereby reducing the many adverse consequences...of premarital sexual activity.”¹² Lastly, the Teen Pregnancy Prevention (TPP) Program historically provided funding to replicate evidence-based teen pregnancy prevention programs.^{9,13} However, in 2017, federal program requirements changed to stipulate that grantees must replicate one of two abstinence-based programs to receive funding (rather than choosing from the list of 44 evidence-based teen pregnancy prevention programs provided by U.S. Department of Health and Human Services [HHS]).⁹ In 2015, Public Health – Seattle & King County (PHSKC) received a 5-year grant through the TPP Program to evaluate its High School Family Life and Sexual Health (FLASH) curriculum.^{11,13,14}

- *Comprehensive sexual health education:* There are two main federal funding programs for comprehensive sexual health education. The Personal Responsibility Education Program (PREP) (\$75 million in federal fiscal year 2017) provides grants to states to support evidence-based sexual health education that provides education about both abstinence and contraception.⁹ Washington State currently receives PREP funding.¹¹ The Division of Adolescent and School Health (DASH) (\$33 million in federal fiscal year 2017) provides funding to reduce AIDS/HIV disparities and increase surveillance of school health policies and practice.⁹ In Washington State, Seattle Public Schools currently receives DASH funding.¹¹
- As of May 2019, 22 states and the District of Columbia mandated both sexual health education and HIV education, and two states mandated sexual health education only.¹⁵ Of states requiring sexual health education, requirements in California, Oregon, and Rhode Island most closely align with the provisions in ESSB 5395, including requirements that content must be medically accurate, age appropriate, culturally appropriate, and inclusive of sexual orientation; that parents/legal guardians may opt-out of curricula; and that

curricula must include contraception, abstinence, avoiding sexual coercion, and skills in making healthy sexual decisions.¹⁵

- Multiple national professional associations have supported comprehensive sexual health education, including the American Medical Association; American Academy of Pediatrics; American College of Obstetricians and Gynecologists; National Academies of Science, Engineering, and Medicine; American School Health Association; and Society for Adolescent Health and Medicine.¹⁶⁻¹⁹
- The 2019-2021 Washington State Enacted Operating Budget required OSPI to convene a Workgroup to explore the feasibility of requiring comprehensive sexual health education for public school students in grades K-12 in Washington State.²⁰ In December 2019, the workgroup submitted its report and recommendations to the Legislature and the Governor's Office.²¹ The Workgroup recommended that "all students in Washington's public schools should have access to comprehensive sexual health education in grades K-12." The report states, "Mandating [comprehensive sexual health education] is an issue of equity" and that "several groups are often excluded from relevant, inclusive instruction, including students in out of home care, students with disabilities, students who identify as LGBTQ+, and English learners, among others."²¹ In response to concerns from the public, Workgroup members proposed that any effort to require comprehensive sexual health education include language clarifying specific topics for students in grades K-3.²¹
- In August 2019, Lake Research Partners conducted a polling project for Planned Parenthood Votes Northwest and Hawaii to assess registered voters' views on a variety of topics related to reproductive health.²² Washington State findings are based on a statewide phone survey of 500 registered voters with an oversample of 100 people of color. Results were weighted by gender, region, age, race, and party identification.²² The survey of Washington State voters found 86% support (70% strongly support) teaching medically accurate, age appropriate, comprehensive sexual health education in public schools.²²

Summary of ESSB 5395

- Requires every public school (K-12) to provide comprehensive sexual health education, which is evidence-informed, medically and scientifically accurate, age-appropriate, and inclusive of all members of protected classes by September 1, 2021.
 - Specifies comprehensive sexual health education curriculum in public schools must include skills-based instruction on abstinence and other methods of preventing unintended pregnancy; healthy relationships; identifying and responding to attitudes and behaviors that contribute to sexual violence; and affirmative consent.
 - Requires instruction and materials be inclusive and use language and strategies that recognize all members of protected classes.
- Directs OSPI to develop a list of comprehensive sexual health education curricula that meet state requirements, to create instructional materials review tools, and to publish the list and tools on the OSPI website.

- Requires public schools to either implement a comprehensive sexual health education curriculum from the OSPI curricula list or to use the OSPI review tools when choosing curricula other than those on the list.
- Requires school districts to report the curricula used to provide comprehensive sexual health education on an annual basis.
- Allows parents or legal guardians to excuse their child(ren) from planned instruction in comprehensive sexual health education through a written request submitted to either the school's principal (or designee) or the school district board of directors (or designee).
 - Requires schools grant a parent's or legal guardian's written request to excuse their child(ren) from comprehensive sexual health education instruction.

Pathway to health impacts

The potential pathway leading from the provisions of ESSB 5395 to decreased health inequities are depicted in Figure 1. We made the informed assumption that requiring every public school (K-12) in Washington to provide comprehensive sexual health education that meets state standards would result in school districts implementing evidence-informed, comprehensive, inclusive sexual health education curriculum. This informed assumption is based on discussions with staff at OSPI, Oregon Department of Education, and Rhode Island Department of Education. There is strong evidence that implementing evidence-informed, comprehensive, inclusive sexual health education curricula in public schools would improve sexual and reproductive health outcomes for students.²³⁻³⁰ Lastly, there is very strong evidence that ESSB 5395 will reduce health inequities for multiple groups of students, including for students by disability status, foster care status, gender identity, geography, housing status, juvenile detention, migrant students, sexual orientation, race/ethnicity, and victims and survivors of violence.^{17,30-32} However, there is unclear evidence for how ESSB 5395 will impact health inequities for students that are opted-out of school-based comprehensive sexual health education.^{16,33,34} Each of these factors is analyzed beginning on page 13.

Due to time limitations, we only researched the most direct connections between the provisions of the bill and decreased health inequities and did not explore the evidence for all possible pathways. For example, we did not evaluate potential impacts related to:

- Whether requiring public schools to teach inclusive, comprehensive sexual health education impacts youths' access to and use of reproductive health services. Lack of or limited sexual health education has been documented as a barrier to accessing reproductive healthcare services.^{35,36}

Magnitude of impact

Washington State has 295 public school districts,³⁷ which served 1,105,391 students (K-12) during the 2018-2019 school year.³⁸ This includes approximately 507,000 students enrolled in elementary school (grades K-5); 256,000 students in middle school (grades 6-8); and 343,000 in high school (grades 9-12).³⁸

Providing school-based sexual health education, other than HIV and STD prevention instruction, is not currently mandatory in Washington State. Current law stipulates that if a public school

provides sexual health education it must ensure that instruction meets the requirements outlined in the State Healthy Youth Act and AIDS Omnibus Act.² However, key informants shared it is challenging to assess to what extent Washington public schools are currently in compliance with these laws, and available data are limited. OSPI considers a school as teaching comprehensive sexual health education if it reports teaching at least 18 out of 20 CDC identified critical sexual health topics (OSPI, personal communication, June 2019). Approximately 80% of high schools in Washington State reported teaching 18 out of 20 topics in 2018 (unpublished data, OSPI, personal communication, June 2019). Data from the CDC's 2018 School Health Profiles found 59.2% of all high schools and 29.5% of all middle schools in Washington State reported teaching all 20 CDC identified critical sexual health topics (unpublished data, OSPI, personal communication, May 2019) (See Appendix 1 for more information). However, because the survey asks for a binary response (i.e., yes or no) to report whether or not the topic was taught, responses do not indicate whether the instruction provided aligns with state requirements. Additionally, because School Health Profiles data are collected from only a sample of schools and the survey consists of self-administered questionnaires completed by the principal and lead health education teacher at each sampled school, responses may be representative of the instruction expectations (principal) or respondent's classroom instruction (lead teacher) rather than school-wide or district-wide practices (OSPI, personal communication, May 2019).

A recent survey with 156 youth across the state found that approximately 89% of respondents said they had received sexual health education in school just once, with 41% of respondents indicating they had received sexual health education once in middle school and 48% indicating they had received sexual health education once in high school.³⁹ About 18% of respondents said they had not received any sexual health education in school.³⁹ Key informants shared that schools may be providing instruction once during high school (e.g., in 9th grade) rather than once per grade level (personal communication, May to June 2019). According to the School Health Profiles, teacher-reported hours of sexual health education in Washington increased between 2016 and 2018.⁴⁰ In 2016, about 20% of middle and high schools taught no sexual health education or provided less than 1 hour of instruction, while just over a quarter provided 10 or more hours of instruction.⁴⁰ In 2018, 39% of middle and high schools reported more than 10 hours of sexual health instruction, 54% reported 1-10 hours, and 7% reported less than 1 hour or no instruction (unpublished data, OSPI, personal communication, May 2019).

In addition, key informants shared that some schools are providing abstinence-only sexual health education despite curriculum not aligning with state law (personal communication, June 2019). While it is unclear exactly how many schools in the state are doing so, a random survey of schools in Washington found that 17 schools reported using abstinence-only curricula in 2014; 19 schools in 2016; and 5 schools in 2018 (OSPI, personal communication, June 2019). As part of their biannual review of curricula, OSPI prioritizes curricula in use by multiple schools. They intended to review two abstinence-only curricula reported being used by schools as part of their 2019 review, but neither curricula publisher responded to OSPI's request for access to the instructional materials (OSPI, personal communication, June 2019).

School Health Profiles also asked respondents to estimate what percentage of students are waived out of the sexual health education classes (not the required HIV/AIDS education) by their parents/guardians. Approximately 17% of 264 responding lead health teachers estimated no opt-

outs; 48% estimated less than 1% were opted-out; 30% estimated 1-5% were opted-out; less than 1% estimated 6-10% were opted-out; and 4% estimated more than 10% were opted-out (unpublished data, OSPI, personal communication, June 2019). However, there is limited information about which students are being opted-out and whether they are being opted-out from sexual health education curricula completely or out of specific lesson plans.

To address some data gaps, OSPI added questions to a mandatory survey to assess what grade levels sexual health education instruction was provided and what curriculum was used during the 2018-2019 school year (OSPI, personal communication, May 2019). Results of the survey were reported to the Legislature in December 2019. Of the 285 responding districts, 93% (266) reported providing sexual health education in at least one grade band: K-5th (64.7%), 6th-8th (86.1%), and 9th-12th (75.2%).⁴¹ Nineteen (6.6%) school districts reported that the district does not offer sexual health education.⁴¹ The survey also showed “a significant number of districts (42.1%) reported using district-developed curricula or ‘other’ curricula (17.7%),” which were not reviewed by OSPI in 2015 or 2017 for compliance with State requirements.⁴¹ While provisions of ESSB 5395 do not give OSPI the authority to enforce the requirement, school districts would still be required to report to OSPI the curriculum used on an annual basis for monitoring purposes.

In terms of health outcomes, results of the 2018 Healthy Youth Survey found that 9% percent of 8th graders, 26% of 10th graders, and 47% of 12th graders in Washington State reported ever having sex.⁴² Survey results demonstrated that sexual behaviors among Washington students who have had sex put them at risk for unplanned pregnancy and STIs.⁴² For example, among 10th graders who reported having had sex, 4% had sex before age 13 years, 5% had sex with four or more partners, and 55% used a condom during last sexual intercourse.⁴² In 2017, Washington youth aged 13-17 years comprised 9.0% (2,922 cases), 3.7% (77 cases), and 3.6% (359 cases) of new chlamydia, herpes, and gonorrhea diagnoses, respectively (unpublished data, DOH, personal communication, August 2018). A recent DOH analysis shows rates of STDs among youth ages 15 to 19 years of age have increased significantly over the past five years (chlamydia rates increased 23%; gonorrhea rates increased 71%; and syphilis rates increased 120%).⁴¹ Meanwhile, Washington data show adolescent pregnancy rates have declined steadily over the past five years (37% decrease among youth ages 15 to 17 years and 24% decrease among those ages 18 to 19 years).⁴¹ In 2016, the teen pregnancy rate among youth aged 15-19 years in Washington State was 24.4 pregnancies per 1,000 women.⁴³ The rate was 10.8 pregnancies per 1,000 women aged 15-17 years and 44.7 pregnancies per 1,000 women aged 18-19 years.⁴³ Healthy Youth Survey data also show “statewide rates of youth-reported depression increased from 2014 to 2018, with females much more likely to report feeling depressed.”⁴¹ Overall, “18.5% more 8th graders, 14.3% more 10th graders, and 20.6% more 12th graders reported feeling depressed in 2018 than in 2014.”⁴¹ Meanwhile, suicide rates among youth ages 15 to 19 years of age were 32% higher in 2017 than in 2013, with rates for males significantly higher than females.⁴¹ “However, total numbers of suicides are low enough that rates fluctuate widely from year to year.”⁴¹

Overall, since there is limited data available about the extent to which public schools are in compliance with current law as well as limited information about which students and how many students are currently receiving comprehensive sexual health education in Washington, this HIR

cannot estimate how many additional students would receive comprehensive sexual health education as a result of ESSB 5395. Therefore, this HIR also cannot estimate the potential magnitude of impact on health outcomes, including changes in the rate of STIs or teen pregnancies.

Logic Model

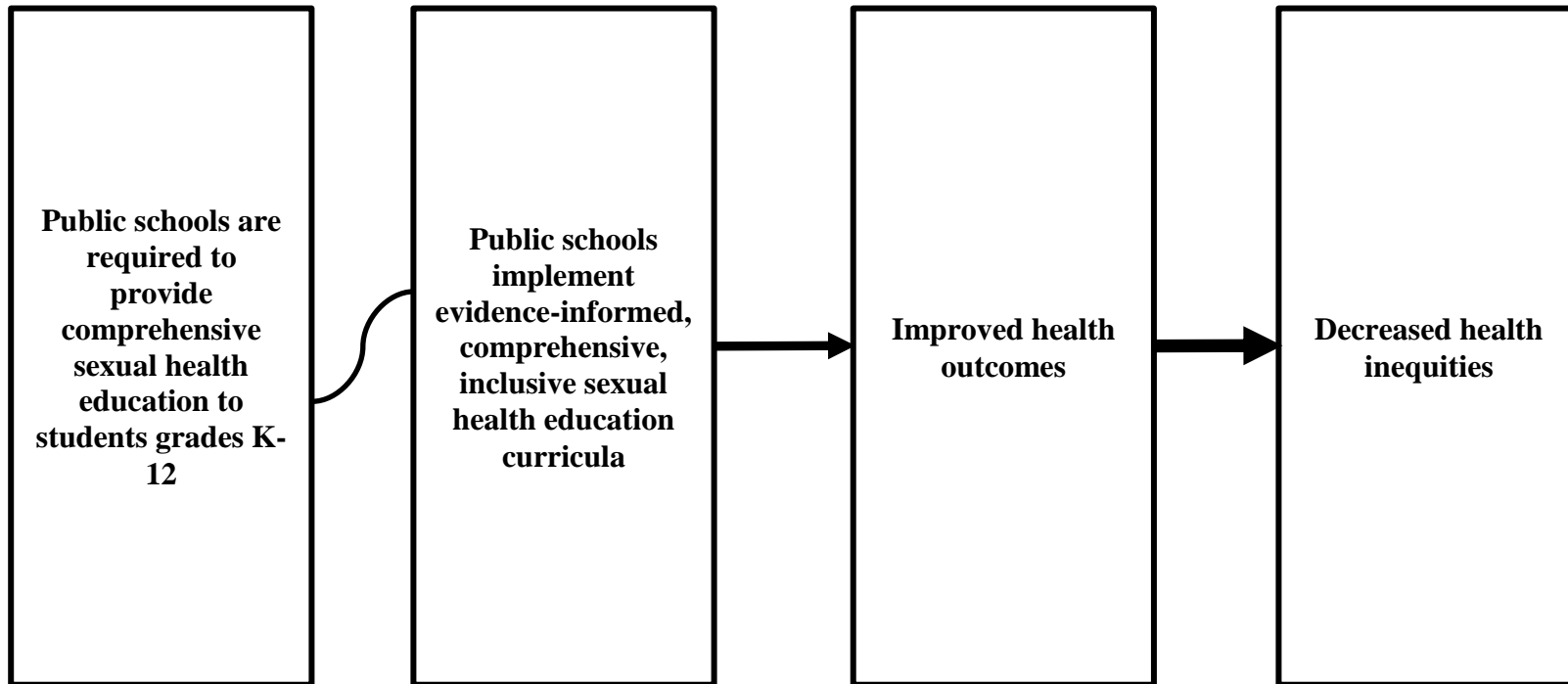
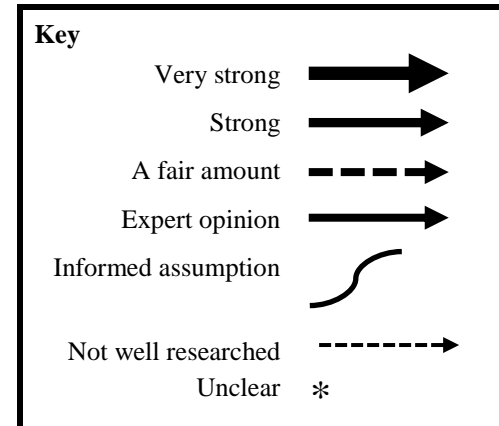


Figure 1
Concerning comprehensive sexual health education
ESSB 5395



Summaries of Findings

Will requiring public schools to provide comprehensive sexual health education to students in grades K-12 result in schools implementing evidence-based, comprehensive, inclusive sexual health education curricula?

We have made the informed assumption that requiring public schools (K-12) in Washington to provide comprehensive sexual health education that meets state standards would result in more school districts becoming more compliant with and/or implementing evidence-informed, comprehensive, inclusive sexual health education curriculum. This assumption is based on discussions with staff at OSPI, Oregon Department of Education (ODE), and Rhode Island Department of Education (RIDE).

Like Washington, Oregon and Rhode Island are local control states, in which local school committees are responsible for determining how they implement state requirements (ODE, personal communication, June 2019; RIDE, personal communication, June 2019). Both ODE and RIDE monitor compliance with state regulations through an annual survey. In Oregon, districts are required to report to ODE each February whether or not the district is teaching mandated academic requirements, which includes sexual health education standards (ODE, personal communication, June 2019). According to its statutory authority, RIDE asks schools when the health curriculum was last modified or updated (minimum every 5 years) and how many minutes of dedicated health and physical education instruction it provides (minimum of 100 minutes per week) (RIDE, personal communication, June 2019). Neither survey asks what curriculum is being used, as regulating curriculum is outside the agencies' statutory authority. Staff members in both states acknowledge the limitations of self-reported compliance data. ODE staff noted that in practice they know that many school districts are not meeting compliance requirements (ODE, personal communication, June 2019). However, without additional data it is difficult to know to what extent schools and districts are out of compliance. Meanwhile, RIDE staff also recognize self-report is not a perfect system. However, by virtue of school leaders asking questions to make sure they are calculating instructional time and reporting correctly, RIDE staff think these actions support the fact that schools are actually doing what they report (RIDE, personal communication, June 2019). Cardea Services, which provides technical assistance to schools to implement comprehensive sexual health education in multiple states, has noted that, to truly assess the extent of compliance with statutes would require direct observation in classrooms across each state (Cardea Services, personal communication, June 2019).

RIDE has statutory authority to enforce compliance with Rhode Island's mandated sexuality and family life standards. If a school does not meet the final deadline by which to report either compliance with or actions underway to meet state requirements, then the compliance issue is elevated from RIDE's sexual health education program, and the Commissioner's Office is notified and a legal intervention is initiated (RIDE, personal communication, June 2019). Despite having statutory authority to enforce compliance, RIDE staff members regularly receive questions from schools and districts seeking guidance (RIDE, personal communication, June 2019). RIDE's sexual health education program notifies schools and districts when they are not following the legislation and works to help them get into compliance. Staff noted that, "we want schools to be successful within the guardrails of the legislation" (RIDE, personal

communication, June 2019). Conversely, ODE does not currently have the statutory authority to enforce its comprehensive sexual health requirement, and staff noted that it is too soon to enforce compliance, since it was only first required for implementation in the 2018-2019 school year (ODE, personal communication, June 2019). Many schools and districts, particularly those in rural parts of the state, need additional time and resources to get into compliance (increased availability of appropriate curriculum, teacher professional development, etc.) (ODE, personal communication, June 2019). In the future, the state may consider appropriate enforcement mechanisms (e.g., curriculum audit), but for now the agency is focused on providing resources and support to help schools and districts to implement the requirements (ODE, personal communication, June 2019). This is similar to Washington, as provisions of ESSB 5395 do not give OSPI the authority to enforce the requirement but require school districts to report annually which curriculum are used to OSPI for monitoring purposes.

Staff from all three states stressed the importance of state department of education staff connecting school districts and schools to resources to support successful implementation of sexual health education and to overcome challenges (personal communication, May to June 2019). Common challenges include identifying curricula that meet state standards, providing appropriate teacher training and professional development, designating enough time to teach standards, and, for under resourced schools, accessing financial resources to implement (personal communication, May to June 2019). Similarly, interviews with 16 school districts in Washington State found that no respondents were opposed to mandating sexual health education, but that respondents had concerns about implementation.³⁴ For example, respondents were concerned about adding one more required component to graduation requirements and about where to fit content into existing curricula.³⁴

Key informants shared that curriculum requirements outlined by the California, Oregon, and Washington state legislatures are so comprehensive and detailed that currently no single curriculum teaches all necessary requirements (personal communication, May to June 2019). Therefore, school boards and school districts face the initial challenge of screening curricula, determining which topics or standards are not addressed in any given curriculum, and considering how to supplement the material (personal communication, May to June 2019). OSPI noted that initially districts might need to divert resources from or delay curriculum review of other subjects in order to meet the proposed requirement (OSPI, personal communication, May 2019). Once established, districts can be expected to incorporate subsequent reviews into the rotating curricula review schedule. For example, in Rhode Island districts are required to review curriculum being used every five years (RIDE, personal communication, June 2019).

Additionally, key informants noted successful implementation of comprehensive sexual health education requires ongoing access to professional development and training related to current health issues and communication about sensitive topics (personal communication, June 2019). For example, although data indicated that sex education in Rhode Island was meeting standards, RIDE received input from advocates and students that the curriculum was not meeting student needs (RIDE, personal communication, June 2019). Specifically, students requested instruction that addressed the relational aspects of healthy relationships (RIDE, personal communication, June 2019). Moreover, youth shared that it was apparent that some educators were not comfortable teaching the comprehensive sexual health education curriculum (RIDE, personal

communication, June 2019). RIDE has since worked to provide resources that build teacher confidence and competence related to the relational components of comprehensive sexuality education, including how to answer students' questions factually and without judgment (RIDE, personal communication, June 2019). In a recent survey of 156 youth in Washington, 50% of respondents reported that their teacher was comfortable teaching sex education and 53% reported that their teacher answered questions truthfully.³⁹ To build teachers' comfort and competence at schools new to comprehensive sexual health instruction, a few key informants supported phased rollouts of curriculum (e.g., beginning with half of lessons and adding more lessons each year) (personal communication, May to June 2019).

Both ODE and RIDE identified limited instructional time as a challenge to complying with state law (personal communication, June 2019). Although Rhode Island mandates 100 minutes of instructional time for health and physical education per week, school districts have authority to allocate instructional time and must balance competing requirements (mathematics, English language arts, etc.) (RIDE, personal communication, June 2019). ODE staff report that districts and schools often contact the department for recommendations on how to integrate the sexual health standards into other subject areas (ODE, personal communication, June 2019). Similarly, RIDE's Comprehensive Health Instructional Outcomes document notes that, "the content area of Sexuality and Family Life lends itself to considerable overlap with all other health content areas [e.g., Mental and Emotional Health, Injury Prevention]," and that "linkages with Social Studies, Science, English Language Arts, Family Life and Consumer Sciences are also possible."⁴⁴ However, the option for parents/guardians to opt their child(ren) out of sexual health instruction has the potential to complicate integration of these standards into other subjects (ODE, personal communication, June 2019).

Overall, many school schools in Washington already provide some level of comprehensive sexual health education (see Magnitude of Impact on page 9), and we expect these schools and school districts to take steps to come into compliance with the new standards. Moreover, based on discussions with key informants, we would expect that requiring public schools (K-12) in Washington to provide comprehensive sexual health education that meets state standards would result in some number of schools and districts not currently implementing evidence-informed, comprehensive, inclusive sexual health education curriculum to take steps to comply with the new law. For example, some school districts in Oregon that cited limited resources as barriers to implementing comprehensive sexual health education prior to Oregon's requirement took steps to come into compliance when it became state law (ODE, personal communication, June 2019). Similarly, when ESSB 5395 was proposed during the 2019 Legislative Session, at least one district contacted Planned Parenthood staff for support to meet proposed comprehensive sexual health education requirements (Planned Parenthood Greater Washington and North Idaho [PPGWNI], personal communication, June 2019). District leaders did not pursue implementation when the legislation did not pass. We expect some districts to need additional support and some to take longer to achieve compliance with the law than those that have already begun implementing according to the Healthy Youth Act.

Therefore, we made the informed assumption that requiring every public school (K-12) in Washington to provide comprehensive sexual health education that meets state standards would

result in more school districts becoming more compliant with and/or implementing evidence-informed, comprehensive, inclusive sexual health education curriculum.

Will public schools implementing evidence-informed, comprehensive, inclusive sexual health education curricula improve sexual and reproductive health outcomes for students?

There is strong evidence that implementing evidence-informed, comprehensive, inclusive sexual health education curricula in public schools would improve sexual and reproductive health outcomes for students.

Data from the National Survey of Family Growth has shown that, compared to not receiving any education, receiving education about abstinence or birth control was positively associated with healthier behaviors and outcomes.³⁰ Individuals receiving education about both abstinence and birth control were statistically significantly more likely to use contraception or a condom compared to individuals that did not receive any education.³⁰ Moreover, the survey found no evidence that providing youth with sexual health information or education was associated with earlier onset of sex, greater sexual risk taking, or poorer health outcomes.¹⁶ They found that “the direction of association was consistently toward less healthy [sexual and reproductive] health behaviors and outcomes among those that did not receive instruction in either abstinence or birth control before first sex.”³⁰ Other researchers have also found no evidence indicating that sexual health education increases sexual risk behaviors.^{30,31}

Generally, research has also indicated that comprehensive sexual health education has a greater positive impact on health behaviors and outcomes than abstinence-only education.^{9,17} In 2004, a report by the U.S. House of Representatives Committee on Government Reform found that 11 out of 13 (over 80%) of the abstinence-only-until-marriage programs most frequently used by federal grantees “contain false, misleading, or distorted information about reproductive health.”⁴⁵ The report concluded that abstinence-only curricula contained, “misrepresentations about the effectiveness of condoms in preventing [STIs] and pregnancy, as well as gender and sexual minority stereotypes, moral judgments, religious concepts, and factual errors.”^{10,45} A 2017 comprehensive systematic review of school-based interventions found that abstinence-only programs can be effective in improving knowledge, but do not lead to effective behavior change.²⁵ Studies have found that abstinence-only programs are not effective in delaying initiation of sexual intercourse, reducing other sexual risk behaviors, reducing the number of sexual partners, increasing contraceptive or condom use, or reducing STIs.^{9,17,23,46} For example, one review of abstinence-only-until-marriage programs found that individuals who intend to remain abstinent and fail to do so are less likely to use condoms or other contraception at first sex.¹⁰ Other evidence has suggested that abstinence-only programs may increase sexual activity, STIs, and pregnancy.²⁵

A large body of evidence has established the association between comprehensive sexual health education and improved health outcomes.^{23,26} A report from Guttmacher Institute summarized that, “strong evidence suggests that approaches to sex education that include information about both contraception and abstinence help young people to delay sex, and also to have healthy relationships and avoid STDs and unintended pregnancies when they do become sexually active. Many of these programs have resulted in delayed sexual debut, reduced frequency of sex and number of sexual partners, increased condom or contraceptive use, or reduced sexual risk-

taking.”¹⁶ Results from a meta-analysis of 62 studies of comprehensive sexual health education interventions showed favorable and significant effects for most primary outcomes, with approximate decreases of 12% in sexual activity; 14% in number of sex partners; 25% in unprotected sexual activity; 31% in prevalence of STIs; and an approximate increase of 13% in use of protection.²⁶ A 2016 Cochrane Review, including a systematic review and meta-analysis of published and unpublished research, found that educational interventions significantly increased condom use at last sex and that contraception promoting initiatives significantly increased use of hormonal contraception.²⁴ The review also found moderate quality evidence that interventions combining educational and contraceptive promoting components significantly lowered the risk of unintended pregnancy among adolescents over the medium and long-term.²⁴

Research has also found that traditional gender norms, unequal power in sexual relationships, and experiences of intimate partner violence (IPV) are associated with negative sexual and reproductive health outcomes.²⁷ One review of literature found that curricula that included at least one explicit lesson, topic, or activity addressing gender norms, gender equality, harmful or biased practices or behaviors driven by gender, or power inequities were five times as effective as programs that did not address gender norms or power in decreasing pregnancy, childbearing, or STIs.²⁷ Specifically, the review found that, of programs that addressed gender and power, 80% led to a significant decrease in one of these health outcomes, compared to only 17% of programs that did not address gender and power.²⁷ Programs that included gender and power specific content were also more likely to impact condom use, number of sexual partners, and reductions in IPV.²⁷ Similarly, one respondent to interviews with school districts in Washington State observed that the greatest positive shift in classroom culture and climate occurred following lessons addressing gender and sexual violence.³⁴

Evidence-based interventions exist related to preventing teen pregnancy, preventing STIs, and improving healthy relationships.^{23,28,29} There are numerous sexual health education curricula that have been rigorously evaluated for use in schools and have been proven to impact multiple health outcomes, including recent sexual activity, number of sexual partners, frequency of sexual activity, contraceptive use, condom use, sexual initiation, abstinence, pregnancy, birth, and STDs.^{28,29} For example, HHS conducts an ongoing systematic review of research to identify evidence-based programs to reduce teen pregnancy, STIs, and risky sexual behaviors.²⁹ Since 2009, HHS has identified 44 programs meeting review criteria,²⁹ including 13 sexual health education programs proven effective in school settings.²⁸

Despite numerous evaluations, researchers have also pointed to challenges in determining the effectiveness of sexual health education interventions, including challenges with self-report data, differences in program design and implementation, implementation fidelity, evaluation design complexity, and choosing outcomes measures, and high costs associated with rigorous evaluation.^{19,24,25,27} For example, one researcher noted that the list of evidence-based interventions provided by HHS only examines the impact of curricula on disease prevention and pregnancy outcomes, but does not consider impacts on other factors known to influence adolescent sexual risk behaviors, including psychosocial factors, structural and economic inequities, gender beliefs and inequities, and racism.³¹ A 2017 comprehensive systematic review of school-based interventions noted that programs were more likely to be effective if they did not focus only on abstinence, provided links to school-based health centers, measured multiple

behavioral outcomes, were multi-faceted, employed interactive and participatory educational strategies, and were of sufficient duration and intensity.²⁵ Another study concluded that, “program implementation may be as important as program content for improving outcomes.”²³ For these reasons, information about effectiveness may not be available for all comprehensive sexual health education curricula (personal communication, May and June 2019).

FLASH is the most commonly used comprehensive sexual health education curricula in schools in Washington and is evidence-informed and based on health behavior change theory (OSPI, personal communication, May to June 2019). A federally-funded multi-state evaluation of High School FLASH is currently underway (PHSKC, personal communication, June 2019). The evaluation “is testing the impact of the FLASH curriculum on high school students’ ability to protect themselves from pregnancy and STDs by abstaining from sex and by using condoms or birth control, if they do have sex” (PHSKC, personal communication, July 2019). Study participants include 1,500 students at 20 participating schools in the Midwest and South (PHSKC, personal communication, June 2019). Unpublished student reaction data show 84.9% of respondents said they would be more likely to tell a partner they do not want to have sex, if needed, because of FLASH (unpublished data, PHSKC, personal communication, June 2019). Additionally, 86.5% of respondents reported they would be more likely to use or ask a partner to use birth control, if needed; 90.4% would be more likely to use or ask a partner to use a condom, if needed; and 90.2% would be more likely to get tested for STDs, if needed (unpublished data, PHSKC, personal communication, June 2019).

Overall, since there is a large body of evidence showing that comprehensive sexual health education positively impacts multiple health behaviors and outcomes and since there are comprehensive sexual health education curricula that have been proven effective in schools, we have determined there is strong evidence that implementing evidence-informed, comprehensive, inclusive sexual health education curricula will improve the health of students in Washington State.

Will improving sexual and reproductive health outcomes for students impact health inequities?

There is very strong evidence that ESSB 5395 has the potential to reduce health inequities for multiple groups of students. Data from the National Survey of Family Growth have shown that receiving no education about abstinence or birth control was more common among individuals who were: black or Hispanic, of lower socioeconomic status, of lower maternal education, not living with both parents at age 14, and that attended a religious service less frequently.³⁰ In addition, the Society for Adolescent Health and Medicine found that abstinence-only programs systematically ignore or stigmatize many young people, including LGBTQ+ youth; adolescents who have experienced sexual abuse, violence, or exploitation; sexually experienced adolescents; and pregnant and parenting teens.¹⁷ Researchers have also noted that sexual health education can influence inequities related to gender, race, sexuality, and poverty.³¹ One study noted that, “structural racism, poverty, gender inequality, and the stigmatization of LBGQTQ people all negatively impact health outcomes, including sexual health outcomes” and “while sexual health education cannot remove the inequalities in society at large, it can aid students in acquiring the critical thinking skills that allow them to more effectively confront and challenge them.”³¹

Moreover, intersectionality, the understanding that multiple systems of oppression interact in the lives of those with multiple marginalized identities,⁴⁷ impacts the need, access, quality, and outcomes of reproductive health services.³² Since experiences of oppression are not mutually exclusive, additional systems of oppression and lived experiences may further reduce an individual's access to sexual health education and reproductive healthcare.³¹ Evidence suggests that intersecting oppressed identities (e.g., race/ethnicity, sexual orientation, gender identity, disability status, and gender) influence individuals' educational and healthcare experiences, often in disadvantageous ways. Reproductive health risks and inequities may compound and "sexual health education must thus recognize the diverse life course trajectories and family formations that characterize students' lives."³¹

Since many students that experience inequities related to sexual health education also experience inequities in reproductive health outcomes and access to care, ESSB 5395 has the potential to improve health inequities for students by disability status, foster care status, gender identity, geography, housing status, juvenile detention, migrant students, sexual orientation, race/ethnicity, and victims and survivors of violence.

Lastly, there is unclear evidence for how ESSB 5395 will impact health inequities for students that are opted-out of school-based comprehensive sexual health education.

Inequities by disability status

As of November 2018, Washington State special education served 130,488 students (ages 6-21 years) with disabilities.⁴⁸ Adolescents and young adults with physical disabilities engage in sexual activity at similar rates to their nondisabled peers.⁴⁹ However, less is known about the rate of sexual activity among adolescents with developmental disabilities.⁴⁹ Nationally, adolescents with disabilities (physical and intellectual) are "significantly less likely than their peers to received information on contraceptive options, screening for STIs, and screening for breast and cervical cancer."⁴⁹ Specifically, those with developmental disabilities are "often systematically excluded from sexual health education, which may place them at risk for poor health outcomes,"⁴⁹ particularly sexual assault.

It is unknown how many of Washington's schools implement comprehensive sexual health education that is inclusive of students with disabilities.⁵⁰ OSPI shared, "[s]ome portion of students with disabilities may need the comprehensive sexual health education curriculum and instruction adapted to meet their needs, based on reading levels, ability to understand, and need for opportunities to generalize the instruction to other settings [e.g., home, school, public]" (OSPI, personal communication, July 2019). Overall, the agency estimates less than 15% of students in special education would require major modifications to the comprehensive sexual health curriculum (OSPI, personal communication, July 2019), and community resources are available to help school districts adapt curriculum. Additionally, as part of their 2019 curricula review, OSPI is reviewing a curriculum developed specifically for students with developmental disabilities (OSPI, personal communication, July 2019).

Disability Rights Washington (DRW), a private non-profit organization that protects the rights of people with disabilities statewide, quoted an advocate with disabilities who shared, in the absence of high-quality sexual education, these messages "leave [students with disabilities] with

a sense that they are undesirable, which can in turn cause vulnerability to negative sexual attention or abuse that many do not feel safe enough to report.”⁵¹ Similarly, the Washington State Special Education Advisory Council, which advises the State Superintendent on matters pertaining to the provision of special education and related services, emphasized that “curriculum should include areas focusing on self-advocacy, refusal skills, and affirmative consent.”⁵⁰

It is well documented that children and adolescents with developmental disabilities are sexually abused at greater rates compared to nondisabled peers.⁴⁹ One report explained that, “the most cited factors contributing to sexual abuse in children and adolescents with developmental disabilities include heightened vulnerability that results from dependence on others including relatives and caregivers, lack of sexual health education to equip them with the skills to be able to discern between appropriate and inappropriate touch from caregivers, and type of disability, with those with intellectual disabilities being at most risk.”⁴⁹ Evidence indicates this disproportionality continues into adulthood.^{52,53} Furthermore, people with intellectual disabilities reported sexual assault at more than seven times the rate of people with no disabilities, and women with intellectual disabilities reported sexual assault at more than 12 times the rate of people with no disabilities.⁵³ People with intellectual disabilities are more likely than the general population to be raped by someone they know (family member, caregiver, etc.). DOJ reported, “[f]or women without disabilities, the rapist is a stranger 24 percent of the time, but for a woman with an intellectual disability it is less than 14 percent of the time.”⁵³ Evidence also indicates people with co-occurring disabilities are at greatest risk of victimization. Between 2011 and 2015, “[65%] of rapes or sexual assaults against persons with disabilities were committed against those with multiple disability types, the highest percentage among the crime types examined.”⁵⁴

The lack of sexuality education among adolescents with developmental disabilities may lead to poor health outcomes, including “increased rates of STIs, decreased access to reproductive care, increased risk of unintended pregnancies, and significantly higher rates of sexual abuse.”⁴⁹ Specifically, trauma from sexual violence experienced by people with intellectual disabilities often goes unrecognized and/or untreated, which can result in mental health concerns which can be undiagnosed, misdiagnosed, and/or mistreated by healthcare providers.⁵⁵ Inclusive, comprehensive sexual health education can provide youth with developmental disabilities an understanding of their bodily autonomy and rights, signs of healthy and unhealthy relationships, enthusiastic consent (i.e., the concept that affirmative consent requires ongoing enthusiastic agreement from both parties and that consent cannot be given where there is manipulation, pressure, threats, etc.), and what constitutes sexual abuse and assault.

Inequities by foster care status

There are approximately 4,500 youth (grades K-12) in foster care (youth in care) in Washington State at any point in time, with about 7,000 youth (grades K-12) served over the course of a year (Washington State Department of Children, Youth and Families [DCYF], personal communication, July 2019). The Washington State Supreme Court Commission on Children in Foster Care’s Normalcy Workgroup noted that “[a]ccording to youth and young adults in the Washington foster care system, many have missed or never received a comprehensive sexual health education prior to exiting the system.”⁵⁶ Barriers to receiving sexual health education include multiple placements, changing schools, or missing the one time it was taught.⁵⁶ For

example, youth in the foster care system may miss comprehensive sexual health education lessons due to multiple placements or moving out of their school district into a district that has either already taught comprehensive sexual health education or does not teach sexual health education (personal communication, July 2019).

A survey with alumni of care (ages 18-26 years old) serving on the Washington State Children's Administration's Passion to Action advisory board showed that all 11 respondents had received sexual health education in school, but most (82%) did not feel that it met their needs.⁵⁷ Multiple alumni of care shared that they wished the sexual health education they received in school included topics like sexual orientation, gender identity, sexuality (especially for female empowerment), consent, anatomy, birth control, and healthy relationships.⁵⁷

Youth in care have the added challenge of navigating the rights of and relationship dynamics with and between biological parents and foster parents. For example, a youth in care's biological parent(s) and foster parent(s) might have different, and potentially contradictory, beliefs and values regarding sexual health education (Normalcy Workgroup, personal communication, June 2019). For example, if youth perceive asking their foster parent(s) questions about sexual health might put their housing stability in jeopardy, youth will likely be less willing to seek the sexual health and healthy relationship information they need (Normalcy Workgroup, personal communication, June 2019).

Compared with youth in the general population, youth who have been in foster care are at significantly increased risk of STIs (2-14 times greater risk) and teen pregnancy (2-4 times greater risk) and birth (2 times higher rate).^{58,59} Researchers note, "[t]hese outcomes are likely due to high rates of exposure to adversities early in life (e.g. poverty, abuse and neglect, parental substance abuse, [IPV], and the disruption of relationships with biological caregivers), which in turn lead to increased rates of sexual risk behaviors such as early sexual debut, higher numbers of total and casual partners, and higher rates of reporting sex with an infected partner."⁵⁸ Evidence from a 2015 study assessing associations between adverse childhood experiences (ACEs) found that, after adjusting for age, race/ethnicity, income, education, insurance and marital status, women who were neglected as children were 31.5 times as likely to have sexual debut before age 13 compared to women unexposed to ACEs.⁶⁰ Results of a 2017 analysis of California child protective services records for female foster youth matched to maternal information found that of the 30,339 girls who spent time in foster care as adolescents, 18.3% (5,567) gave birth for the first time before they were 20 years of age.⁶¹ After adjusting for confounders, "the highest birth rates were observed among girls who entered care between the ages of 13 and 16 years; had been in care for relatively short periods of time; lived in congregate care at the estimated date of conception; had a history of running away; and were Latina, black, or Native American [racial/ethnic groups disproportionately represented in California's child welfare system]."⁶¹

Inequities by gender identity and sexual orientation

Nationally, less than 6% of students identifying as lesbian, gay, bisexual, or transgender (LGBT) reported having received formal sexual health education that included positive representations of LGBT-related topics.¹⁶ Data collected by the GLSEN 2017 National School Climate Survey show only 12% of the 745 respondents attending schools in Washington reported receiving

LGBTQ-inclusive sex education through school.⁶² Similarly, in spring 2019, OSPI conducted a survey of 156 gender and sexually diverse youth to evaluate whether they were receiving sexual health education in school.³⁹ Overall, fewer than a quarter responded that the sexual health education met their needs or wants (22%), and 23% felt the sexual health education they received was appropriate for all sexual orientations.³⁹

These results are consistent with information shared by key informants that schools implementing comprehensive curricula often drop lessons designed to be inclusive of LGBTQIA+ youth⁶³—specifically lessons that discuss sexual orientation and gender identity (personal communication, May and June 2019). According to 2018 School Health Profiles data, sexual orientation and gender roles, identity, or expression are the topics that the fewest percentage of schools report teaching (unpublished data, OSPI, personal communication, June 2019) (See Appendix 1 for more information). However, results of a 2015 random, national survey of 1,592 parents found that 85% of parents surveyed supported discussion of sexual orientation as part of sex education in high school and 78% supported it in middle school.³³

Evidence indicates that LGBTQ-inclusive sexual health education has the potential to help reduce health inequities. An analysis of 2015 Youth Risk Behavior Survey and 2014 School Health Profiles data found a “20% reduction in reported suicide plans for every 10% increase in schools teaching LGBTQ-inclusive sex education in a state.”⁶⁴ Similarly, a study in California found “school safety was higher for schools in which more students reported the presence of LGBTQ-inclusive sexuality and health education.”⁶⁵ Moreover, “in schools where sexuality and health education was perceived as supportive of LGBTQ people and issues, there was more safety and less bullying” at both the school and student level.⁶⁵ Conversely, a 2017 review noted that abstinence-only-until marriage programs may be especially harmful to sexual minority youth as these programs are “largely heteronormative and often stigmatize homosexuality as a deviant and unnatural behavior. Stigma and discrimination can contribute to health problems such as suicide, feelings of isolation and loneliness, HIV infection, substance abuse, and violence among sexual minority youth.”¹⁰

Evidence also shows that youth who identify as LGBTQ disproportionately experience poor sexual health outcomes (e.g., teen pregnancy, STIs, and HIV infections)⁶⁶ and mental health concerns (e.g., feeling sad or hopeless, suicide ideation).⁶⁷ In particular, a recent survey of LGBTQ youth found that younger youth (aged 13-17 years) reported considering suicide (47%) and attempting suicide (26%) in the previous 12 months more often than older youth (aged 18-24 years; 31% and 11%, respectively).⁶⁷ LGBTQ youth are also at “increased risk for experiencing harmful social environmental factors, such as higher levels of sexual abuse, parental physical abuse, partner violence, and victimization at school as compared to their heterosexual and cis-gendered peers.”⁶⁶ Such experiences may contribute to the increased likelihood that LGBTQ youth engage in sexual risk behaviors (e.g., early sexual intercourse debut, unprotected intercourse, and having multiple sexual partners).⁶⁶

Gender identity

Results of the 2018 Healthy Youth Survey found that about 1% of Washington students identify as transgender, 1% are not sure or are questioning their gender identity, and 1% state that something else fits better than the other options (i.e., female, male, transgender, questioning/not

sure).⁴² Results of a 2018 survey of LGBTQ youth (aged 13-24 years) showed that transgender and non-binary respondents were more likely than their cisgender peers to report having considered suicide (54% vs. 31%, respectively) and attempted suicide (29% vs. 14%, respectively).⁶⁷ Evidence indicates that environments that are more inclusive and affirm the identity of transgender persons are associated with lower depression, suicidal ideation, and suicidal behavior.⁶⁸

Sexual orientation

Results of the 2018 Healthy Youth Survey found that about 18% of Washington students identify as lesbian, gay, bisexual, or questioning their sexual orientation.⁴² Evidence indicates that sexual minority youth are at substantially heightened risk for suicide^{67,69,70} and depression⁶⁹ and that bullying and harassment experienced at school and in other contexts contributes to poor health outcomes.^{65,70} Results of a 2011 meta-analysis found that “on average 28% of sexual minority youth reported a history of suicidality as compared with 12% of heterosexual youth.”⁶⁹ Moreover, disparities increased in size as the severity of suicidality increased [i.e., ideation, intent/plans, attempts, and attempts resulting in injury or medical attention].⁶⁹ LGB youth also disproportionately experience physical and sexual dating violence as compared to other students⁷⁰ as well as exposure to ACEs compared to heterosexual youth.⁶⁰

Inequities by geography

A 2016 study of data from the National Survey of Family Growth found that, between 2000 and 2014, fewer high schools were teaching formal sexual health education, with the greatest declines occurring in rural communities.^{16,71} For example, young women living in rural areas reported a decrease in education about birth control from 71% in 2006-2010 to 48% in 2011-2013.¹⁶ While there are limited data about school-based sexual health education by geography in Washington State, researchers have found that, generally, rural areas in Washington tended to have less access to community resources and fewer sexual health education resources compared to urban areas.⁷²

Generally, women in rural areas have worse health outcomes than women in urban areas, as well as less access to healthcare in general and to obstetrics in particular.⁷³ People who live in rural areas face numerous access barriers, including transportation infrastructure, population distribution, and configuration of healthcare facilities.⁷⁴ Other geographic factors associated with inequities in access are rural closures of family planning clinics,⁷⁵ increased travel time to clinics,⁷⁶ and shortages of providers in rural areas.⁷⁷

Inequities by housing status

During the 2017-2018 school year, 39,299 (3.4%) Washington students (grades K-12) were identified as experiencing homelessness.⁷⁸ Youth who experience homelessness are more likely to engage in risky sexual behaviors than youth who are housed.⁷⁹ Specifically, youth experiencing homelessness are at higher risk for early sexual debut, unprotected sex, survival (or exchange) sex, lack of access to and inconsistent use of birth control and condoms, multiple sex partners, teen pregnancy, and drug use.⁸⁰ In a survey of 1,839 high school students, youth that experienced homelessness in the past 12 months were statistically significantly more likely to have had sexual intercourse.⁷⁹ During their experience with homelessness, youth that identified as LGBTQ and youth that identified as black/African American were more likely to have stayed

with a stranger, and youth that stayed with a stranger were 3 times as likely to be sexually active and more likely to have unprotected sex.⁷⁹

In addition, youth that experience homelessness are less likely to have access to healthcare, including reproductive healthcare, due to a number of barriers (e.g., lack of transportation, need for parental consent, lack of coordinated services). One study noted that, “school-based sexual health programs should recognize the prevalence of sexual risk taking among adolescents who experience homelessness” and should include topics like healthy relationships and power dynamics within relationships.⁷⁹

Inequities by juvenile detention

OSPI’s Institutional Education program oversees 6 educational service districts (ESDs) and 19 school districts that provide K-12 basic education services to six programs serving incarcerated and previously incarcerated juveniles. Comprehensive sexual health education is not currently offered through OSPI’s Institutional Education program to youth who are incarcerated (OSPI, personal communication, July 2019). Board staff were unable to determine if detention centers or other facilities provide sexual health education through other sources. As in Washington’s traditional K-12 education settings, if ESSB 5395 were implemented, ESDs and school districts would still have the responsibility to implement the requirements in those institutional settings for which they provide educational services (OSPI, personal communication, July 2019).

Key informants shared that implementing comprehensive sexual health education in institutional education settings in Washington has additional logistical challenges related to the non-traditional classroom settings. For example, students receive educational services in mixed grade level classrooms and transition in and out of State run juvenile institutions at varying times depending on the length of stay, with a minimum sentence of 15-36 weeks (OSPI, personal communication, July 2019).

While justice-involved youth have similar health needs to peers in the community,⁸¹ they are more likely to experience high-risk behaviors (e.g., violence, substance use and misuse, and sexual activity)^{81,82} and ACEs which may influence certain health outcomes.⁸² For example, males and females in juvenile detention experience sexual (10-24%) and physical (11-58%) violence, with all forms of abuse more commonly experienced by girls.⁸¹ Long-term outcomes for judicially-involved adolescent females “reveal greater persistence of emotional problems and worse outcomes complicated by relationship and parenting issues, drug problems, and suicidality.”⁸¹ A 1991 study by the National Commission on Correctional Health Care (NCCHC) evaluated sexual activity and contraceptive use among a nationally representative sample of incarcerated youth. Results showed these incarcerated youth had “higher rates of substance abuse, trauma, unprotected sexual activity, history of [STIs], suicidal ideation, and reported violence than those in a general high school population.”⁸¹ Additionally, a 2003 survey found that one-fifth of incarcerated youth were currently a parent (14%) or expecting a child (12%).⁸¹ Results showed “males (15%) were more likely to have fathered a child compared with 9% of females who reported having a child.”⁸¹ These rates were disproportionately higher than those of the general population of 12- to 20-year-olds, “in which 2% of males and 6% of females have children.”⁸¹

Inequities for migrant students

During the 2013-2014 school year (the most recent year data is available), there were approximately 36,423 migrant students across Washington State.⁸³ Approximately 31,816 students were in 51 school districts receiving funding through the state Migrant Education Program and an additional 4,607 students were in 116 districts that did not receive funding.⁸³ In 2018, 88,000 children under the age of 18 lived with at least one parent who was undocumented, and the majority of individuals who are undocumented in Washington State work in agriculture.⁸⁴

The goal of the Migrant Education Program is to “help migrant children overcome educational disruption, cultural and language barriers, social isolation, health-related programs, and other factors inhibiting migratory children from doing well in school.”⁸³ Among students in the Migrant Education Program, about half (46%) move within Washington.⁸³ However, many other students begin the school year in Washington, but leave for other locations (e.g., California, Mexico) by November.⁸³ In addition to educational disruption, studies have found that transiency and moving may make it difficult to access regular, consistent, and preventive reproductive health services, treatment, and follow-up.⁸⁵ For adolescents, parental citizenship and immigration status has also been identified as a barrier to accessing healthcare, even for children who are U.S. citizens.⁸⁵ Learning to navigate a new health system may pose an additional challenge to migrant youth, whose parents/guardians may be working multiple jobs, and parents of migrant students participating on the Migrant State Advisory Committee have expressed concerns about students accessing healthcare (OSPI, personal communication, May to June 2019). For example, in Washington State, youth have medical autonomy at 14 years of age. However, key informants indicated that migrant youth are unaware of their right to apply for health insurance, make medical appointments, and access care independent of their parents (PPGWNI, personal communication, June 2019). Approximately 96% of migrant youth in Washington identified as Hispanic and 40% identified as English Language Learners.⁸³ Lack of access to culturally-appropriate care and services, limited English proficiency, limited access to or lack of interpretation services, lack of translated materials and information in preferred or primary language also serve as barriers to accessing reproductive health services.^{86,87} Parents of migrant students in Washington have also expressed a desire for sexual health education in schools, especially to address sexual coercion and violence, healthy relationships, unintended pregnancy, and STDs (OSPI, personal communication, May to June 2019).

Inequities by race/ethnicity

Multiple inequities experienced by students intersect with race/ethnicity. For example, identifying as ‘other race’ has been statistically significantly associated with experiencing homelessness in the past year.⁷⁹ Youth of color are also disproportionately represented in the child welfare⁸⁸ and juvenile justice systems.⁸² Black and Hispanic teens in the U.S. experience rates of unintended teen pregnancy at twice that of white teens.²³ In Washington State, Hispanic youth (36.7 pregnancies per 1,000 women aged 15-17 years) and American Indian/Alaska Native youth (31.1 pregnancies per 1,000 women aged 15-17 years) experience the highest rates of teen pregnancy, compared to white youth (7.5 pregnancies per 1,000 women aged 15-17 years).⁸⁹

STI rates continue to increase among Latino adolescents, despite leveling off or declining among other racial/ethnic groups.⁸⁷ For example, 24% of newly diagnosed cases of HIV are among

Latino youth.⁸⁷ Latino adolescents were also less likely to use contraception than their black and white counterparts; approximately 31.2% of Latino youth said they had never used contraception during sex compared to 23.3% of blacks and 17% of whites.⁸⁷ Previous research has also shown that African American middle school students were more likely to report higher levels of lifetime sex, sexual activity before age 11 years, and having more than three sexual partners as compared to other racial/ethnic groups.⁴⁶

CDC noted that these inequities by race/ethnicity may partially be due to inequities in socioeconomic status.⁵⁹ Cultural differences may also play a role. For example, traditional cultural gender roles of *marianismo* and *machismo* put Latino youth at greater risk of STIs and HIV.⁸⁷ One author explained that, “machismo is strongly associated with early initiation of sex and multiple partners, and is negatively associated with condom use among Latino men.”⁸⁷ Of five successful STI/HIV interventions aimed at Latino adolescents, only STI/HIV knowledge and gender roles were found as common factors for intervention success.⁸⁷ Previous research has also found that Latino youth have fewer reliable sources of sexual health information, including school-based or community-based settings, than other populations.⁸⁷

Inequities for victims/survivors of violence

Lack of comprehensive sexual health education that addresses healthy relationships (e.g., negotiating reproductive decision-making, identifying coercive behaviors), the full range of contraceptive options, and harm reduction strategies serves as a barrier to individuals experiencing or at risk of experiencing IPV⁹⁰⁻⁹² and trafficking.⁹³ In particular, adolescents may not recognize controlling behaviors in romantic relationships as abusive or coercive.⁹² Comprehensive sexual health education has been identified as a potential primary prevention strategy for sexual violence perpetration.⁹⁴

Data from National Intimate Partner and Sexual Violence Survey (NISVS) demonstrate that IPV often begins in adolescence.⁹⁵ IPV that occurs when individuals first begin dating, generally during adolescence, is often referred to as teen dating violence (TDV).⁹⁵ According to the CDC, “IPV is most prevalent in adolescence and young adulthood and then begins to decline with age, demonstrating the critical importance of early prevention efforts.”⁹⁵ Additionally, results of the 2015 NISVS show among female victims of completed or attempted rape, 43.2% reported that it first occurred prior to age 18 years, with 12.7% reporting their first victimization occurred at age 10 years or younger.⁹⁶ Among male victims of completed or attempted rape, 51.3% first experienced victimization before age 18 years, with 26.0% reporting victimizations occurred at age 10 years or younger.⁹⁶ Comprehensive sexual health education beginning in kindergarten can help to prevent child sexual abuse and the formation of gender roles that may serve as risk factors for sexual violence perpetration later in life.⁹⁴

Results of the 2011 National Survey of Family Growth show that 11% of female and male subjects aged 18-24 years who had first sex before 20 years of age reported unwanted first sexual encounters.⁹⁷ Additionally, those who reported first sex at 14 years of age and younger were more likely to report that it was not voluntary, compared with those who were 17 to 19 years at sexual debut.⁹⁷ Unwanted sexual encounters may include, “dating violence, stranger assaults, and intrafamilial sexual abuse/incest.”⁹⁷ Results of a 2015 study found that, after adjusting for other confounders (race/ethnicity, income, etc.), men who were sexually abused had 9.9 times the

likelihood as men who were not exposed to ACEs to have sexual debut before age 13 years.⁶⁰ Moreover, women who were sexually abused had 90.5 times the likelihood as women who were not exposed to ACEs to have sexual debut before age 13 years.⁶⁰

Overall, since many students that experience inequities related to sexual health education also experience inequities in reproductive health outcomes and access to care, ESSB 5395 has the potential to improve health inequities for students by disability status, foster care, gender identity, geography, housing status, juvenile detention, migrant students, sexual orientation, race/ethnicity, and victims and survivors of violence.

Inequities for students that are opted-out

A provision of ESSB 5395 allows parents or legal guardians to excuse their child from planned instruction in comprehensive sexual health education. Students that are opted-out of school-based curricula in Washington State are not required to take another form of sexual health education. However, students may be at a disadvantage if they do not receive other forms of sexual health education since receiving education about abstinence or birth control has been positively associated with healthier behaviors and outcomes compared to not receiving any education.³⁰

In 2018, Teen-Aid Inc. received federal Sexual-Risk Avoidance Education funding to develop an alternative, online-based curricula.¹¹ Teen-Aid Inc. is marketing the program to students that are opted-out of school-based curricula, and approximately 200 students have enrolled in the program since it launched in February 2019 (Teen-Aid Inc., personal communication, June 2019). “The Alternative” curriculum is based on effectiveness data from Teen-Aid Inc. and provides students with information about abstaining from sexual intercourse, healthy relationships, primary prevention skills for all risk-taking behaviors, and violence prevention (Teen-Aid Inc., personal communication, June 2019).

Published literature and key informants have suggested that parents may choose to opt their child out of sexual health education due to personal and family values, political beliefs, religious beliefs, concerns about age-appropriateness of curricula, or objections to specific topics or content (personal communication, May and June 2019).³³ For example, in interviews with 16 school districts, one respondent expressed concern that requiring schools to use specific curricula would cause some parents to opt their child out of sexual health education.³⁴ Two respondents indicated that parents had opted their child out of specific lessons (rather than the entire curricula), and that opt-outs were highest for lessons on gender and sexual violence.³⁴

However, while some parents may choose to opt their child out of formal sexual health education, national surveys suggest that the majority of parents support school-based sexual health education.^{16,33} Surveys suggest about 93% of parents think sexual health education in schools is important, and most think it should include education about contraception.¹⁶ A 2017 survey with 1,592 parents found that 74.9% of parents felt it was important to have sexual health education in middle school and 86% of parents felt it was important in high school.³³ Only 2.6% of parents felt sexual health education should not be taught in middle school and less than 1% (8 parents) felt it should not be taught in high school.³³ Only about 2.5% of parents felt sexual health education should not be taught at all.³³ Looking at specific topics, over 94% of parents

surveyed supported teaching topics related to puberty, healthy relationships, abstinence, birth control, and STDs in high school sexual health education curricula.³³ However, 85% of parents supported including education about sexual orientation.³³

In Rhode Island, while information about parental opt-out is tracked at the school district level and is not reported to RIDE, staff indicated that most parents want their children to receive sex and family life and HIV education and they have “heard from districts that a very limited number of parents choose to opt their children out of instruction” (RIDE, personal communication, May 2019). For example, out of a large cohort of 10 Rhode Island school districts only 1 to 2 parents per district opted their child(ren) out of instruction (RIDE, personal communication, May 2019).

Overall, key informants from other states and within Washington are unable to predict which students are likely to be opted-out; how many students will be opted-out; whether students will be opted out from the full curriculum or specific lessons; whether students will be opted out formally or informally (e.g., parents may keep students home sick); or whether students that are opted-out will receive another form of sexual health education or no sexual health education (personal communication, May and June 2019). For these reasons, there is unclear evidence for how ESSB 5395 will impact health inequities for students that are opted-out of school-based comprehensive sexual health education.

Appendices

Appendix 1: Percentage of Washington State middle and high schools indicating that they taught each of the 20 CDC identified critical sexual health topics in 2018*

CDC identified critical sexual health topic	High schools (%)	Middle schools (%)
How HIV and other STDs are transmitted	97.9%	89.7%
Health consequences of HIV, other STDs, and pregnancy	97.9%	88.8%
The benefits of being sexually abstinent	97.9%	84.9%
How to access valid and reliable health information, products, and services related to HIV, other STDs, and pregnancy	94.0%	76.2%
The influences of family, peers, media, technology, and other factors on sexual risk behaviors	95.0%	78.1%
Communication and negotiation skills related to eliminating or reducing risk for HIV, other STDs, and pregnancy	96.0%	82.0%
Goal-setting and decision-making skills related to eliminating or reducing risk for HIV, other STDs, and pregnancy	89.3%	78.0%
Influencing and supporting others to avoid or reduce sexual risk behaviors	86.9%	76.4%
Efficacy of condoms, that is, how well condoms work and do not work	92.1%	71.4%
The importance of using condoms consistently and correctly	93.2%	67.6%
How to obtain condoms	83.9%	55.2%
How to correctly use a condom	88.1%	49.0%
Methods of contraception other than condoms	91.9%	64.0%
The importance of using a condom at the same time as another form of contraception to prevent both STDs and pregnancy	89.1%	63.0%
How to create and sustain healthy and respectful relationships	95.0%	78.4%
The importance of limiting the number of sexual partners	95.0%	73.9%
Preventive care that is necessary to maintain reproductive and sexual health	92.0%	67.3%
Sexual orientation	67.0%	47.1%
Gender roles, gender identity, or gender expression	68.2%	47.1%
The relationship between alcohol and other drug use and sexual risk behaviors	95.2%	78.4%

*Unpublished 2018 School Health Profiles data, OSPI, personal communication, June 2019

Annotated References

1. **AIDS Omnibus Act, 28A.230.070 Revised Code of Washington(1994).**

This Revised Code of Washington statute, known as the AIDS Omnibus Act (1994), establishes the requirement that students in public schools receive annual education on human immunodeficiency virus (HIV) in fifth through twelfth grades.

2. **Healthy Youth Act, 28A.300.475 Revised Code of Washington(2007).**

This Revised Code of Washington statute, also known as the Healthy Youth Act (2007), establishes the requirement that if public schools provide sexual health education then the curriculum used must meet specified requirements dictated in this statute.

3. **Washington State Office of Superintendent of Public Instruction. Washington State Sexual Health Education Instructional Materials Review Instruments. 2017; Available at: <http://www.k12.wa.us/CurriculumInstruct/HECAT-Eforms.aspx>. Accessed May, 209.**

This Office of Superintendent of Public Instruction (OSPI) webpage discusses the review process OSPI and the Washington State Department of Health (DOH) undergo to assess the alignment of sexual health education instructional materials, both comprehensive and supplemental, with requirements in state law. The page also includes hyperlinks to each of the Washington specific review instruments OSPI adapted from the Centers for Disease Control and Prevention (CDC) Sexual Health Education Curriculum Analysis Tool (SHECAT). These tools are available for school districts to use when evaluating which curriculum to implement.

4. **Washington State Office of Superintendent of Public Instruction. Instructional Materials Review Reports and Tools. 2018; Available at: <http://www.k12.wa.us/HIVSexualhealth/InstructionalMaterials.aspx>. Accessed May, 2019.**

This Office of Superintendent of Public Instruction (OSPI) webpage lists the Sexual Health Education Curriculum Review Reports completed by OSPI and the Washington State Department of Health (DOH). The reviews assess the alignment of sexual health education instructional materials, both comprehensive and supplemental, with requirements in state law. The reports are available to "assist local school districts in considering the adequacy of curricula currently being used and those under consideration for use."

5. **2015-17 Reviewed HIV/Sexual Health Instructional Materials. Olympia, Washington: Washington Office of Superintendent of Public Instruction; 2018.**

This document lists those HIV prevention and sexual health instructional materials assessed by Office of Superintendent of Public Instruction and Department of Health staff for consistency with Washington State law. It identifies those that meet requirements, require modification to meet requirements, or do not meet requirements.

6. **K-12 Education--Prohibition of Discrimination, 28A.642.020 Revised Code of Washington(2010).**

This Revised Code of Washington statute establishes the requirement that the Superintendent of Public Instruction develop rules and guidelines to eliminate discrimination prohibited in RCW 28A.642.010 as it applies to textbooks and instructional materials used by students as well as public school employment, counseling and guidance services to students, recreational and athletic activities for students, and access to course offerings.

7. Washington State Learning Standards | Kindergarten - 12th Grade Health & Physical Education. Olympia, Washington: Washington State Office of Superintendent of Public Instruction; 2016:1-125.

The Office of Superintendent of Public Instruction developed the 2016 Health and Physical Education K-12 Learning Standards collaboratively with teachers, administrators, subject matter experts, state and national associations, and stakeholders in health and physical education. The standards are meant to ensure students acquire the skills and knowledge they need and to promote consistency in what students are taught across the state. The Health education and physical education provide students a global perspective on health and wellness. The standards are organized by six core ideas: wellness, nutrition, sexual health; social and emotional health; safety; and substance use and abuse protection.

8. Washington State Health Education K-12 Learning Standards: Talking Points. Olympia, Washington: Washington State Office of Superintendent of Public Instruction.

This Washington State Office of Superintendent of Public Instruction (OSPI) document discusses the State Health Education K-12 Learning Standards. Requirements outlined in the Healthy Youth Act (2007) are consistent with the Guidelines for Sexual Health and Disease Prevention released in 2005 by the Washington State Department of Health and OSPI. The document noted, "[a]ll of the [sexual health education] grade-level outcomes are optional and were developed using: research on what kind of health education is needed to keep students safe and healthy; and guidelines from organizations such as the American Academy of Pediatrics and the Centers for Disease Control and Prevention (CDC) that recommend when students need information."

9. Foundation Henry J. Kaiser Family. Fact sheet: Abstinence Education Programs: Definition, Funding, and Impact on Teen Sexual Behavior.2018.

In 2017, U.S. federal funding for sexual health education totaled \$299 million. In this factsheet, Kaiser Family Foundation provides an overview of the 5 current federal sexual health education funding programs in the U.S. Federal programs fall into two main categories: abstinence-only and comprehensive sex education. Abstinence-only or "sexual risk avoidance" programs teach that refraining from sex is the only morally acceptable option for youth and the only effective way to prevent unintended pregnancy and STIs. In 2017, federal funding for abstinence-only totaled \$90 million across two main federal funding programs: Title V Abstinence-Only-Until-Marriage (AOUM) (\$75 million) and Sexual-Risk Avoidance Education (SRAE) (\$15 million). Title V of the 1996 Social Security Act provides federal funding tied to an 8-point definition of abstinence. The Title V federal definition includes points, "A) has as its exclusive purpose teaching the social, psychological, and health gains to be realized by abstaining from sexual activity; B) teaches abstinence from sexual activity outside marriages the expected standard for all school-age children; C) teaches that abstinence from sexual activity is the only certain way to avoid out-of-wedlock pregnancy, sexually transmitted diseases, and other associated health problems; D) teaches that mutually faithful monogamous relationship in the context of marriage is the expected standard of sexual activity; E) teaches that sexual activity outside of the context of marriage is likely to have harmful psychological and physical effects; F) teaches that bearing children out-of-wedlock is likely to have harmful consequences for eth child, the child's parents, and society; G) teaches young people how to reject sexual advances and how alcohol and drug

use increase vulnerability to sexual advances; and H) teaches the importance of attaining self-sufficiency before engaging in sexual activity." Title V is the largest source of federal funding for abstinence, and approximately half of states receive funding. Funding requires that states match "every four federal dollars with three state dollars" and that funds are passed-through state health departments to schools and community organizations. In 2012, Congress created the "Sexual Risk Avoidance Education" program, which bypasses state authority and provides grants directly to community organizations. Comprehensive sexual health education programs generally provide medically accurate, evidence-based information about abstinence, contraception, condoms, STIs, and information about healthy relationships. There are currently three main federal funding programs for comprehensive sexual health education totaling \$209 million: Personal Responsibility Education Program (PREP) (\$75 million); Teen Pregnancy Prevention Program (TPPP) (\$101 million); and Division of Adolescent and School Health (DASH) (\$33 million). PREP was created under the Obama Administration and is "the first federal funding stream to provide grants to states in support of evidence-based sex education that teach about both abstinence and contraception." The Teen Pregnancy Prevention Program provides funding to replicate evidence-based pregnancy prevention programs and to evaluate new and innovative models. However, in 2017, the Trump Administration notified grantees that funding would be ending two years early due to "lack of evidence of the program's impact." Nine organizations, including those in Washington State sued and federal judges ruled in favor of the organizations requiring funding to be extended until the end of the five-year grant cycle (2020). The report summarized that, "at the same time, the Trump Administration announced the availability of new funding for the TPPP program with updated guidelines. These new rules require grantees to replicate one of the two abstinence programs--one that follows a sexual risk avoidance models, and one that follows a sexual risk reduction model--in order to receive funding. This marks a sharp departure from the rules under the Obama administration, which allowed grantees to choose from a list of 44 evidence-support programs." In addition, in 2017, U.S. Department of Health and Human Services announced a \$10 million research initiative to improve teen pregnancy prevention and sexual risk avoidance programs. In 2018, Congress increased funding for the SRAE program by 67%. Overall, the report states that federal funding continues to shift toward abstinence-only education despite the fact that there is a "large body of evidence suggesting that abstinence-only programs are ineffective at delaying sexual activity and reducing the number of sexual partners of teens." Moreover, "there is currently no strong body of evidence to support that abstinence-only programs have these effects on the sexual behavior of youth and some have documented negative impacts on pregnancy and birth rates."

10. Santelli J. S., Kantor L.M., Grilo S.A., et al. Abstinence-Only-Until-Marriage: An Updated Review of U.S. Policies and Programs and Their Impact. *Journal of Adolescent Health*. 2017;6:273-280.

Santelli et al. conducted a review of abstinence-only-until-marriage policies and programs that receive federal funding. They conducted a review of literature published since 2006 and gathered reports from researchers, educators, policymakers, governmental organizations, and advocacy organizations. This article provides general summary and commentary information. The authors provided background and history of abstinence-only-until-marriage funding in the U.S. Federal funding for abstinence-only programs began in 1981 as a result of the Adolescent Family Life Act and was expanded in 1996 as part of welfare reform. Funding increased from 1996 to 2006, and again in 2012 and 2016. "Abstinence education" is defined federally in the 1996 Social

Security Act (Title V, Section 510) stipulating that abstinence-only-until-marriage education, “has as its exclusive purpose, teaching the social, psychological, and health gains to be realized by abstaining from sexual activity.” The definition specifies eight points in the definition and, “programs funded through this funding stream to the states did not have to address all the eight points of the A-H definition; however, they could ‘not be inconsistent with any aspect of the abstinence education definition’ and, therefore, could not in any way advocate contraceptive use or discuss contraceptive methods except to emphasize their failure rates.” In addition, funding requirements specified that programs had to target 12-18 year olds and “could not provide young people with information about contraception or safer-sex practices even with their own nonfederal funds.” Lastly, the program defined abstinence to include “abstaining from all ‘sexual activity,’ which ‘refers to any type of genital contact or sexual stimulation between two persons, including, but not limited to sexual intercourse.” The authors cited a 2014 report by the House Committee on Government Reform that found that, “11 of the 13 [abstinence-only-until-marriage) programs most widely used by [Community-Based Abstinence Education] grantees contained false, misleading, or distorted information about reproductive health, misrepresentations about the effectiveness of condoms in preventing sexually transmitted infections (STIs) and pregnancy, as well as gender and sexual minority stereotypes, moral judgements, religious concepts, and factual errors.” In 2016, the federal government provided \$85 million in funding for abstinence-only-until-marriage programs and \$176 million to comprehensive sexual health education through the Teen Pregnancy Prevention Program and Personal Responsibility Education Program. The authors stated that the goal of abstinence-only programs is to delay sexual initiation until marriage; however, worldwide trends show that age at marriage is increasing and “the rising age at marriage has led to a substantial increase in premarital sex.” The authors noted that federal abstinence-only programs offer a “misleading and potentially harmful message that conflates theoretical effectiveness of intentions to remain abstinent and the actual practice of abstinence. Abstinence is often not effective in preventing pregnancy or STIs as many young people who intend to practice abstinence fail to do so.” Individuals who intend to remain abstinent and fail to do so may are less likely use condoms or other contraception at first sex. In addition, some individuals who intend to remain abstinent are unable to do so as a result of sexual violence or coercion. The authors concluded, “studies suggest that user failure with abstinence is high. Thus, although theoretically completely effective in preventing pregnancy, in actual practice the efficacy of [abstinence-only-until-marriage] interventions may approach zero.” The authors also noted that sexual health education policies differ vastly at the state and school district level and, “policymaking, occurring at the state and local levels, frequently is done without reference to data on effectiveness, the need to support healthy sexual development, or the ethics of withholding potentially lifesaving sexual health information.” The authors also summarized that abstinence-only-until-marriage programs may be especially harmful to sexual minority youth as abstinence-only programs are “largely heteronormative and often stigmatize homosexuality as deviant and unnatural behavior. Stigma and discrimination can contribute to health problems such as suicide, feelings of isolation and loneliness, HIV infection, substance abuse, and violence among sexual minority youth.” Overall, this review found that abstinence-only-until-marriage programs demonstrated little efficacy in delaying sexual initiation or protective sexual behaviors. The authors summarized, “U.S. abstinence-only-until-marriage policies and programs are not effective, violate adolescent rights, stigmatize or exclude many youth, and reinforce harmful gender stereotypes. Adolescent sexual

and reproductive health promotion should be based on scientific evidence and understanding, public health principles, and human rights.”

11. **Washington Adolescent Pregnancy Prevention Grantees. 2019; Available at: <https://www.acf.hhs.gov/fysb/grants/washington-app>. Accessed 17 June 2019.**

In 2019, Washington States received federal funding for comprehensive sexual health education through a State Personal Responsibility Education Program (PREP) grant. The funding is provided to Washington State Department of Health. In addition, Teen-Aid Inc., located in Spokane, Washington received funding through the Competitive Sexual Risk Avoidance Education Program.

12. **Teen-Aid Inc.: Charter & By-Laws. 2019; Available at: <http://teen-aid.com/getting-to-know-teen-aid/charter-by-laws/>. Accessed June 20, 2019, 2019.**

Teen-Aid Inc. is a non-profit organization founded in 1981 to develop an alternative approach to sexual health education. Their by-laws state that, “the purpose of this corporation is to encourage premarital abstinence as a life-style among teens and foster virtuous character development...by promoting effective parent-teen communication, increasing fertility awareness and respect for the power to create life, and embracing the standard of parenting within wedlock thereby reducing the many adverse consequences...of premarital sexual activity.”

13. ***KING COUNTY, Plaintiff, v. ALEX M. AZAR, in his official capacity as Secretary, U.S. Dept. of Health and Human Services; and U.S. Dept. of Health and Human Services, Defendants. (Case No. C18-0242-JCC), 29 May 2018 (United States District Court, Western District of Washington at Seattle 2018).***

This court ruling outlines U.S. District Court Judge John Coughenour’s May 29, 2018 ruling in the Case No. C18-0242-JCC (King County v. Alex M. Azar and U.S. Department of Health and Human Services (HHS)). As background, in 2010, the U.S. Congress directed HHS, Office of Adolescent Health to create the Teen Pregnancy Prevention (TPP) Program. The Program included two tiers of grants. Tier 1 grants were established “to fund programs with demonstrated positive impacts on sexual behavior outcomes,” and Tier 2 grants were established “to fund development and testing of new and innovative approaches to preventing teen pregnancy.” King County, Washington received a Tier 2B grant, which focuses on “[increasing] the number of evidence-based TPP interventions available by rigorously evaluating new or innovative approaches for preventing teen pregnancy and related high risk behaviors.” Judge Coughenour found, “HHS’s decision to terminate King County’s grant without following regulatory requirements was unlawful. Consequently, HHS’s refusal to consider King County’s future non-competing continuation applications unlawfully withheld agency action.” The Court vacated HHS’s decision to terminate King County’s grant award and ordered the agency “to accept and timely process the County’s year-four non-competing continuation application as if HHS had not terminated King County’s grant award.”

14. **After King County's lawsuit win, Trump administration restores sex-ed research funding [press release]. Seattle, Washington: King County Executive 24 July 2018 2018.**

This King County Executive news release reported on the successful lawsuit the county brought against the U.S. Department of Health & Human Services (HHS) for cutting funds awarded to the County for the purpose of evaluating the FLASH sexual health education curriculum. The

FLASH curriculum, developed by Public Health – Seattle & King County, is used in every school district in King County, across much of Washington State, and in at least 40 other states. “While it is based on the latest research and evidence, the full curriculum has never been evaluated for its effectiveness.” Authors noted, “it’s rare for any sexual health curriculum to received scientific evaluation because conducting such a study is both complex and expensive.” Therefore, County leadership was pleased with the reinstated funding.

15. Institute Guttmacher. Sex and HIV Education: State Policy. Guttmacher Institute;2019.

In May 2019, Guttmacher Institute provided a summary of existing state policies related to sexual health education and HIV education and educational content requirements. Twenty-two states and Washington D.C. mandated both sexual health education and HIV education, and two states mandated sexual health education only. Twenty-seven states specified content requirements: 26 required content be age-appropriate, 13 required educational content be medically accurate, 9 required content be inclusive of sexual orientation, and 8 required content be culturally-appropriate and not biased by race/ethnicity or sex. Two states prohibited schools to promote religion. Specific to sexual health education content, 37 states required information on abstinence (27 required abstinence to be stressed; 10 required abstinence to be covered), 25 required information about avoiding coerced sex, 22 required information on healthy decisions around sexuality, 18 required information on contraception, 18 required instruction about engaging in sexual orientation only within marriage, 13 required information about negative outcomes of teen sex and pregnancy, and 11 required instruction about how to talk to family members (i.e., parents) about sex. In addition, 22 states and D.C. required parents receive notification that sexual health education and/or HIV education will be provided, 3 states required parental consent for students to participate in education, and 37 states allowed parents to exempt students from education. States that mandated sexual health education; required content be medically accurate, age appropriate, culturally appropriate, and inclusive of sexual orientation; allowed for parental opt-out; and mandated content include contraception, abstinence, avoiding coercion, and healthy decision-making skills included California, Oregon, and Rhode Island. Oregon and Rhode Island both require abstinence to be stressed; California and Oregon both require instruction on family communication.

16. Institute Guttmacher. Factsheet: American Adolescents' Sources of Sexual Health Information.2017.

In this factsheet, Guttmacher Institute summarizes research related to adolescents' experiences with formal sexual health education. They define formal sexual health education as "instruction that generally takes place in a structured setting, such as a school, youth center, church, or other community-based location" that is often a "central source of information for adolescents." Based on 2011 to 2013 data, they report that 80% of adolescents aged 15 to 19 received formal sexual health education related to sexually transmitted diseases (STDs), HIV or AIDS, and how to say no to sex, but that only 55% of young men and 60% of women received education related to contraception. Only 50% of young women and 58% of young men reported education about how to use a condom. They also found that only half of adolescents received formal education about contraception and only 40% received instruction about where to get birth control before they first had sex. Overall, they found a decrease in youth reporting receiving formal sexual health education from 2006 to 2013. Between 2000 and 2014, fewer percentages of high schools were

teaching abstinence, resisting peer pressure, human development, methods of contraception, or how to correctly use a condom. The greatest declines in formal sexual health education occurred in rural communities. For example, young women living in rural areas reported a decrease in education about birth control from 71% in 2006-2010 to 48% in 2011-2013. In addition, less than 6% of students identifying as lesbian, gay, bisexual, or transgender reported having received formal sexual health education that included positive representations of LGBT-related topics. Guttmacher Institute notes that comprehensive sexual health education is supported by the American Medical Association, American Academy of Pediatrics, American College of Obstetricians and Gynecologists, National Academies of Science, Engineering, and Medicine, American School Health Association, and the Society for Adolescent Health and Medicine. They summarize that, "strong evidence suggests that approaches to sex education that include information about both contraception and abstinence help young people to delay sex, and also to have healthy relationships and avoid STDs and unintended pregnancies when they do become sexually active. Many of these programs have resulted in delayed sexual debut, reduced frequency of sex and number of sexual partners, increased condom or contraceptive use, or reduced sexual risk-taking." Similarly, they note that a large body of evidence has found "no evidence that providing young people with sexual and reproductive health information and education results in increased sexual risk-taking." Formal sexual health education is more common in high school than in middle or elementary school. In 2014, 76% of U.S. public and private high schools taught abstinence as the most effective way to prevent pregnancy, STDs, and HIV; 72% provided instruction about pregnancy prevention; 61% taught contraception efficacy; and 35% taught students how to use a condom. At the middle school level, 50% taught that abstinence is the most effective method; 38% taught pregnancy prevention; 26% taught contraceptive efficacy; and 10% taught students how to use a condom. For schools that taught pregnancy prevention, high schools provided an average of 4.2 hours annually on pregnancy prevention and middle schools provided an average of 2.7 hours. Surveys suggest that about 93% of parents think sexual health education in schools is important, and most think it should include education about contraception. The factsheet also provides a discussion about federal efforts to identify evidence-based curricula as well as an overview of adolescents' likelihood to talk with parents or healthcare providers about sex and sexuality.

17. Medicine Society for Adolescent Health and. Abstinence-Only-Until-Marriage Policies and Programs: An Updated Position Paper of the Society for Adolescent Health and Medicine. *Journal of Adolescent Health*. 2017;61(3):400-403.

In 2017, the Society for Adolescent Health and Medicine (SAHM) updated their 2006 position paper on abstinence-only-until-marriage policies and programs to reflect current evidence. Regarding sexual health education, SAHM believe that, "sexuality education should be comprehensive, medically accurate, and culturally competent; promote healthy sexuality; and prepare young people to make healthy sexual decisions. Instruction in sexuality education should include essential concepts and issues such as sexual orientation, sexual health, gender identity and power dynamics, intimate partner violence and sexual exploitation, healthy relationships, social and structural determinants, personal responsibility, risks for HIV and other sexually transmitted infections (STIs) and unwanted pregnancy, access to sexual and reproductive health care, and the benefits and risks of condoms and other contraceptive methods." They also believe that Title V, Section 510(b) of the Social Security Action should be repealed and abstinence-only-until-marriage "as a basis for adolescent health policy and programs should be abandoned."

SAHM also noted that abstinence-only programs also systematically ignore or stigmatize many young people, including LGBTQ+ youth, adolescents who have experienced sexual abuse, violence, or exploitation, sexually-experienced adolescents, and pregnant and parenting teens. They concluded that, “[abstinence-only-until-marriage programs are not effective in delaying initiation of sexual intercourse or changing other behaviors. Conversely, many comprehensive sexuality education programs successfully delay initiation of sexual intercourse and reduce sexual risk behaviors.]”

18. Dickson E., Lobo M. L. Critical caring theory and public health nursing advocacy for comprehensive sexual health education. *Public Health Nursing*. 2018;35(1):78-84.

Dickenson and Lobo define comprehensive sexual health education as an approach that "emphasizes evidence-based, medically and scientifically accurate, age-appropriate content that includes human development, puberty and reproduction, relationships, decision-making, sexual violence prevention, body image, gender identity and sexual orientation, abstinence or delaying sexual activity, contraception, condom use, and disease prevention." The authors state that school settings are key locations for comprehensive sexual health education. They write, "from a health equity standpoint, the advantages of offering [comprehensive sexual health education] are crucial...this is particularly important in communities where adolescents are at high risk [of unplanned pregnancy], where the presence and quality of [comprehensive sexual health education] can significantly affect adolescent outcomes, and where the absence of [comprehensive sexual health education] is arguably unjust and unfair." The article provides a discussion about the role of public health nurses to advocate for comprehensive sexual health education in communities they serve.

19. Gynecologists American College of Obstetricians and. Comprehensive Sexuality Education. Committee Opinion No. 678. Washington, DC: The American College of Obstetricians and Gynecologists; November 2016 2016.

The American College of Obstetricians and Gynecologists (“ACOG” or “the College”) Committee on Adolescent Health Care published a committee opinion on comprehensive sexuality education. The Committee notes that current quality of sexuality education varies widely in "the accuracy of content, emphasis, and effectiveness." Furthermore, evaluations of sexuality education programs' biological outcomes (e.g., STIs and pregnancy rates) are expensive and complex. Such evaluations can also be unreliable since they often rely on self-reported behaviors to measure effectiveness. Having noted contextual limitations, the Committee asserts, "comprehensive sexuality education should begin in early childhood and continue through a person's lifespan." In addition to focusing on reproductive development, the prevention of STIs, and unintended pregnancies, ACOG recommends comprehensive sexuality education should "teach about forms of sexual expression, health sexual and nonsexual relationships, gender identity and sexual orientation and questioning, communication, recognizing and preventing sexual violence, consent, and decision making." Such education should include "[p]articipatory and culturally sensitive teaching approaches that are appropriate to the student's age as well as identification with distinct subpopulations, including adolescents with intellectual and physical disabilities, sexual minorities, and variations in sexual development." The Committee reaffirmed this opinion in 2018.

20. Legislature 66th Washington State. Engrossed Substitute House Bill 1109, 2019-2021 Operating Budget, Session Law 2019 (Chapter 415). Olympia, Washington: Washington State Legislature; 2019:257-259.

The 2019-2021 Enacted Operating Budget for Washington State requires the Office of Public Instruction to convene a workgroup to explore the feasibility of implementing comprehensive sexual health education for students in grades K-12 in Washington State. The workgroup is required to submit a report and recommendations to relevant committees of the Legislature and the Governor's Office by December 1, 2019. Relevant information is in Part V, Section 501, 3, (h)(i)(A) beginning on page 257.

21. Instruction Washington State Office of Superintendent of Public. Report to the Legislature Comprehensive Sexual Health Education Workgroup. Olympia, Washington: Washington State Office of Superintendent of Public Instruction; 2019.

This OSPI Report to the Legislature is the result of House Bill 1109, Section 501(3)(h) and documents the Sexual Health Education (SHE) Workgroup's findings and recommendations related to the provision of comprehensive sexual health education in Washington State. The SHE Workgroup met four times in August through September 2019 with two in-person meetings and two virtual meetings. Overall, members of the Workgroup "agreed that all students in Washington's public schools should have access to comprehensive sexual health education (CSHE) in grades K–12." Members found requiring CSHE is "an issue of equity and would help to ensure all students across the state receive quality, evidence-informed instruction, regardless of who they are or where they live." Furthermore, the Workgroup found evidence that "several groups are often excluded from relevant, inclusive instruction, including students in out of home care, students with disabilities, students who identify as LGBTQ+, and English learners, among others." Additionally, to inform the Workgroup's work OSPI created a public comment survey consisting of 9 questions: 4 demographic questions and 5 questions to assess respondents' opinions related to the provision of comprehensive sexual health education to students in all grades in Washington public schools. The public comment survey was provided in English and Spanish and was available on the OSPI website for about 6 weeks in August and September (OSPI, personal communication, January 2020). OSPI's survey methods can be described as a voluntary convenience sample with no restrictions on how often individuals could respond to the survey. Specifically, OSPI provided information about the survey to all of the organizations asked to appoint members to the workgroup (WSSDA, AWSP, WEA, DOH, WSPTA, WA State Special Education Advisory Council), with a request to disseminate it to their constituents (OSPI, personal communication, January 2020). Additionally, a link to the survey was provided on OSPI's main sexual health education webpage, the SHE Workgroup webpage, in the SHE e-newsletter (distributed to approximately 2,800 subscribers [e.g., educators and public] twice per month), and posted multiple times on OSPI's social media feeds (Twitter, Facebook) (OSPI, personal communications, January 2020). The survey link was also disseminated by OSPI's Migrant Health program and sent out to all stakeholder groups who requested information about the Workgroup, as well as The Washington State Legislative Youth Advisory Council (OSPI, personal communication, January 2020). Appendix E of the Workgroup's Report to Legislature includes a summary of public comments received by OSPI. Of the 10,543 survey respondents who provided information about their residence, 44.3% reported living in the Puget Sound Region, 21.3% in Northwest Washington; 12.2% in Northeast Washington; 10.7% in Southwest Washington; 7.3% in Central Washington; and 6.9% in Southeast Washington. Fourteen

respondents lived outside Washington. The majority of respondents identified as female (7,084 of 9,621 respondents or 73.6%; 22.6% Male; 2.5% Prefer not to answer; 0.7% Non-binary; 0.3% Transgender; 0.1% Questioning; 0.1% Not sure; 0.1% Something else fits better). The majority of respondents were 31 to 50 years of age (50.3%; 2.3% were 18 years and younger; 8.9% were 19 to 30 years of age; 28.2% were 51 to 70 years of age; and 7.0% were 71 years of age and older; with 3.1% preferring not to answer. The survey did not include a question to assess the racial/ethnic composition of survey respondents. Overall, 10,092 respondents answered the question: Should comprehensive, age appropriate, medically accurate sexual health education be required for all students in grades K-12; 58.4% said no; 38.3% said yes, and 3.3% were unsure. Of the 10,099 respondents who answered "Are changes needed to current statutes related to sexual health education (e.g., Healthy Youth Act, AIDS Omnibus Act), 36.6% replied "yes", 28.6% replied "no", and 34.8% replied "not sure". Finally, when asked "How familiar are you with the Washington State K-12 Learning Standards", 27.1% of 10,059 respondents reported "very", 56.2% noted "some", 11.6% said "hardly", and 5.1% reported "not at all." Questions 7 and 8 involved short answers; respondents were asked to describe benefits associated with requiring CSHE for students in all grades and associated challenges with this approach, respectively. In response to concerns from the public, SHE Workgroup members proposed "that any effort to require CSHE include language clarifying specific topics for [students in grades] K-3."

22. Lake Celinda. Planned Parenthood Washington Findings based on a statewide phone survey of 500 registered voters with an oversample of 100 people of color. In: Hawaii PPVNa, ed. Washington, D.C.: Lake Research Partners; 2019.

This presentation by Lake Research Partners discusses polling conducted with Planned Parenthood Votes Northwest and Hawaii. Information presented was collected as part of a larger scale polling project with 6 states (Alaska, Washington, Hawaii, Idaho, Indiana, and Kentucky). Results presented in this presentation are specific to Washington State respondents. Findings are based on a statewide phone survey of 500 registered voters (drawn from the voter file) with an oversample of 100 people of color. Polling was conducted by phone from August 15 - August 20, 2019. "The base sample was weighted by gender, region, race, gender by race, educational attainment, and party identification. The people of color oversample was weighted by gender, region, age, race, and party identification." Finally, "the oversample was weighted down into the base to reflect their proportion of the overall population." The margin of error is +/- 4%. Results show 86% support teaching medically accurate, age appropriate, comprehensive sex education in public schools; 70% strongly support; 11% oppose; and 2% don't know. Results show strong support among Democratic women (88%); those who rarely attend religious services (82%); those who are pro-choice (81%); mothers (78%); those residing in Southeast Washington (77%); and younger women (77%). Researchers assessed statements as "strong" if the met certain thresholds (i.e., 60% agree and 40% strongly agree). Accordingly, the following statements are considered strong : "Young people need to understand what a healthy relationship looks like and have the opportunity to practice good communication skills before they become sexually active" (92% agree; 82% strongly agree); "It's important that all students across WA have access to comprehensive, medically accurate, age appropriate sex education, no matter their zip code" (87% agree; 75% strongly agree); "We should require that all schools teach medically accurate, age appropriate sex education" (86% agree; 68% strongly agree); "It's important to dispel myths and stigma around sexual health for the LGBTQ community and that starts with awareness and

sex education" (67% agree; 54% strongly agree); and "Sex education that is LGBTQ inclusive provides young people opportunity to understand sexual orientation and gender identity in an open and inclusive way" (63% agree; 46% strongly agree)." Conversely, there was strong disagreement with the statement "Sex education encourages the transgender lifestyle (71% disagree; 60% strongly disagree; with 17% agreeing; 9% strongly agree). When asked about policy proposals, 86% were in favor (72% strongly favor) of "Requiring existing age-appropriate medically accurate sex education curriculum in schools to include healthy relationships and communication skills." Similarly, 83% favored (66% strongly favor) "Expanding existing age-appropriate medically accurate sex education curriculum in schools to include healthy relationships and communication skills."

23. Manlove J., Fish H., Moore K. A. Programs to improve adolescent sexual and reproductive health in the US: a review of the evidence. *Adolescent Health, Medicine and Therapeutics*. 2015;6:47-79.

Manlove, Fish, and Moore completed a review of 103 evaluations of 85 programs (including abstinence-only education, comprehensive sexual health education, clinic-based programs, youth development programs, and parent-youth relationships) to determine their impact on teen pregnancy, childbearing, sexually transmitted infections (STIs), contraceptive use, and sexual activity. The authors cite previous research that 77% of teen births are unintended. Rates of teen pregnancy are twice as high for U.S. black and Hispanic teens compared to white teens. U.S. adolescents also have higher rates of teen pregnancy than teens in other developed countries, including rates twice as high as Canada and five times as high as Sweden. Teen pregnancy/childbirth is associated with lower educational attainment and higher poverty, and children of teen parents are more likely to experience poorer academic and behavioral health outcomes. U.S. adolescents also have high rates of STIs, with almost half of STIs reported in the U.S. occurring among adolescents and young adults. STIs can result in infertility, pregnancy complications, organ damage, and death. Overall, "programs that help teens delay the timing of first sex or increase condom use or other contraceptive use can help reduce high rates of teen pregnancy and STIs." This review examined rigorously evaluated programs that incorporated random-assignment and intent-to-treat analyses. The review included articles published from 1990 to 2014 that were peer-reviewed, evaluation reports and included in the Child Trends' What Works/Lifecourse Interventions to Nurture Kids Successfully (LINKS) database. Child Trends is a national non-profit, non-partisan, independent research organization focusing on children and youth and receives funding from a variety of organizations including the Bill and Melinda Gates Foundation, Centers for Disease Control and Prevention, Robert Wood Johnson Foundation and the U.S. Departments of Education, Health and Human Services, and Justice, among others. The LINKS database includes program evaluations showing both positive and negative impacts on health. Inclusion criteria included evaluations of programs conducted with adolescents age 18 and younger, did not specifically target teen parents, and assessed impacts on sexual behaviors, condom use, contraceptive use, STIs, pregnancy, and/or childbirth. Overall, 52 of the 85 programs reviewed had impacts across a range of programs and populations: 31 were effective for some measure of sexual activity, 31 were effective for condom use or contraceptive use, 5 were effective for reducing STIs, and 9 were effective for reducing pregnancy/birth. The authors identified 5 out of 14 effective abstinence-based programs. Of the five effective programs, 4 delayed sexual initiation, 2 reduced sexual frequency, and one reduced pregnancies or births. The authors noted, "however, none of the abstinence programs reduced the number of sexual

partners, increased condom or contraceptive use, or reduced STIs.” Specific to comprehensive sexual health education programs, the review found that 21 out of the 47 programs (less than half) were effective. Of these, 16 were effective for some measure of sexual activity, 14 impacted condom use, 4 increased contraceptive use, 1 reduced STIs, and 1 found a mixed impact on pregnancies/births. The authors state, "although many more effective comprehensive sex-education programs were identified than abstinence-only programs, their rate of effectiveness...was similar to that of abstinence-education programs. These findings highlight the need to identify key implementation components that are particularly effectively for improving sexual and reproductive health outcomes across program approaches. In fact, many of the programs that were not effective...included components that were similar to the effective programs...which suggests that program implementation may be as important as program content for improving outcomes." The review also found that parent-youth relationship programs and clinic-based approaches were particularly effective. The article includes findings for each of the 85 programs reviewed.

24. Oringanje C., Meremikwu M. M., Eko H., et al. Interventions for preventing unintended pregnancies among adolescents. *Cochrane Database of Systematic Reviews*. 2016;2:CD005215.

This Cochrane Review evaluated available evidence to determine the impact of school-based, community-based, clinic-based, and faith-based interventions on reducing unintended pregnancy among adolescents. The review team conducted a systematic review and meta-analysis of literature published prior to November 2015. Articles were included if they were an evaluation of an intervention designed to increase knowledge/attitudes related to the risk of unintended pregnancy or to delay the initiation of sexual intercourse and encourage consistent contraceptive use to reduce unintended pregnancy among adolescents 10 to 19 years old. They included 53 randomized control trials in their analysis. Interventions were classified as educational (health education, HIV/STD education, community services, counseling, health education plus skill-building, faith-based group or individual counseling); contraceptive-promoting (contraception education with or without distribution of contraceptives); and multiple (combination of educational intervention with contraceptive-promotion interventions). The authors made three main conclusions. First, they found moderate quality evidence that multiple interventions (those that combined educational and contraceptive-promoting components), significantly lowered the risk of unintended pregnancy among adolescents (RR 0.66, 95% CI= 0.50-0.87). However, this finding was only significant for individual-level RCTs and not for randomized cluster RCTs (e.g. school level). Second, they found moderate quality evidence that educational interventions significantly increased condom use at last sex (RR 1.18, 95% CI 1.06-1.32); low quality evidence that educational interventions were unlikely to significantly delay the initiation of sexual intercourse (RR 0.95, 95% CI 0.71-1.27); and unclear evidence if educational interventions impacted risk of unintended pregnancy. Third, they found high quality evidence that adolescents participating in contraceptive promoting initiatives had significantly higher use of hormonal contraception (RR 2.22, 95% CI= 1.07-4.62); and moderate quality evidence that contraceptive promoting initiatives had little or no impact on the risk of unintended pregnancy (RR 1.01, 95% CI 0.81-1.26). Overall, the authors concluded, "only interventions involving a combination of educational and contraception promotion (multiple interventions) was seen to significantly reduce unintended pregnancy over the medium-term and long-term period." There was also some evidence to suggest educational interventions increased condom use at last sex,

and contraception promoting initiatives increased use of hormonal contraception. The authors also note that results for secondary outcomes were inconsistent, including for initiation of sexual intercourse, use of birth control methods, abortion, childbirth, and sexuality transmitted diseases. Cochrane Reviews use rigorous methods to eliminate bias and for this study, “considered all published and unpublished randomized controlled studies that assessed the effectiveness of interventions to reduce unintended pregnancy among adolescents, written in any language.” One limitation to this Cochrane Review is that it included multiple intervention types in the "educational interventions" category, including school-based, community-based, clinic-based, and faith-based interventions. While the authors note that most of the studies included in the review occurred in schools, others were conducted in hospitals, family planning health agencies, communities, and clubs. Intervention outcomes may differ by setting. The authors note that other limitations included most studies using self-reporting for outcomes, differences in program design and implementation, and little information about implementation fidelity.

25. **Denford S., Abraham C., Campbell R., et al. A comprehensive review of reviews of school-based interventions to improve sexual-health. *Health Psychol Rev.* 2017;11(1):33-52.** Denford et al. completed a comprehensive systematic review of 37 systematic reviews (summarizing 224 primary randomized controlled trials) of school-based sexual-health and relationship education (SHRE) programs. Systematic reviews included met the following inclusion criteria: 1) articles published from 1990-2016; 2) systematic reviews and meta-analyses of randomized controlled trials (RCTs), cluster randomized trials (C-RCTs) and studies using quasi-experimental design; 3) reviewed interventions targeting children and young people aged 4-18 years of age in full-time education; 4) school-based intervention recipients were teachers, school students, parents, or a combination of the three; 5) control conditions received usual care or a modified (including simplified) version of the intervention. Additionally, eligible reviews assessed primary outcomes (i.e., sexual behavior and health and social outcomes related to sexual-health) or secondary outcomes (i.e., knowledge and understanding of sexual-health and relationship issues, personal and social skills, and attitudes and values). Authors assessed the risk of bias, study quality, and reliability. Finally, researchers extracted data on studies relevant to the aims of the current review of reviews and excluded data on studies with unrelated aims. Generally, the systematic reviews analyzed distinct sets of primary studies, but no comprehensive review of available primary studies was identified. Interventions were categorized into five subtypes: abstinence-only intervention, comprehensive interventions, pregnancy programs, HIV-prevention interventions, and school-based healthcare centers. Authors note, "many reviews reported weak and inconsistent evidence of [behavior] change. Nonetheless, integration of review findings generated a list of 32 design, content and implementation characteristics that may enhance effectiveness of school-based, sexual-health interventions." Specific to reviews of abstinence-only interventions (8 reviews), reviews "consistently found that interventions promoting abstinence-only can be effective in improving knowledge about how abstinence can protect against STIs, about STIs and about the risks and consequences of unprotected sex and pregnancy, but are not effective in changing [behavior]. Furthermore, there is tentative evidence that such [programs] may increase sexual activity, STIs and pregnancy." For example, a high-quality English review, which included 10 U.S.-based abstinence only-interventions, found improvements in knowledge and attitudes did not lead to positive changes in sexual behavior. Additionally, authors reviewed 13 systematic review of comprehensive interventions that aim to "prevent, stop, or decrease sexual activity, but also

promote condom use and other safer-sex strategies as alternatives for sexually active participants." Overall, comprehensive interventions led to improvements in knowledge, attitudes, and skills. Although these reviews also assessed a variety of behavioral outcomes, findings of reported positive behavior changes "were not consistent enough to draw firm conclusions." Authors note that the reviews highlight weaknesses and inconsistencies in the evidence related to behavioral health effects. However, "comprehensive, sexual-risk reduction and HIV-prevention interventions were consistently effective in changing knowledge, attitudes and skills [...] Some interventions in all five categories led to [behavior] change but reviewers reported that positive changes were inconsistent; some interventions leading to change in one outcome, and others failing to replicate this." As fidelity of delivery was rarely assessed, authors stated it was "difficult to attribute ineffectiveness to intervention design and content rather than failure to implement in accordance with the intervention protocol." Authors found that "particular design, content and implementation characteristics appear to be associated with greater effectiveness." The most common content features associated with school-based program effectiveness included, programs: do not focus on abstinence (supported by 8 reviews); include school based/school-linked health centers (3); specify measurable and multiple behavioral targets and outcomes (3); specify and target mechanisms that regulate behavioral outcomes (3); include multiple program strategies and methods to change behavior (3); employ interactive and participatory educational strategies that actively engage the recipient (3); and are of sufficient duration and intensity (3). Authors recommend consideration of these characteristics by designers of school-based sexual-health interventions.

26. Chin H. B., Sipe T. A., Elder R., et al. 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. *American Journal of Preventive Medicine*. 2012;42(3):272-294.

Chin et al. completed systematic reviews to assess "(1) the effectiveness of comprehensive risk-reduction and abstinence education interventions for reducing adolescent pregnancy, HIV, and other STIs and (2) the influence of moderator variables including delivery setting, type of deliverer, intervention focus (pregnancy or STIs), and targeting (adapting interventions for specific groups)." Authors noted that despite declines in the national teen birth rate evidence indicates it is still high compared to other high income countries. Additionally, young people are disproportionately represented among new STI diagnoses. For example, "although young people aged 15-24 years account for one quarter of the sexually experienced population, they contract nearly half of the 19 million new STIs diagnosed each year." Disparities in STI rates also exist by race/ethnicity. For instance, HIV data from 2006 showed that "[a]mong male adolescents and young adults, the rate of infection per 100,000 was seven times higher among African Americans than among whites (128.3 vs 18.1) and three times higher among African Americans than Hispanics (128.3 vs 42.8)." The reviews included articles published from 1988 to August 2007. Of the 62 qualifying studies, 12 studies had good quality of execution and 50 had fair quality of execution. More than half the studies reviewed used a Randomized Control Trial (RCT) study design. Results of the meta-analyses showed "reductions in sexual activity (sexual activity OR=0.84, frequency of sexual activity OR=0.81); sexual risk behaviors (number of sex partners OR=0.83, unprotected sexual activity OR=0.70); and the biologic outcomes (STIs OR=0.65, pregnancy OR=0.88), as well as increases in protective sexual behaviors (use of protection

OR=1.39). The effect estimates for all outcomes for comprehensive risk reduction, except pregnancy, were significant.” Sensitivity testing found no indication of publication bias. Evidence from the comprehensive risk-reduction interventions is generalizable to a range of populations and settings (i.e. representation from range of ages, racial/ethnic groups, and adolescents of differing baseline virginity status, school and community settings). An analysis of 10 studies that considered the economic efficiency of comprehensive risk-reduction interventions found that, overall, most studies demonstrated a positive economic value (e.g., cost saved by preventing pregnancy, STI, and HIV, and secondary benefits [e.g., educational attainment]) from investments in interventions. The review of abstinence education yielded 21 studies with the greatest study design suitability, of which 2 studies had good quality of execution and 19 studies had fair quality of execution. Almost all participants were aged 10-14 years, with representation across gender and race/ethnicity, and most were virgins at baseline. Results of the meta-analysis indicated “reduction in sexual activity and frequency of sexual activity with significant reduction for sexual activity only.” However, when results were stratified by study design, RCTs found smaller effect estimates than non-RCTs. Additionally, analysis found RCTs incorporated longer follow-up periods (maximum = 6.5 years; Mean = 3.2 years) than non-RCTs (maximum = 1 year; Mean = 0.6 years). Meanwhile, effect estimates were unfavorable for both pregnancy and STIs. Number of sex partners, unprotected sexual activity, and use of protection during sexual activity were not significant. Analysis suggested the possible presence of publication bias, as studies with small sample sizes, which are subject to more chance variation, showed a pattern of greater intervention effects than larger studies.” Evidence of economic efficiency of abstinence education interventions is limited. Authors also assessed evidence of potential harms related to both comprehensive risk-reduction interventions and abstinence education interventions. A commonly cited concern about comprehensive risk-reduction interventions is that they may lead to earlier initiation and greater frequency of sexual activity. However, results of this review “indicate reductions in both sexual activity and frequency of sexual activity among adolescents [receiving the comprehensive risk-reduction interventions] compared to adolescents not receiving the intervention.” Additionally, despite concerns that condoms do not provide complete protection from STIs and pregnancy due to inconsistent use by adolescents, the review found similar effects for consistent condom use compared to the broader condom use outcome. Specific to abstinence education interventions, the review found that among interventions measuring use of protection results did not show any difference in usage between the treatment and comparison groups. Therefore, the results do not support the hypothesis that abstinence education interventions could lead to a reduction in the use of protection during sexual activity. Researchers found no consistent evidence of differential effects on outcomes for 12 critical moderator variables: gender, virginity status, age, race/ethnicity, setting, dosage, focus, deliverer, multicomponent, targeting, study design, and comparison group type.

27. Haberland N. The Case for Addressing Gender and Power in Sexuality and HIV Education: A Comprehensive Review of Evaluation Studies. *International Perspectives on Sexual and Reproductive Health*. 2015;41(1):31-42.

Haberland conducted a review of literature published between 1990 and 2012 to evaluate whether the inclusion of gender and power matters in sexual health curriculum impacted program efficacy. Haberland explained that, “despite extensive investments in and evaluations of sexuality and HIV education for young people, questions of effectiveness persist...consensus has been reached about several [characteristics]- i.e., the benefits of comprehensive versus

abstinence-only content, and of participatory, skills-building teaching approaches- but, overall, the literature raises a number of questions.” Since prior evidence has found that traditional gender norms, unequal power in sexual relationships, and experiences of intimate partner violence are associated with negative sexual and reproductive health outcomes, this review sought to determine whether including gender and power topics in sexual health education curriculum impacted health outcomes (i.e. unintended pregnancy, childbirth, STIs, HIV). Haberland identified 22 studies that met inclusion criteria. Fourteen studies were conducted in the U.S.; 10 studies were in schools; 15 studies were randomized controlled trials; and 10 studies included topics of gender and power (12 did not). All of the included studies were evaluations of curricula among adolescents under 19 years old. In addition, “curricula had to go beyond the conventional content on resisting sexual advances (refusal skills) to include at least one explicit lesson, topic, or activity covering an aspect of gender or power in sexual relationships” including gender norms, gender equality, harmful or biased practices or behaviors driven by gender, or power inequities. Overall, the review found that “programs that addressed gender or power were five times as likely to be effective as those that did not.” Specifically, “among the 10 programs that addressed gender and power, eight (80%) led to significant decreases...in at least one of the health outcomes (pregnancy, childbearing, or STIs. In contrast, among the 12 programs that did not address gender and power, only two (17%) significantly reduced rates of pregnancy or STIs.” In addition, the eight effective programs that addressed gender and power also found, “significant, independent beneficial effects on reported behavior, attitudes, or other desirable health or social outcomes” (e.g. condom use, decreased number of sexual partners, reductions in intimate partner violence). Haberland also identified curriculum components for gender and power topics that may make a program more effective. Effective components included, interactive or learner-centered pedagogical approaches, explicit activities on gender/power in intimate relationships, critical thinking about how gender norms manifest (e.g. in media or music), opportunities for personal reflection, and emphasis on personal power.

28. Health Office of Adolescent. Evidence-Based Teen Pregnancy Prevention Programs at a Glance. U.S. Department of Health and Human Services;2018.

This At-a-Glance reference report provides an overview of programs recommended by the U.S. Department of Health and Human Services (HHS) as part of their "Teen Pregnancy Prevention Evidence Review." HHS has identified 44 evidence-based teen pregnancy prevention programs, including 13 sexual health education programs in school settings. These programs include: Aban Aya Youth Project (outcomes: recent sexual activity); Be Proud! Be Responsible! (outcomes: recent sexual activity, number of sexual partners, frequency of sexual activity, contraception use and/or consistency); Cuidate! (outcomes: recent sexual activity, number of sexual partners, contraception use and/or consistency); Draw the Line/Respect the Line (outcomes: recent sexual activity, sexual initiation/abstinence); FOCUS (outcomes: number of sexual partners); Get Real (outcomes: sexual initiation/abstinence); It's Your Game: Keep It Real (IYG) (outcomes: frequency of sexual activity, contraceptive use/consistence, sexual initiation/abstinence); Making Proud Choices! (outcomes: contraceptive use/consistency); Nu-CULTURE (Healthy Futures) (outcomes: sexual initiation/abstinence); Positive Prevention PLUS (outcomes: recent sexual activity, contraceptive use/consistence, sexual initiation/abstinence); Promoting Health Among Teens! Comprehensive Abstinence and Safer Sex Intervention (outcomes: number of sexual partners); Reducing the Risk (outcomes: contraceptive use/consistency); and Safer Choices (contraceptive use/consistency).

29. Lugo-Gil J., Lee A., Vohra D., et al. Updated findings from the HHS Teen Pregnancy Prevention Evidence Review: August 2015 through October 2016. U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation;2018.

The U.S. Department of Health and Human Services (HHS) contracts with Mathematica Policy Research to conduct an ongoing systematic review of research to identify evidence-based programs to reduce teen pregnancy, sexually transmitted infections (STIs), and risky sexual behaviors. Review criteria "require programs to show evidence of at least one favorable, statistically significant impact on at least one sexual risk behavior or reproductive health outcome of interest (sexual activity, number of sexual partners, contraceptive use, STIs, or pregnancy)." Research must also meet criteria related to study quality and execution, including study design, sample attrition, baseline equivalence, reassignment of sample members, and confounding factors. Overall, Mathematica has identified 44 programs meeting review criteria since 2009. This update identified research for an additional 3 programs not previously evaluated that had evaluations published between August 2015 and October 2016 and met inclusion criteria. The 3 new programs included, "Crossroads," "POWER Through Choices," and "Possessing Your Power." Only the Power Through Choices program is a comprehensive sexual health education program. This program was provided to adolescents living in foster care, juvenile justice facilities, and other out-of-home care setting and was delivered in 10 90-minute sessions over a 5-10 week timeframe. Using a cluster randomized controlled trial with 885 students aged 13 to 18, the study found that adolescents in the program were significantly less likely to report ever being pregnant or getting someone pregnant at 12-month follow-up than students in the control group. In addition, Mathematica identified 41 new publications on 25 programs they had previously evaluated. For 22 programs, "the new publications did not materially affect the review team's previous assessment of these programs or their impacts on other youth outcomes" and 15 of these programs were already determined to be effective. The "Positive Potential," "Teen Options to Prevent Pregnancy" (T.O.P.P.), and "Teen Outreach Program" (TOP) programs presented new evidence of positive impacts, and the "Familias Unidas" program met review criteria for effectiveness for the first time. None of these new programs are a school-based, comprehensive sexual health education program. However, Positive Potential and Teen Outreach Program (TOP) are a school-based, youth development programs. New evaluation findings for Positive Potential have shown that the program is effective at reducing sexual activity and delaying sexual initiation among rural, middle school students. TOP has been found effective at reducing teen pregnancy.

30. Lindberg L.D., Maddow-Zimet I. Consequences of sex education on teen and young adult sexual behaviors and outcomes. *Journal of Adolescent Health*. 2012;51:332-338.

Lindberg and Maddow-Zimet presented past research showing that abstinence-only programs are ineffective in delaying sexual debut or reducing sexual risk behaviors in teens, and that comprehensive sexual health education programs have had positive behavioral effects. They analyzed data from the 2006-2008 National Survey of Family Growth to determine whether formal sexual health education is associated with sexual health behaviors and outcomes. The National Survey of Family Growth was conducted with 15-24 year olds and included measures related to formal sexual health education (abstinence, abstinence and birth control, neither), timing of first sex, contraceptive use at first sex, condom use at first sex, first sex with a romantic

(rather than casual partner), first sex with an age-discrepant partner (greater than 3 year age difference), unwanted first sex, number of sexual partners, even been/gotten a partner pregnant, STI treatment in the past 12 months, and contraceptive use at last sex. They also collected sociodemographic information, including age, race/ethnicity, socioeconomic status, mother's education, living arrangement at age 14, attendance at religious services at age 14, and community type. Their final sample size was 2,505 females and 2,186 males aged 15 to 24 years old. They found that two-thirds of sexually-experienced females and 55% of sexually experienced males received both abstinence and birth control education before first vaginal sex. Receipt of neither topic was more common among individuals who were black or Hispanic, lower socioeconomic status, lower maternal education, not living with both parents at age 14, and attended religious services less frequently. In addition, for both males and females, "healthier behaviors and outcomes were generally positively associated with receipt of sex education of either type, whereas riskier behaviors were more likely among respondents not receiving instruction in either topic." Overall, they found that receiving any type of formal sexual health education was associated with delay in first vaginal sex. Individuals receiving formal sexual health education about both abstinence and birth control were also statistically significantly more likely to use contraception (Odds Ratio= 1.73, females or OR=1.91, males; $p<0.5$) or a condom (OR= 1.69, females or OR= 1.90 males; $p<0.5$) at first sex and less likely to have an age-discrepant partner (OR= 0.67, females, or OR= 0.48, males; $p<0.5$) compared to individuals that did not receive instruction. They also noted that, "we found no evidence that receipt of either type of sex education was associated with either onset of sex, greater risk taking, or poorer [sexual and reproductive health] outcomes. Even when the estimated associations were not statistically significant at conventional levels, the direction of association was consistently toward less healthy [sexual and reproductive health] behaviors and outcomes among those who did not receive instruction in either abstinence or birth control before first sex. As both receipt of [abstinence and birth control] or only abstinence education significantly increased age at first sex, it appears that talking with adolescents about sex- before they first have sex- seems to be what is important, regardless of the specific subject matter." They concluded that, "sex education about abstinence and birth control was associated with healthier sexual behaviors and outcomes as compared with no instruction. The protective influence of sex education is not limited to if or when to have sex, but extends to issues of contraception, partner selection, and reproductive health outcomes."

31. **Schalet A. T., Santelli J. S., Russell S. T., et al. Invited commentary: broadening the evidence for adolescent sexual and reproductive health and education in the United States. *Journal of Youth and Adolescence*. 2014;43(10):1595-1610.**

In this commentary, Schalet et al. argue that, "while sexual health education cannot remove the inequalities in society at large, it can aid students in acquiring the critical thinking skills that allow them to more effectively confront and challenge them." Specifically, the authors note that sexual health education can influence inequities related to gender, race, sexuality, and poverty. The authors noted that, "structural racism, poverty, gender inequality, and the stigmatization of LGBTQ people all negatively impact health outcomes, including sexual health outcomes, and...it is incumbent upon educators not to perpetuate inequalities within the classroom through explicit or implicit stereotyping." They also noted that, "opponents of sexual health education have argued that teaching young people about sex encourages them to be sexually active, even though there is no evidence to support such claims." The authors provided a critique of evidence-

based interventions compiled by the U.S. Department of Health and Human Services Office of Adolescent Health. First, they stated that program effectiveness is based on disease prevention and pregnancy prevention, but do not include impacts on other factors known to influence adolescent sexual risk behaviors including psychosocial factors and structural and economic inequities. The authors stated, “social and behavioral science research documents the significance of sexual orientation of young people, the gender beliefs and inequities that shape their sexual agency and relationships, and the economic and racial inequities that constrain their options, as crucial to a holistic understanding of adolescent sexual health.” These factors are often not addressed by current evidence-based interventions. The article presents and summarizes research related to sexual health education and health outcomes by sexual orientation, gender identity, socioeconomic status, and race/ethnicity. They also discuss the impacts of intersectionality. For example, they stated, “poverty limits knowledge about and access to sexual and reproductive health services, constrains positive sexual expression and feelings of self-efficacy, and makes disadvantaged youth vulnerable to sexual exploitation and violence. This is why the experience of poverty is associated with greater sexual risk-taking.” They concluded that, “sexual health education must thus recognize the diverse life course trajectories and family formations that characterize students’ lives.”

32. Kozhimannil K. B., Hardeman R. R., Henning-Smith C. Maternity care access, quality, and outcomes: A systems-level perspective on research, clinical, and policy needs. *Seminars in Perinatology*. 2017;41(6):367-374.

Kozhimannil, et al. found that rural residents, low-income individuals, and people of color have less access to maternity care in the United States, including access to prenatal care, labor and delivery care, emergency obstetric care, and postpartum care. Factors such as health care financing, health care delivery and organization, and the policy context contribute to access to reproductive health services. The authors state that, "multiple other factors- and the intersection of these factors- affect need for, access to, quality, and outcomes of maternity care. These factors include clinical conditions, health insurance coverage, geographic location (rural or urban), and sociodemographic characteristics including race and ethnicity."

33. Kantor L., Levitz N. Parents' views on sex education in schools: How much do Democrats and Republicans agree? *PLOS ONE*. 2017;12(7):1-9.

Kantor and Levitz stated that the “vast majority of Americans support comprehensive sex education in public schools.” They cite previous research that more than 90% of American adults think that sex education in public schools is very or somewhat important. Although more people support sexual health education in high school, “most adults believe middle school is the most appropriate time to start sex education.” Generally, “younger age, African American race, attending religious services less frequently, higher education levels, lower household income, and being more politically liberal increases the odds of parents supporting comprehensive sex education.” In this study, Kantor and Levitz used data from an online survey of 1,592 parents to determine whether support among parents varied by political affiliation. The survey was conducted by GfK, a multinational, marketing research firm, and parent surveys were included in the analysis if respondents indicated they identified as a Democrat or Republican (undecideds, others, and Independents were removed from analysis). The survey included 91 questions about the importance of sexual health education generally, in middle school, and in high school; support for various topics of sexual health education (i.e. puberty, healthy relationships,

abstinence, birth control, sexually transmitted disease (STDs), and sexual orientation), and political affiliation. Approximately 60% of the sample were Democrat, and 38% were Republican. They found that, “generally, white individuals, married individuals, and men are less likely to support sex education compared to people of color, unmarried individuals, and women. Despite this, we still see high levels of support no matter the group.” Overall, 74.9% of parents felt it was important to have sexual health education in middle school and 86% of parents felt it was important in high school. Only 2.6% of parents felt sexual health education should not be taught in middle school and 0% (8 parents) felt it should not be taught in high school. Only about 2.5% of parents felt sexual health education should not be taught at all. For Democrats, 82% felt sexual health education was important in middle school and 92% of parents felt it was important in high school. For Republicans, 64% of parents felt it was important in middle school and 77% in high school. However, after controlling for race/ethnicity, income, employment, marital status, gender, and educational attainment, “there was essentially no difference by political affiliation.” More than 94% of parents supported including puberty, healthy relationships, abstinence, birth control, and STDs in high school sexual health education. Only 85% of parents supported including sexual orientation. There were differences by political affiliation for topics of birth control and sexual orientation. For birth control, 98% of Democrats and 89% of Republications felt it should be included in high school sexual health education. For sexual orientation, 92% of Democrats and 75% of Republicans felt it should be included. After controlling for demographic factors, identifying as Democrat significantly increased the odds that parents would support including birth control (middle school OR 2.5, 95% CI 1.8-3.5, $p < 0.001$; high school OR 6.0, 95% CI 3.4-10.5, $p < 0.001$), STDs (middle school OR 2.6, 95% CI 1.4-2.6, $p = 0.003$; high school OR 7.1, 95% CI 2.6-19.1, $p < 0.001$), healthy relationships (middle school OR 2.5, 95% CI 1.6-3.9, $p < 0.001$; high school OR 6.6, 95% CI 3.3-13.2, $p < 0.001$), and sexual orientation (middle school OR 3.5, 95% CI 2.6-4.6, $p < 0.001$; high school OR 3.9, 95% CI 2.8-5.5, $p < 0.001$) in both middle and high school curriculum, and including puberty in high school (OR 2.0, 95% CI 1.1-3.5, $p = 0.021$). There was no significant difference by political affiliation in support for including abstinence in sexual health education curriculum. Overall, the authors concluded that, “regardless of political affiliation, parents overwhelmingly report that sex education in both middle and high school is important and want sex education to include a variety of topics...Republicans and Democrats place almost equal value on the importance of sex education controlling for demographic factors.”

34. **Instruction Office of Superintendent of Public. Sexual Health Education**

Legislation: Notes from school contacts. 2019.

The Office of Superintendent of Public Instruction (OSPI) contacted 22 school districts across Washington State with questions about mandating comprehensive sexual health education in public schools. They shared unpublished, de-identified qualitative responses from districts with Board of Health staff. Staff analyzed data using an open coding approach by reading all responses, identifying emerging themes, developing inductive codes, grouping responses by theme, and summarizing responses by theme. OSPI spoke with 16 school districts (73% response rate); 12 (75%) were from West of the Cascade Mountains and 4 (25%) were from East of the Cascade Mountains. Districts represented a mixture of large and small, and urban, rural, and suburban school districts. Respondents were a mix of educators, school staff, and School Board members. Overall, most respondents expressed support for mandating comprehensive sexual health education. Respondents felt that mandating sexual health education was in the best interest

of students, would support what districts were already doing, and would provide districts with a clear path forward for implementation. While no respondents were opposed to mandating sexual health education, some respondents expressed concerns or challenges about implementation. First, respondents felt they were already struggling to meet graduation requirements and this would add one more required component. Second, some respondents expressed concern about how and where they would fit the content into existing curriculum. One respondent was also concerned about funding for implementation. Another was concerned that requiring schools to use specific curricula would cause some parents to opt their student out of sexual health education. Two respondents indicated that parents had opted their child out of specific lessons (rather than the entire curricula). One respondent noted that opt-outs were highest for lessons on gender and sexual violence. However, they stated that they noticed the greatest shift in classroom culture/climate following lessons addressing gender and sexual violence. Respondents suggested willingness to write letters of support, contact their legislators, disseminate information, testify in support of mandating comprehensive sexual health education, and talk with their district leadership. Overall, respondents were unsure about the level of support from districts, school administration, or the School Board and whether leadership would be willing to support or take action.

35. Thaxton L., Espey E. Family Planning American Style Redux: Unintended Pregnancy Improves, Barriers Remain. *Obstet Gynecol Clin North Am.* 2017;44(1):41-56. Thaxton and Espey take a broad look into factors affecting unintended pregnancy in the U.S., particularly teen pregnancy, and the barriers that remain to seeking contraceptive services. While rates of unintended pregnancy have declined, they are still significantly higher than similar Western countries, and barriers to accessing the care necessary to improve reproductive health outcomes still remain. This review focuses on teens and young adults with regards to education, young parenting, and health insurance coverage. The authors took into account various sources of research and literature to determine barriers to reducing unintended pregnancy in the U.S. Structural, economic, and social barriers identified by the authors include inadequate sex education, confusing media messages, cultural attitudes, lack of accurate knowledge of abortion and birth control, inadequate availability of medical care, unnecessarily burdensome contraceptive dispensing practices, and hospital limitations on services provided. The authors note the decline in adolescents receiving sex education in recent decades, as well as the proven inefficacy of abstinence-only education, as contributing to barriers to care. Washington State is one of 13 states that mandate sex education in public schools be scientifically and medically accurate. Washington does not, however, require that sex education be taught. The authors also note that even with the ACA coverage of contraception, objections to it disproportionately affect minors among other vulnerable populations. On the other hand, the American College of Obstetricians and Gynecologists' expansion of recommendations for IUDs to adolescent and nulliparous women (see: American College of Obstetricians and Gynecologists, 2017) has resulted in providers being more comfortable offering IUDs to adolescents who have often been overlooked for this highly effective type of LARC due to its original recommendation for adult women who had previously given birth.

36. Goodman M., Onwumere O., Milam L., et al. Reducing health disparities by removing cost, access, and knowledge barriers. *Am J Obstet Gynecol.* 2017;216(4):382 e381-382 e385.

Goodman et al. conducted a secondary analysis on the Contraceptive CHOICE Project database to determine the effect of removing barriers to access (cost, availability, and education) for long-acting reversible contraception (LARC) among White and Black adolescent girls (aged 15-19). CHOICE was a longitudinal cohort study of sexually active girls and women (n = 9256) age 14-45 years in the St. Louis, MO, region from 2007 through 2013. Authors selected girls age 15-19 for their analysis. Goodman et al. estimated an absolute measure (rate difference [RD]) and a relative measure (rate ratio [RR]) to examine Black-White disparities in the rates of unintended pregnancy. At the beginning of the CHOICE study (2008-2009), the Black-White disparities among program participants were greater than the Black-White disparities among sexually active teenagers in the U.S. (RR, 3.7 2008-2009 compared to RR, 2.6 in 2008 and RR, 2.5 in 2009, respectively). Once enrolled, CHOICE participants were informed and educated about long-acting reversible contraception (LARC), including the efficacy, side effects, benefits and risks associated with each method. CHOICE participants then chose their preferred method, and were offered same-day insertion at no cost. The authors compared their secondary analysis of CHOICE data with data from National Vital Statistics reports and National Survey of Family Growth (NSFG). Analysis of the NSFG data revealed a national decline in teen pregnancies, with larger decreases seen among White teens than Black teens. On average nationally, Black teens had 2.5 times the rate (RR, 2.5) of unintended pregnancy as White teens. Meanwhile, the secondary analysis of the CHOICE program, showed pregnancy rates were much lower than national averages among both Whites and Blacks: 18.2 pregnancies per 1,000 in 2008-09 combined in CHOICE compared to 158.5 and 145.9 in 2008 and 2009, nationally. By 2012-2013, there was essentially no disparity in pregnancy rates by race (RR, 0.95) among CHOICE program participants. While, nationally Black-White disparities (RR, 2.5). This analysis indicates that not only are cost, availability, and education barriers to accessing LARC, but that these barriers are more prevalent for Black teens than White. Eliminating these barriers is possible and will have a significant and large effect on teen pregnancy rates.

37. **Washington State Office of Superintendent of Public Instruction. About OSPI | Key Facts About Washington Public Schools. 2016; Available at: <http://www.k12.wa.us/AboutUs/KeyFacts.aspx>. Accessed June, 2019.**

This Washington State Office of Public Instruction webpage provides key facts about public schools in Washington State. There are 295 public school districts in the state.

38. **Washington State Office of Superintendent of Public Instruction. Data and Reports | Enrollment. 2019; Available at: <http://www.k12.wa.us/dataadmin/enrollment.aspx>. Accessed June, 2019.**

This webpage lists the annual October Enrollment Reports for public schools in Washington. Data include student enrollment on the first business day of October. Data are available at the state, district, or school level. Data include enrollment by grade and both Federal & State Ethnicity/Race Enrollment reports. On October 1, 2018 (2018-19 school year), 1,105,391 students were enrolled in Washington public schools: Kindergarten (80,320 full day; 1,662 half day), 1st grade (82,732); 2nd (83,751); 3rd (83,978); 4th (86,487); 5th (88,217); 6th (87,544); 7th (84,877); 8th (83,110); 9th (84,396); 10th (83,700); 11th (82,401); and 12th (92,216). The racial/ethnic composition of the K-12 student population is 1.63% American Indian/Alaskan Native (AI/AN)-Hispanic/Latino; 1.19% AI/AN-Not Hispanic; 0.23% Asian-Hispanic/Latino; 7.16% Asian-Not Hispanic; 0.61% Black/African American-Hispanic/Latino; 4.30%

Black/African American-Not Hispanic; 0.10% Native Hawaiian/Other Pacific Islander (NHOPI)-Hispanic/Latino; 0.99% NHOPI-Not Hispanic; 0.01% Not Provided-Hispanic/Latino; 0.01% Not Provided-Not Hispanic; 3.17% Two or More Races-Hispanic/Latino; 9.50% Two or More Races-Not Hispanic; 17.70% White-Hispanic/Latino; and 53.52% White-Not Hispanic.

39. Instruction Office of Superintendent of Public. Washington Youth Sexual Health Plan- Youth Engagement Survey. 2019.

In Spring 2019, Washington State Office of Superintendent of Public Instruction (OSPI) conducted a survey with youth across the state to learn whether they were receiving sexual health education and sexual health services. The survey was approved by the Washington State Institutional Review Board. The survey description stated that it will ask questions "about your experiences and feelings about sex education, your access to sexual health services, your experiences receiving sexual health services, and some information about you." The survey did not ask youth about their sexual history or how often they engaged in sexual activity. 156 youth agreed to take the survey. Respondents ranged from 12 years old to 21 years old or older; the majority of respondents were 15, 16, or 17 years old. Most (78%) of respondents lived in Western Washington. Most respondents (62%) would not consider themselves sexually active. 58% of respondents identified as female, 31% as male, 13% as transgender, 13% as non-binary, 3% as something else fits better, and 3% as questioning/not sure. In addition, 44% of respondents identified as heterosexual, 22% as bisexual, 22% as queer, 16% as gay or lesbian, 8% as questioning/not sure, and 6% as something else fits better. Most respondents reported they had received sexual health education in school just once, with 41% of respondents indicating they had received sexual education once in middle school and 48% indicating they had received sexual health education once in high school. About 18% of respondents said they had not received sexual health education in school. Half of students said that the sexual health education they received was not what they needed or wanted; 22% were not sure and 22% responded yes. More than 50% of respondents said that the sexual health education they received was appropriate for their age group (69%) and taught them about STD prevention (85%), birth control (66%), and abstinence (77%). About half of respondents also reported that their teacher was comfortable teaching sex education (50%) and answered students' questions truthfully (53%). The fewest percentage (23%) of respondents reported that the sexual health education they received was appropriate for all sexual orientations. Approximately 61% of respondents said that they first learned about sexual topics from friends, including topics like the body, masturbation, sex, and sexual orientation, and 71% of respondents said they most often go online to find this information. The survey also asked whether youth could talk to a trusted adult about their sexual health, whether they have a usual source of care, whether they knew where to access sexual or reproductive health services, whether they have seen their healthcare provider for sexual or reproductive health services, whether they have seen a school nurse for sexual or reproductive health services, and barriers of accessing healthcare.

40. Instruction Office of Superintendent of Public. Youth Sexual Health; Education, Youth Behaviors, & School Safety Fact Sheet.2017.

Both the Healthy Youth Survey (HYS) and the School Health Profiles Survey (SHPS) were administered in 2016 to both students and school principals and health educators, respectively, to examine the scope and quality of sexual health education in Washington State. The HYS was administered by the Washington State Office of Superintendent of Public Instruction (OSPI) and

other state agencies to students in grades 6, 8, 10, and 12 in schools that chose to participate. Information on participation rates is not readily available. The SHPS was designed by the CDC with an added WA supplemental survey, and is administered every two years. Students in Washington are still engaging in risky sexual behavior; only 53-57% reported using condoms during last sexual intercourse. Students receiving low grades are more likely to engage in risky sexual behavior than those receiving high grades. Similarly, additional health risks for students are correlated with lower academic achievement. Receipt of sexual education decreases later in high school when teens are more sexually active. Ninety-three percent (93%) of parents placed a high importance on sex education in middle and high school, and 89% supported comprehensive sex education. Although WA State requires any sexual health education in public schools to be medically accurate and comprehensive, the reality of its implementation is varied. Just 19% of middle schools and 54% of high schools taught all 16 of the critical sexual health education topics laid out by the CDC. Additionally, 7% of schools report using curricula that do not meet the state requirements, and only 53% of schools had a curriculum consistent with the 2005 DOH-OSPI guidelines. Just 20% of schools reported teaching 10 or more hours of sex health instruction, and 20% reported either less than one hour or none at all. A lack of resources for teachers is an issue; just 55% of schools gave teachers all the materials they needed to teach sex education. Less than half of all teachers received professional development on some topic related to sex education, and 60% wanted more PD in all areas of sex education. Having health services on campus improve student health, and therefore academic achievement. Just 21% of schools have a school-based health center, and 28% have a full-time nurse. Although WA State Law makes reproductive health services available to adolescents without parental consent or notification or an age requirement, 29% of schools require parental consent for sexual and reproductive health (SRH) services and 29% for SRH referrals. Recommendations are as follows: WA State should improve professional development, utilization of evidence-based curricula, and provide resources for marginalized and at-risk youth.

41. Instruction Washington State Office of Superintendent of Public. Report to the Legislature Comprehensive Sexual Health Education Data Survey. Olympia, Washington: Washington State Office of Superintendent of Public Instruction; 2019.

In 2019 the Legislature directed OSPI in collaboration with the Washington State Department of Health to conduct a data survey of availability of sexual health education and relevant health measures in public schools. "For the 2018–19 school year, OSPI collected data on sexual health curricula being used in public schools through a required Health Assessment survey of all districts;" with a response rate of 96.6%. "Of the 285 responding districts, 93% (266) reported providing sexual health education in at least one grade band: K-5: 64.7%; 6-8: 86.1%; and 9-12: 75.2%." Nineteen (6.6%) districts reported "District does not offer Sexual Health Education." The survey showed "a significant number of districts (42.1%) reported using district-developed curricula or 'other' curricula (17.7%)." Appendix B of the report details survey results by district (2018-2019). Additionally, "OSPI collaborated with DOH to determine rates of sexually transmitted diseases (STDs), teen pregnancy, suicide, depression, and adverse childhood experiences for each of the five previous years for which data is available." Overall, rates of STDs among youth ages 15–19 have increased significantly in the past five years (chlamydia rates increased 23%; gonorrhea rates increased 71%, and syphilis rates increased 120%). Data show the largest increases have been among males. Finally, rates vary significantly from county to county. Washington data also show adolescent pregnancy rates have declined steadily over the

past five years, with a 37% decrease among youth ages 15–17 years and a 24% decrease among ages 18–19 years. Specific to youth suicide, rates among youth ages 15–19 year were 32% higher in 2017 than in 2013. Suicide rates for males were significantly higher than females. However, authors noted, "total numbers of suicides are low enough that rates fluctuate widely from year to year." Additionally, "statewide rates of youth-reported depression increased from 2014 to 2018, with females much more likely to report feeling depressed." The report also presents data related to adverse childhood experiences (ACES). For example, "while rates of bullying and harassment due to perceived sexual orientation decrease between 8th and 12th grades, statewide rates for each grade have remained steady over time." Additionally, data show steady rates of increase for dating violence during the past five years.

42. Washington State Healthy Youth Survey. In: Instruction WSOoSoP, ed. State W, trans. Olympia, Washington 2018.

The Washington State Healthy Youth Survey (HYS) is a collaborative effort between the Office of Superintendent of Public Instruction, the Department of Health, the Health Care Authority - Division of Behavioral Health and Recovery, Liquor and Cannabis Board, and the contractor, Looking Glass Analytics. It is an "effort to measure health risk behaviors that contribute to morbidity, mortality, and social problems among youth in Washington State." In 2018, over 230,000 students from all 39 counties participated in the sixteenth HYS of Washington students. Behaviors addressed in the survey include "alcohol, marijuana, tobacco and other drug use; behaviors that result in intentional and unintentional injuries (e.g., violence); dietary behaviors and physical activity; mental health; school climate; and related risk and protective factors." The 2018 HYS was funded by an appropriation from the Dedicated Marijuana Account. The survey is available in Spanish and English. Therefore, results may not be generalizable for those students with Limited English Proficiency. Results found that among 8th graders who have had sex, 4% had sex before age 13 years, 2% have had sex with four or more partners, and only 51% used a condom during last sexual intercourse. Among 10th graders who have had sex, 4% had sex before age 13 years, 5% have had sex with four or more partners, and only 55% used a condom during last sexual intercourse. Meanwhile, among 12th graders who have had sex, 3% had sex before age 13 years, 12% have had sex with four or more partners, and only 51% used a condom during last sexual intercourse. Students reported being taught about abstinence in schools at roughly the same rate as being other methods to prevent STD and pregnancy (65% vs. 63% among 8th graders, 72% vs. 73% among 10th graders, and 39% vs. 43% among 12th graders, respectively).

43. Washington State Department of Health Center for Health Statistics. Teenage Pregnancy Rates by Age Group, Washington State Residents, 1980-2016. 2016.

Washington State Department of Health 2016 data showed a teen pregnancy rate of 24.4 per 1,000 women aged 15-19. The rate was 10.8 per 1,000 women aged 15-17, and 44.7 per 1,000 women aged 18-19. Teen pregnancy rates in 2016 were the lowest they have ever been since data tracking began in 1980.

44. Rhode Island Department of Education Comprehensive Health Instructional Outcomes. March 2015 ed. Providence, Rhode Island: Rhode Island Department of Elementary and Secondary Education; 2015.

The Rhode Island Department of Education Comprehensive Health Instructional Outcomes document was developed by a committee of teachers, a representative from higher education, consultants and Department of Education, Department of Health and Department of Mental Health, Retardation and Hospitals staff. The committee used the Health Education Framework to update and align outcomes with new standards. It addresses the 7 comprehensive health instructional outcome topics including sexuality and family life.

45. **U.S. House of Representatives Committee on Government Reform. The Content of Federally Funded Abstinence-Only Education Programs. U.S. House of Representatives, Committee on Government Reform-- Minority Staff, Special Investigations Division;2004.** This 2004 report by the U.S. House of Representatives, Committee on Government Reform found that "over 80% of the abstinence-only curricula...contain false, misleading, or distorted information about reproductive health." The Committee evaluated the content of the 13 most popular abstinence-only curricula used by federal funding grantees for accuracy. In 2004, there were three main federal funding sources of abstinence-only programs: the Special Programs of Regional and National Significance Community-based abstinence education (SPRANS) grant; Title V of the 1996 Social Security Act; and the 1981 Adolescent Family Life Act. SPRANS is the largest federal funding abstinence-only initiative and administered by U.S. Department of Health and Human Services. Abstinence curricula used by federally-funded programs are not reviewed for accuracy. However, the report noted that "collectively, these three programs reach millions of children and adolescents in the [U.S.] each year. In fact, given the scarcity of comprehensive sex education courses in schools across much of the [U.S.], abstinence-only education programs may be the only formal reproductive health education that many children and adolescents receive. Comprehensive sexual health education has been found more effective at delaying sex, reducing the frequency of ex, and increasing the use of condoms and contraceptives. The report found that, "eleven of thirteen abstinence-only curricula contain errors and distortions; abstinence only curricula contain false and misleading information about the effectiveness of contraceptives; abstinence-only curricula contain false and misleading information about the risks of abortion; abstinence-only curricula blur religion and science; abstinence-only curricula treat stereotypes about girls and boys as scientific fact; abstinence-only curricula contain false and misleading information about the risks of sexual activity; abstinence-only curricula contain scientific errors." The report also found that abstinence-only curricula reinforced gender stereotypes and male sexual aggressiveness. Curricula also provided inaccurate information about cervical cancer, HIV exposure and risk, chlamydia, and mental health. The report concluded that "serious and pervasive problems with the accuracy of abstinence-only curricula may help explain why these programs have not been shown to protect adolescents from sexually-transmitted diseases and why youth who pledge abstinence are significantly less likely to make informed choices about precautions when they do have sex."

46. **Shepherd L. M., Sly K. F., Girard J. M. Comparison of comprehensive and abstinence-only sexuality education in young African American adolescents. *Journal of Adolescence* 2017;61:50-63.**

Shepherd et al. presented previous research showing that African American middle school students were more likely to report higher levels of lifetime intercourse, sexual activity before age 11, and having more than three sexual partners as compared to other racial/ethnic groups. This study enrolled 633 African American students in three middle schools in the urban South;

450 students (73.5%) completed the full intervention. The average age of participants was 12.87, and most were in 7th grade. Participants were assigned to one of three interventions: comprehensive sexuality education intervention (i.e., Becoming a Responsible Teen); abstinence-only education intervention (i.e., Choosing the Best Path); or an interactive intervention (i.e. African Tradition and Vibes), which was developed for the comparison group. Participants completed surveys pre-intervention, post-intervention, and at 3, 6, and 9 months. Measures included: sexual behavior, condom use, attitude toward sex, attitude toward condoms, sexual social norms, condom use social norms, sexual self-efficacy, and condom self-efficacy. They found that self-efficacy did not predict sexual activity, and condom use was not predicted by any of the variables. However, they note that these findings may be due to the small number of participants who reported being sexually active. Over time, participants in both the abstinence-only and comprehensive sexuality education groups had more social norms favoring sex, increased recent sexual activity, greater sexual self-efficacy, greater social norms favoring condoms, and greater condom self-efficacy. Participants in the comprehensive sexuality education intervention had significantly more favorable condom attitudes compared to the abstinence-only group. The authors summarized that, “neither intervention in the current study was effective in reducing [African American] adolescents’ sexual behavior or increasing condom use compared to the comparison group, though it is important to note that [abstinence-only education] negatively impacted condom attitudes which may have contributed to the increased likelihood of unprotected sex.”

47. University of California, Davis. LGBTQIA Resource Center Glossary. Available at. Accessed, 2018.

This Glossary has been collectively built and collected by the staff members of the University of California, Davis' LGBTQIA+ Resource Center since the early 2000s. The terms and definitions included in the glossary are always evolving and changing and often mean different things to different people. They are provided as a starting point for discussion and understanding.

48. Washington State Office of Superintendent of Public Instruction. State Special Education Data Collection Summaries | Special Education Federal Child Count and Educational Environment Data. [Excel Data]. November 2018: Available at. Accessed July, 2019.

The Office of Superintendent of Public Instruction published Special Education Federal Child Count and Educational Environment Data per federal and state special education requirements. School districts are required to provide information on the "numbers and types of students receiving special education services by placement option within the district's continuum of alternative placements, as well as student's disability category, ethnicity, gender, and English Language Learner (ELL) status." Data from November 2018 show that Washington schools serve 130,488 students ages 6-21 years with disabilities. Specifically, students served have disabilities including developmental delays (8,431 students); emotional/behavioral disability (5,324); orthopedic impairments (371); health impairments (27,249); specific learning disabilities (47,606); intellectual disability (5,011); multiple disabilities (2,946); deafness (239); hearing impairments (766); visual impairments (419); deaf-blindness (22); communication disorders (17,431); Autism (14,363); and traumatic brain injury (310).

49. **Walters Frinny Poanco, Gray Susan Hayden. Addressing sexual and reproductive health in adolescents and young adults with intellectual and developmental disabilities. *Adolescent Medicine*. 2018;30(4):451-454.**

Walters and Gray conducted a review of literature, and their findings support “promoting the sexual health of adolescents and young adults with developmental disabilities, and particularly those with intellectual disabilities.” Evidence reviewed indicates that adolescents and young adults with developmental disabilities are “often systematically excluded from sexual health education, which may place them at risk for poor health outcomes.” For example, adolescents and young adults with developmental disabilities are “at significantly higher risk of sexual abuse than their nondisabled peers.” Authors noted, “[h]istorically, the sexual and reproductive healthcare needs of people with intellectual and developmental disabilities have been neglected, as they have often been perceived as either asexual or as hypersexual.” Research shows that “adolescents and young adults with physical disabilities engage in sexual activity at similar rates as their nondisabled peers, but the rate of sexual activity in adolescents with developmental disabilities is largely unknown.” Overall, researchers recommend normalizing sexuality in disabled youth by addressing the same aspects of sexual healthcare needs present in nondisabled children and adolescents (at school, at home, and at healthcare offices). Comprehensive sexuality education is necessary to foster healthy transition into adulthood among adolescents and youth with developmental disabilities. For example, “adolescents with autism and intellectual disabilities may be more prone to exhibiting socially unacceptable behaviors such as public masturbation, given limited social skills and delayed psychosocial development. Young people should be taught to masturbate in private spaces, such as their own bedroom.” Evidence consistently found “children and adolescents with developmental disabilities are sexually abused at an increased rate compared to nondisabled peers.” Therefore, all individuals, including individuals with intellectual disabilities, “need to be taught about appropriate partner selection and the need for active, enthusiastic, and ongoing consent for sexual relationships to occur.” Medical providers should discuss sex identity, timing of sex identity development, and preferred pronouns using language that demonstrates acceptance to all patients including LGBTQ patients. Overall, authors found “[t]he lack of sexuality education among adolescents with developmental disabilities may lead to poor health outcomes in this population, including increased rates of STIs, decreased access to reproductive care, increased risk of unintended pregnancies, and significantly higher rates of sexual abuse.”

50. **Council Special Education Advisory. The SEAC Position on SB 5395. 2019.**

The Washington State Special Education Advisory Council (SEAC) was established through the Individuals with Disabilities Education Act (IDEA) to advise the State Superintendent on matters pertaining to the provision of special education and related services. According to SEAC, “[c]urrently, it is unknown how many of Washington's Local Education Agencies (LEAs) implement a comprehensive sexual health education that is inclusive of all students.” In this position paper, the SEAC documents its support of SB 5395, Concerning comprehensive sexual health education. It notes, “these acts amend the current Healthy Youth Act with an additional focus on consent, sexual violence prevention and healthy relationships which benefits all students.” Evidence from the National Crime Victimization Survey indicates that “people with disabilities are victimized by crime at higher rates” than the general population, and “people with disabilities are sexually assaulted at nearly three times the rate of people without disabilities.” Therefore, the requirement that inclusive, comprehensive sexual health education be provided to

"all students regardless of their protected class status under chapter 49.60 RCW" has the potential to benefit students who have no access to sexual health education.

51. Disability Rights Washington Letter of Support. In: Committee CSTSaMoHE, ed2019.

Disability Rights Washington (DRW) wrote a letter to Representative Santos, Chair of the House Education Committee, and members of the committee to support SB 5395, Concerning comprehensive sexual health education. The letter explained how students with disabilities experience significantly higher rates of sexual abuse and assault, and that "[t]hose closest to people with developmental disabilities are often the abusers". Additionally, the letter quoted an advocate with disabilities from Rooted in Rights who wrote that "the absence of high-quality sexual health education can 'leave [students] with a sense that they are undesirable, which can in turn cause vulnerability to negative sexual attention or abuse that many do not feel safe enough to report' (McMahon)."

52. Morgan Rachel E., Truman Jennifer L. Criminal Victimization, 2017. Washington, DC: U.S. Department of Justice; December 2018 2018. NCJ 252472.

This report from the U.S. Department of Justice's Bureau of Justice Statistics summarizes data from the National Crime Victimization Survey which documents criminal victimizations that occurred in 2017. Violent crime includes rape/sexual assault, robbery, assault, domestic violence, stranger violence, violent crime involving an injury. Overall, "[p]ersons whom the survey classified as having disabilities had a higher rate of violent victimization (40.4 per 1,000 persons age 12 or older) than persons without disabilities (17.7 per 1,000). Persons with a cognitive disability experienced 76.0 violent victimizations per 1,000 persons age 12 or older, the highest rate among persons with any disability." With the exception of those with hearing impairments, violent victimization rates in 2017 were statistically significantly higher for each disability category compared to those of persons without disabilities: Ambulatory (28.9 per 1,000); Vision (43.5 per 1,000); Limited independent living (31.8 per 1,000); and Limited self-care (34.4 per 1,000).

53. Shapiro Joseph. Abused And Betrayed | The Sexual Assault Epidemic No One Talks About. National Public Radio. 8 January2018, 2018.

This National Public Radio (NPR) article was part of a special investigative reporting series, *Abused And Betrayed*, in which NPR's Investigations Unit spent a year reporting on sexual assaults against people with intellectual disabilities. Correspondent Joseph Shapiro found previously undisclosed government numbers for the U.S. Department of Justice's (DOJ) Bureau of Justice Statistics showing they are attacked far more often than other people. Specifically, the rate of sexual assault against people with intellectual disabilities from 2011-2015 was "more than seven times higher than the rate for persons with no disabilities" (4.4 per 1,000 people compared to 0.6 per 1,000 people, respectively). Among women with intellectual disabilities the rate was 7.3 victimizations per 1,000 people, more than 12 times that of people with no disabilities. The only other group with comparable high risk of sexual assault are women between the ages of 18 and 24 who are not in college, who "tend to be poorer and more marginalized." However, the rate of sexual assault among people with intellectual disabilities - DOJ numbers count people ages 12 and older - "is almost certainly an underestimate," said Erika Harrell a DOJ statistician. "Because those numbers from household surveys don't include people living in institutions -

where [...] research shows people are even more vulnerable to assault. Also not counted are the 373,000 people living in group homes." Additionally, "numbers from [DOJ] found that people with intellectual disabilities are even more likely to be raped by someone they know. For women without disabilities, the rapist is a stranger 24 percent of the time, but for a woman with an intellectual disability it is less than 14 percent of the time." Data from DOJ found that people with intellectual disabilities are even more likely than the general population to be raped by someone they know. "For women without disabilities, the rapist is a stranger 24 percent of the time, but for a woman with an intellectual disability it is less than 14 percent of the time." The article goes on to interview people with intellectual disabilities regarding their lived experiences of sexual assault and their desires for future healthy relationships.

54. Harrell Erika. Crime Against Persons with Disabilities 2009-2015 - Statistical Tables. Washington, DC: U.S. Department of Justice; July 2017 2017. NCJ 250632.

This report from the U.S. Department of Justice's Bureau of Justice Statistics summarizes data from the National Crime Victimization Survey which documents criminal victimizations that occurred from 2009 to 2015. The report "details the rates of nonfatal violent victimization against persons with and without disabilities, describes types of disabilities, and compares victim characteristics." Nonfatal violent crimes include rape or sexual assault, robbery, aggravated assault, and simple assault. Results show, "[d]uring the 5-year aggregate period from 2011 to 2015, for each age group measured except persons age 65 or older, the rate of violent victimization against persons with disabilities was at least 2.5 times the unadjusted rate for those without disabilities." Additionally, "[t]he rate of serious violent crime (rape or sexual assault, robbery, and aggravated assault) for persons with disabilities (12.7 per 1,000) was more than three times the rate for persons without disabilities (4.0 per 1,000)." Finally, "[65%] of rapes or sexual assaults against persons with disabilities were committed against those with multiple disability types, the highest percentage among the crime types examined."

55. Shapiro Joseph. Abused And Betrayed | From The Frontlines Of A Sexual Assault Epidemic: 2 Therapists Share Stories. National Public Radio. 18 January 2018, 2018.

This National Public Radio (NPR) article was part of a special investigative reporting series, *Abused And Betrayed*, in which NPR's Investigations Unit spent a year reporting on sexual assaults against people with intellectual disabilities. Correspondent Joseph Shapiro interviewed two psychologists, Karyn Harvey and Nora Baladerian, who treat people with intellectual disabilities who have been the victims of sexual assault. They discussed examples of cases in which people with intellectual disabilities were sexually assaulted by caregivers, transportation providers, family members, and others. They discussed how bias against people with intellectual disabilities can be a barrier to accessing assistance. They also discussed how unrecognized and/or untreated trauma from sexual assault can negatively impact the mental health and medical treatment of individuals with intellectual disabilities.

56. Washington State Supreme Court Commission on Children in Foster Care | Report to the Washington State Supreme Court 2018 Commission Activities Washington State Supreme Court Commission on Children in Foster Care. Olympia, Washington Washington State Administrative Office of the Courts; 2019.

This report to the Washington State Supreme Court discusses the Commission on Children in Foster Care's 2018 activities. The document details the Normalcy Workgroup's activities related

to comprehensive sexual health education. Formed in May 2012, the Normalcy Workgroup's charter is to "develop policies and practices that will provide children and youth in foster care with opportunities to participate in age-appropriate extra-curricular, enrichment, schools and social activities, all to ensure 'normal life' experiences." Workgroup members include youth from the Passion to Action and the Mockingbird Society, a foster parent, and representatives from the Office of Superintendent of Public Instruction, Office of Civil and Legal Aid's Children's Representation Program, Children's Administration, Division of Licensed Resources (DLR) and King County Superior Court. "Much of the Workgroup's work in 2018 centered on school-based sexual health education for youth in care, particularly focusing on requiring medically accurate and trauma-informed curriculum that also addresses the unique needs and considerations for LGBTQ+ youth." The Normalcy Workgroup's Memorandum to the Commission is included on pages 8-10. It states, "[a]ccording to youth and young adults in the Washington foster care system, many have missed or never received a comprehensive sexual health education prior to exiting the system [...] they have experienced the following barriers when it comes to receiving sexual health education: multiple placements, changing schools, or missing the one time it was taught." The report noted, "Pending the outcome of SB 5395 and companion bill HB 1407, the Normalcy Workgroup and the Commission will continue to advocate for comprehensive sex education for children in foster care."

57. Health Washington State Board of. Survey about sexual health education with Passion to Action Advisory Board. 2019.

At the invitation of the Washington State Children's Administration, State Board of Health staff developed a survey for the Passion to Action advisory board. The board includes youth and young adults aged 14-24 who are or have been in foster care in Washington State. The survey included 5 questions, and asked about their experiences with sexual health education in school. The survey was shared at the Passion to Action advisory board meeting on June 29, and all 11 board members in attendance completed the survey. All 11 members were alumni of care ages 18-26 years old. State Board of Health staff conducted summary statistics, as appropriate. For open-ended questions, staff identified emerging themes, grouped responses by theme, and summarized responses by theme. 100% of respondents said they had received sexual health education in school, with the majority (64%) stating they had received sexual health education in elementary school, 45% stating they received it in middle school, and 36% stating they received it in high school. Nine out of 11 alumni of care (82%) felt that the sexual health education they received in school did not meet their needs.

58. Ahrens Kym R., Spencer Renee, Bonnar Mavis, et al. Qualitative evaluation of historical and relational factors influencing pregnancy and sexually transmitted infection risks in foster youth. *Children and Youth Services Review*. 2016;61(2016):245-252.

Ahrens et al. conducted qualitative interviews with former foster youth to explore how attitudes, norms, behaviors, responses to early life experiences, and protective factors influenced pregnancy and sexually transmitted infection risks. Authors cite evidence that compared to youth in the general population, youth who have been in foster care have increased risk of STIs (2-14 times the risk) and teen pregnancy (2-4 times the risk). For example, "[n]early half of young women in foster care report having been pregnant by age 19; males who are currently or have been in foster care also report impregnating partners at a higher rate compared with youth who do not have this history." Researchers used qualitative research sampling techniques to capture a

range of perspectives of the population being studied. The final sample included twenty-two transition-age foster youths (73% response rate) from Washington. Sixty-two percent of participants identified as female, and they ranged in age from 15 to 21 years. Each participated in a semi-structured, in-person interview (45-90 minutes) with either the principal investigator (who has been a foster parent), or one of two research staff (all white females). No participants terminated the qualitative interviews early. Additionally, 21 out of 22 participants (95%) completed a 20 minute audio computer-assisted self-administered survey to collect basic information (e.g., demographics, foster care experiences, and sexual behaviors). Participants identified as 62% female, 33% male, and 5% transgender. Fifty-two percent reported being completely attracted to the opposite sex, 43% attracted to both sexes, and 5% completely attracted to the same sex. Forty-eight percent identified as mixed race, 33% African American, 5% White, 5% Asian, 5% Hawaiian Native/Pacific Islander; and 5% Native American. Additionally, 24% identified as ethnically Hispanic/Latino. Most but not all participants were sexually experienced. "Seven reported that they had experienced a pregnancy/gotten a partner pregnant, and six reported having had an STI." Five participants (24%) reported low sexual risk behavior patterns (i.e., no pregnancies, no STIs, and 0-1 lifetime sexual risk behaviors). All participants reported at least one major stressor (e.g., personal or family struggles with addiction, homelessness, incarceration, and/or death of a biological parent or other family member), and approximately half disclosed a history of abuse. Most participants "described exposure to some sexual education, though it was frequently described as insufficient, boring, or not applicable to their life experiences." Researchers used a stepwise qualitative analysis technique. Norms and attitudes contributing to no or inconsistent condom use included: sex with partner is infrequent; partner is trusted; I am in a long-term relationship; I or my partner have been recently tested for STIs; I am already on birth control; we've already had sex without a condom; and sex doesn't feel as good with condoms. Norms and attitudes contributing to consistent condom use included: condom use shows respect; participant or partner will choose sex with condoms over no sex; and condoms should be used with casual partners. Results showed that it appeared common for older participants to endorse strong attitudes in favor of condom use despite personal non-use or inconsistent use. Participants often described personally or friends using condoms after an STI scare or going on birth control after a pregnancy scare. However, dual contraceptive and condom use was infrequently described. "Around half of the youths described personal pregnancies or scares, and almost all indicated that teen pregnancy was common among peers [...] participants consistently endorsed that pregnancy was an inevitable event regardless of personal desires." Specific to factors that youths perceived as increasing pregnancy and STI risks, participants described difficulties with trust appraisal, communicating effectively in the context of strong emotions, and controlling impulses. For example, "Many participants described conducting rapid appraisal of potential romantic/sexual partners to determine whether a partner was safe or trustworthy ('I can get their vibes and I can tell they're telling the truth.' — Female, age 20)." This strategy was described as an adaptive response to past trauma. However, youth were very distressed by repeated experiences of misplaced trust. Additionally, many youth, particularly female participants, expressed "that early abuse experiences made it difficult to engage in conversations around sex" with sexual partners and/or health care providers. Conversely, youth also identified general and STI/pregnancy-specific protective factors: created family; the foster system; involvement in activities or groups; goals; taking personal responsibility; developing and carrying out plans; seeking out new experiences; and learning emotional regulations. Participants also provided intervention preferences/ideas including: group format; interactive; provided by a

non-judgmental facilitator; environment of open communication; incorporate youth ideas; and peer facilitators/leaders. Additionally, they suggested foster caregivers, kinship caregivers, and caseworkers be trained on basic sexual health information and how to engage in open conversations around these topics with the youths for whom they care. Overall, findings suggest the importance of trauma-informed interventions that address critical norms, attitudes, and emotional regulation and related interpersonal skills for youth in foster care.

59. Reproductive Health: Teen Pregnancy. 2019; Available at:

<https://www.cdc.gov/teenpregnancy/about/index.htm>. Accessed 1 July 2019.

In 2017, for youth ages 15-19, the national birth rate was 18.8 births per 1,000 women. While this is a decline from previous years, the U.S. teen pregnancy rate is higher than other industrialized nations and inequities persist. Data show that the birth rate for Hispanic teens (28.9 births per 1,000 women aged 15-19) and non-Hispanic black teens (27.5 births per 1,000 women aged 15-19) is two times higher than the rate for non-Hispanic white teens. The birth rate for American Indian/Alaska Native teens (32.9 births per 1,000 women aged 15-19) is the highest among all races/ethnicities. Birth rates are lowest among Asian teens (3.3 births per 1,000 women aged 15-19). CDC notes that these inequities may be due to socioeconomic status. They note, "teens in child welfare systems are at higher risk of teen pregnancy and birth than other groups. For example, young women living in foster care are more than twice as likely to become pregnant than those not in foster care."

60. Brown M. J., Masho S. W., Perera R. A., et al. Sex and sexual orientation disparities in adverse childhood experiences and early age at sexual debut in the United States: results from a nationally representative sample. *Child Abuse Negl.* 2015;46:89-102.

Brown et al. assessed the sex and sexual orientation disparities in the association between adverse childhood experiences (ACEs) and age at sexual debut, which has been found to be associated with multiple adverse health outcomes. Researchers obtained data from Wave 2 of the National Epidemiologic Survey on Alcohol and Related Conditions. They used logistic and linear regression models to "obtain crude and adjusted estimates and 95% confidence intervals adjusting for age, race/ethnicity, income, education, insurance and marital status for the association between ACEs (neglect, physical/psychological abuse, sexual abuse, parental violence, and parental incarceration and psychopathology) and early sexual debut." Results were stratified by sex and sexual orientation. Overall, "[l]arger effect estimates depicting the association between ACEs and sexual debut were seen for women compared to men, and among sexual minorities, particularly among men who have sex with men (MSM) and women who have sex with women (WSW), compared to heterosexuals." Authors recommended sexual health education programs that attempt to delay sexual debut among children and adolescents "should also consider addressing ACEs, such as neglect, physical, psychological and sexual abuse, witnessing parental violence, and parental incarceration and psychopathology." Additionally, differences by sex and sexual orientation should be considered when designing sexual health education programs.

61. Bryn King, Wert Melissa Van. Predictors of Early Childbirth Among Female Adolescents in Foster Care. *Journal of Adolescent Health* 2017;61(2017):226-232.

King et al. analyzed a longitudinal, population-based data set which matched California child protective services records for female foster youth to maternal information available on vital

records for children born between 2001 and 2010. Of the 30,339 girls who spent time in foster care as adolescents, 18.3% (5,567) gave birth for the first time before their 20th birthday. “In the fully adjusted survival model, the highest birth rates were observed among girls who entered care between the ages of 13 and 16 years; had been in care for relatively short periods of time; lived in congregate care at the estimated date of conception; had a history of running away; and were Latina, black, or Native American.” Specifically, girls who entered care between ages 13 and 16 years the most vulnerable for early childbirth compared to girls who entered foster care under age 10 or over age 16. Additionally, living in a nonrelative foster home or congregate care (e.g., shelter or group home) was associated with higher rates of childbirth compared to those living with kin, a guardian, or in another arrangement. Finally, those who had ever run away from a placement had significantly higher rates of giving birth as a teenager ($p < 0.001$) regardless of their length of stay or other factors. Authors noted that “the key risk factors for adolescent childbirth—such as poor school performance and low education—among girls in foster care are similar to risk factors found in the general population,” which, “suggests that teen pregnancy interventions applied in the general population may be effective among adolescents in foster care.”

62. GLSEN. School Climate in Washington (2017 State Snapshot). New York, New York: GLSEN; 2019.

This Washington State specific brief provides a snapshot of survey responses gathered in 2017 through GLSEN’s National School Climate Survey, a biennial survey of the experiences of lesbian, gay, bisexual, transgender, and queer (LGBTQ) youth in U.S. secondary schools. “The national sample consisted of 23,001 LGBTQ students from all 50 states, the District of Columbia, and all 5 major U.S. territories.” Of survey respondents, 745 were attending schools in Washington State. “The Washington sample was majority White (72%), 10% Hispanic/Latinx, 10% Multiracial, 4% Asian/South Asian/Pacific Islander, 2% Native American, 1% Black/African American, and < 1% Arab/Middle Eastern. The gender composition was 49% cisgender, 30% transgender, 13% genderqueer, and 8% another gender (e.g. questioning, genderfluid). Most (93%) attended public schools. The school community makeup was 30% rural/small town, 42% suburban, and 29% urban. The results reported for Washington had a margin of error of +/- 4%.” Overall, the survey found that Washington schools were not safe for most LGBTQ secondary school students. Negative experiences include: anti-LGBTQ remarks, anti-LGBTQ victimizations, and discriminatory policies or practices. For example, students reported experiencing verbal harassment, physical harassment, and physical assault related to their sexual orientation (63%, 26%, and 11%, respectively), gender expression (53%, 23%, and 10%, respectively), and gender (56%, 21%, and 9%, respectively). Additionally, many LGBTQ students in Washington reported not having access to in-school resources and supports. For example, only 12% of respondents reported receiving LGBTQ-inclusive sexual health education in school.

63. W.I.S.E. Qualitative Interview Findings. Seattle, Washington: Cardea Services.

From January to March 2015, Cardea Services “conducted 23, semi-structured key informant interviews with experts in the field of youth development and sexuality education policy and practices” in Washington State to learn about their views related to the sustainable implementation of school-based comprehensive sexuality education (CSE). Key informants included stakeholders from school districts, non-profits, health and human service agencies, etc.

Results of the qualitative interview indicate “[k]ey informants most commonly mentioned geography and lack of teacher training as the biggest barriers to implementing quality CSE.” For example, key informants noted that lack of teacher training negatively affects educators’ comfort with the subject or confidence in their ability to provide effective instruction, which prevents some school districts from teaching sexuality education. Interviewees identified a gap in curricula that are inclusive of LGBTQ youth. Facilitators of effective CSE implementation identified included: buy-in at multiple levels (teachers, principals, parents, etc.), teacher comfort and confidence, transparency and trust, easy-to-use tools for teaching sexuality education, and efforts to dispel myths. Interviewees noted the Healthy Youth Act catalyzed positive change among districts already interested in providing CSE. However, overall, they expressed concern that the law did not help districts that lack political or community will to implement quality CSE. The most commonly proposed way to improve sustainable CSE was to mandate its inclusion in K-12 curriculum. Additionally, some interviewees recommended monitoring; engaging local communities in conversations about how to work toward CSE; providing teacher training (i.e., build comfort and confidence) specific to subject matter; and building communities of practice to discuss resource distribution and strength-sharing to facilitate successful implementation. Finally, key informants discussed the use of mapping tools to demonstrate the need for sexuality education.

64. Proulx C. N., Coulter R. W. S., Egan J. E., et al. Associations of Lesbian, Gay, Bisexual, Transgender, and Questioning-Inclusive Sex Education With Mental Health Outcomes and School-Based Victimization in U.S. High School Students. *J Adolesc Health*. 2019;64(5):608-614.

Proulx et al. examined whether lesbian, gay, bisexual, transgender, and questioning (LGBTQ)-inclusive sex education is associated with adverse mental health and school based victimizations among high school youth in the U.S. Researchers used data from the 2015 Youth Risk Behavior Survey (YRBS) and the 2014 School Health Profiles to test their hypothesis, and they tested whether any associations were significantly different for sexual minority youth compared with their heterosexual peers. Eleven states met inclusion criteria: Arizona, Delaware, Florida, Kentucky, Maine, Michigan, New York, North Carolina, South Dakota, West Virginia, and Wyoming. Of the 51,895 total participants, the final sample included 47,730 participants, of which 55.4% white, 17.2% African-American, 19.8% Hispanic, and 7.6% other races. Participants were fairly evenly split among grade levels (9th-12th). Just over 87% of the sample identified as heterosexual, 2.6% identified as gay or lesbian, 6.3% identified as bisexual, and 3.7% reported being unsure of their sexual identity. Overall, “[b]isexual youth reported the highest frequency of past-year depressive symptoms (62.8%), suicidal thoughts (44.6%), and making a suicide plan (39.3%). Gay/lesbian youth reported the highest frequency of bullying victimization on school property (34.2%).” The percentage of schools teaching LGBTQ-inclusive sex education in each state ranged from 16.2% to 57.1% (mean=34.4, standard deviation=13.9). Results indicate, “[s]tudents living in states with higher proportions of schools teaching LGBTQ-inclusive sex education had significantly lower odds of depressive symptoms after controlling for covariates (adjusted odds ratio [AOR]=.86; 95% confidence interval [CI]=.85-.88).” Results found the “disparity between bisexual and heterosexual youth reporting depressive symptoms decreased more in states with higher proportions of schools teaching LGBTQ-inclusive sex education (AOR=.92; 95% CI=.87-.98).” The study controlled for three state-level variables (i.e., population density of same-sex couples, median household income, and

the presence of inclusive antidiscrimination policies) which could influence the proportion of schools with inclusive sex education. “After controlling for state-level covariates, the proportion of schools teaching LGBTQ-inclusive sex education in a state was significantly related to lower odds of suicidal thoughts (AOR=.91; 95% CI=.89-.93) and making a suicide plan (AOR=.79; 95% CI=.77-.80).” The final model showed a significant interaction effect, with gay and lesbian youth experiencing greater reductions “in the odds of experiencing bullying in the last year than heterosexual youth in states with a higher proportion of schools teaching LGBTQ-inclusive sex education (AOR=.83; 95% CI=.71-.97).” Overall authors found a “20% reduction in reported suicide plans for every 10% increase in schools teaching LGBTQ-inclusive sex education in a state.” Similarly, for every 10% increase in the proportion of schools teaching LGBTQ-inclusive sex education in a state, the disparity in depressive symptoms between bisexual and heterosexual youth decreased. Results also showed a significant effect for gay/lesbian youth, in which “a 10% increase in the proportion of schools teaching LGBTQ-inclusive sex education in a state was associated with significantly lower odds of gay/lesbian youth experiencing bullying on school property compared with heterosexual youth.” Despite significant findings, authors noted study limitations including: inability to control for school-level factors (e.g., curriculum), small number of states included in the analysis, unable to account for the proportion of schools with Gay Straight Alliances (GSAs) in the state due to collinearity with the proportion of LGBTQ-inclusive education.

65. **Snapp Shannon D., McGuire Jenifer K., Sinclair Katarina O., et al. LGBTQ-inclusive curricula: why supportive curricula matter. *Sex Education*. 2015;15(6):580-596.** Snapp et al. assessed results of the 2008 Preventing School Harassment (PSH) survey data, a survey of LGBTQ and straight, cis-gender middle and high school students from California (1,232 students ages 12-18 years from 154 schools [75% public, 25% continuation or alternative schools]), to examine whether the use of LGBTQ-inclusive curricula "is associated with bullying and perceptions of safety for individual students and in aggregated measures of school climate." Authors noted a "growing body of research has documented that lesbian, gay, bisexual, transgender, queer and questioning (LGBTQ) young people experience worse outcomes in mental and physical health and education as compared to their heterosexual peers." Evidence indicates that harassment experienced by LGBTQ youth at school and in other contexts contributes to poor health outcomes. For example, "[s]tudies in the USA have found that between 59% and 84% of LGBTQ students experience verbal abuse at school." Furthermore, "LGBTQ students skip classes (13–30%) and miss full days of school (20–32%) at alarming rates because they feel unsafe" and "are at higher risk for dropping out of school compared to their gender-conforming and straight peers." Specifically, other population-based studies have found "homophobic [victimization] predicted higher ratings of anxiety, depression, and lower levels of school belonging among middle school students and higher rates of suicidality among LGBTQ identified students." Use of LGBTQ-inclusive curriculum (i.e., curriculum that reflects the lives and histories of LGBTQ people) is one strategy to improve the climate of schools for LGBTQ students. "Presence of LGBTQ-inclusive curricula has also been associated with greater peer support: 67% of LGBTQ students reported that their classmates were accepting of LGBTQ people when the school taught inclusive curricula." Among study participants, "28.5% identified as gay/lesbian (10.3%), bisexual (11.2%), queer (1.5%) or questioning (4.0%); the rest (71.5%) identified as heterosexual/straight." Most participants identified as female (62.1%), followed by male (35.6%), questioning (n=8) and transgender (n=3). The racial/ethnic composition of the

sample were representative of students enrolled in public schools throughout California in 2008. Authors split data into two groups: 1) heterosexual students who were not members of a GSA (straight, n=581), and 2) LGBTQ students and GSA members (LGBTQ/Ally, n=388). As rates of discussions and supportiveness were similar within LGBTQ students and allies, these groups were combined for subsequent analyses as LGBTQA students (with 'A' representing allies). Researchers reported results at the individual and school level. Authors note that, "[w]hile inclusive and supportive curricula may not reduce bullying for individual students when compared to others within their own school [may actually increase awareness and reporting], they do have broad positive effects through the reduction of bullying across schools." Overall, the "analyses suggest that sexuality and health education is a particularly important setting for inclusive and supportive curricula within schools. LGBTQ-inclusive curricula were most common in sexuality education/health classes, and the results show that at the school level, school safety was higher for schools in which more students reported the presence of LGBTQ-inclusive sexuality and health education." Moreover, "in schools where sexuality and health education was perceived as supportive of LGBTQ people and issues, there was more safety and less bullying; the same holds true at the student level as well."

66. Boyce Karen Stradford, Travers Madeline, Rothbart Betty, et al. Adapting Evidence-Based Teen Pregnancy Programs to be LGBT-Inclusive: Lessons Learned. *Health Promotion Practice*. 2018;19(May 2018):445-454.

Boyce et al. evaluated the New York City's (NYC) Departments of Health and Education's LGBT-inclusive supplement to Reducing the Risk, a high school sexual health education curriculum. As context, authors cited evidence that youth who identify as LGBT disproportionately experience poor sexual health outcomes such as teen pregnancy, sexually transmitted infections, and HIV infections. "LGBT youth are at an increased risk for experiencing harmful social environmental factors, such as higher levels of sexual abuse, parental physical abuse, partner violence, and victimization at school as compared to their heterosexual and cis-gender peers." This may contribute to the increased likelihood that LGBT youth engage in sexual risk behaviors (e.g., early sexual intercourse debut, unprotected intercourse, and having multiple sexual partners). Despite these increased risks, evidence-based programs reviewed by the U.S. Department of Health and Human Services (HHS) often fail to reflect LGBT identities or include inclusive health information (e.g., role plays written specifically for heterosexual, cis-gender couples). They noted, omissions of LGBT sexual health risks "limits the effectiveness of the program in improving the sexual health outcomes of not only LGBT youth who are in need of these interventions but also all youth who may feel left out by the limited frame of the curricula." Examples from other health topics have shown that culturally adapting health interventions, while maintaining component fidelity, increases their effectiveness. Through this evaluation, NYC's Reducing the Risk curriculum was implemented in 21 South Bronx high schools, reaching 5,673 students in a total of 230 classes. The LGBT-inclusive supplement was used in 161 classes. Participating teachers received a 2-day training on the supplement, as well as materials which 1) oriented teachers to LGBTQ needs and issues; 2) provided students with an understanding of sexual and gender identity as part of all students' self-identity; and 3) provided teacher guidance on how to adapt all 16 lessons to be more LGBT inclusive. The program evaluation assessed reach (electronic survey of number of teachers implementing, classes taught, and students receiving the curriculum), curriculum adherence, and implementation quality. Results showed, "[t]eachers who implemented the LGBT supplement

delivered the RTR curriculum with 79% overall fidelity, while those who did not implement with the supplement delivered RTR with 68% overall fidelity.” Teachers who implemented the supplement reported completing an average of 70% of LGBT supplement activities. Overall, “students in classes who received the curriculum with the LGBT-inclusive supplement “demonstrated greater increases in sexual and reproductive health knowledge [i.e., knowledge of: puberty, STI prevention, pregnancy prevention, HIV transmission, and clinical services] than those who received the curriculum without the supplement. Although students were not randomized to an exposure group, [...] scores and demographics at pretest were not significantly different across groups, indicating the groups may be comparable.” Additionally, student posttest satisfaction results showed “70% (n=773) of students who received the supplement reported they felt their sex education lessons were ‘excellent’ or ‘very good,’ overall, compared to 57% (n=163) of their peers who did not receive the supplement (p=.0006).” Similarly, of teachers who implemented the supplement (n=78) the majority rated implementation of the supplemental lesson as “great” (38%) or “good” (46%). Study limitations included: 1) inability to evaluate the curriculum’s impact on youth sexual and reproductive health outcomes; 2) pre- and posttest data were could not be compared at the individual level (identifiable data was not collected due to privacy concerns); 3) student survey response rates were higher among those who received the supplemental LGBT-inclusive instruction (bias results or indicate higher attendance and class engagement among supplemental classes); and 4) no data to assess differences between those teachers who chose to implement the supplement and those who chose not to implement.

67. Project The Trevor. National Survey on LGBTQ Youth Mental Health New York, New York: The Trevor Project; 2019 2019.

The Trevor Project conducted a quantitative cross-sectional design to collect data using an online survey platform between February 2, 2018 and September 30, 2018. A sample of youth ages 13-24 years was recruited via targeted ads on social media. A total of 34,808 youth completed the online survey. A final sample of 25,896 eligible participants (i.e., lived in the U.S., LGBTQ identity) were included after excluding those who did not complete more than half of survey items, completed the survey within 3 minutes, or input mischievous answers (e.g., selected all religious affiliations, race/ethnicity options, provided obvious hate speech against LGBTQ in free response items). The sample included participants who identified as white (72%), Hispanic (14%), mixed race (7%), Asian (3%), Black (3%), and American Indian/Alaska Native (1%). Participants were diverse in sexual orientation (45% gay or lesbian, 33% bisexual, and 22% something else) and gender identity (35% cisgender male, 33% transgender and non-binary, and 32% cisgender female). Overall, 39% of LGBTQ youth seriously considered attempting suicide in the previous 12 months, "with more than half of transgender and non-binary youth having seriously considered." Over 18% of LGBTQ respondents attempted suicide in the previous 12 months. Moreover, 29% of transgender and non-binary respondents reported having attempted suicide compared to 14% of cisgender respondents. Younger youth (ages 13-17) reported considering suicide (47%) and attempting suicide (26%) more than older youth (ages 18-24; 31% and 11%, respectively). Additionally, 71% of respondents reported feeling sad or hopeless for at least two weeks in the past year. "[Seventy-eight percent] of transgender and non-binary youth reported being the subject of discrimination due to their gender identity and 70% of LGBTQ youth reported discrimination due to their sexual orientation." Results indicate that "[g]ender identity (for those identifying as transgender and non-binary) is disclosed at a lower rate than sexual orientation (for those not identifying as straight)." Among both groups, disclosure is

greatest to their LGBTQ friends (1) and straight friends (2) and lowest to their doctor or healthcare professional. Respondents reported disclosure of their sexual orientation (43%) and disclosure of their gender identity (40%) to a teacher or guidance counselor.

68. Russell S. T., Pollitt A. M., Li G., et al. Chosen Name Use Is Linked to Reduced Depressive Symptoms, Suicidal Ideation, and Suicidal Behavior Among Transgender Youth. *J Adolesc Health*. 2018;63(4):503-505.

Russel et al. used data collected between November 2011 and October 2012 to examine the relationship between chosen name use, as a proxy for youths' gender affirmation in various contexts, and mental health among transgender youth. The community cohort sample included 129 transgender and gender nonconforming youth from three U.S. cities (one each in the Northeast, the Southwest, and the West Coast). Although study included a small number of youth, authors noted "it is one of the largest samples of transgender youth to date." Results show, "[a]fter adjusting for personal characteristics [e.g., gender identity, race/ethnicity, sexual identity, age] and social support, chosen name use in more contexts was associated with lower depression, suicidal ideation, and suicidal behavior." Specifically, "[a]n increase by one context in which a chosen name could be used predicted a 5.37-unit decrease in depressive symptoms, a 29% decrease in suicidal ideation, and a 56% decrease in suicidal behavior." Moreover, "[d]epression, suicidal ideation, and suicidal behavior were lowest when chosen names could be used in all four contexts [i.e., at home, at school, at work, or with friends]." Use of transgender youth's "chosen name in multiple contexts appears to affirm their gender identity and lower mental health risks know to be high in this group."

69. Marshal M. P., Dietz L. J., Friedman M. S., et al. Suicidality and depression disparities between sexual minority and heterosexual youth: a meta-analytic review. *J Adolesc Health*. 2011;49(2):115-123.

Marshal et al. conducted meta-analyses to examine the suicidality and depression disparities between sexual minority youth (SMY) and heterosexual youth. Authors cited a growing body of research that suggests that SMY are at increased risk for mood disorders and suicidality, which is consistent with adult studies. Factors associated with psychosocial risks in SMY include "the negative responses of other people to gender atypical behavior, high-risk sexual behavior, conflicts related to disclosure of sexual orientation to family and its consequences, and mistreatment in community settings, especially schools. One or more of these stressors can promote feelings of helplessness and hopelessness that may develop into depression and suicidality." A total of 24 studies—20 studies on suicide, 12 on depression, and 7 on both outcomes—were identified for inclusion. Qualitative and quantitative data extracted from studies fell into four categories: 1) definition of sexual orientation; 2) depression and suicide measures (i.e., suicidal ideation, suicidal plans or intent, suicide attempts, and suicide attempts that caused injury and/or required medical attention); 3) moderating variables (e.g., bisexuality status, gender); and 4) the effect size data. Overall, "SMY reported significantly higher rates of suicidality (odds ratio [OR] = 2.92) and depression symptoms (standardized mean difference, $d = .33$) as compared with the heterosexual youth." Specifically, "the association between sexual orientation and suicidality was strongest among bisexual SMY (OR=4.92; $p < .0001$; CI=2.82-8.59)." Results also suggested that "disparities in rates of suicidality increased with an increase in the severity of the suicidal behavior (ideation [OR=1.96, $n=9$]; intent/plans [OR=2.20, $n=4$]; attempts [OR=3.18, $n=14$]; and attempts resulting in injury or medical attention [OR=4.17,

n=5]).” Furthermore, “a trend suggested that the association was stronger when recent suicidality as measured (OR=3.34) as compared with lifetime measures (OR=1.92).” Additionally, 13 of 19 studies reported data in a way that allowed researchers to estimate the absolute rates of suicidality in each group; “the average of these rates showed that 28% of SMY and 12% of heterosexual youth reported a history of suicidality.” Evidence from 6 studies looked at differences between males and females: “(a) 28% of sexual minority [males] and 17% of heterosexual [males] reported a history of suicidality; and (b) 37% of sexual minority [females] and 23% of heterosexual [females] reported a history of suicidality.”

70. How CDC Prepares Healthy Youth for Successful Futures. Atlanta, Georgia: Centers for Disease Control and Prevention; July 2018 2018.

This CDC fact sheet from the Division of Adolescent and School Health (DASH) noted that while sexual risk behaviors among adolescents are declining (2007-2017), the prevalence of some behaviors remains high and puts youth at risk. Data from the National Youth Risk Behavior Survey (2017) and HIV Surveillance Report (2016) show that half of all new sexually transmitted diseases reported each year are among young people aged 15 to 24. Additionally, the document reported that "while many LGB youth thrive during adolescence, stigma, discrimination, and other factors may put them at increased risk for negative health and life outcomes." For example, 16% LGB youth experience sexual dating violence, they are nearly twice as likely as other students to use illegal drugs, and more than 47% have seriously considered suicide.

71. Lindberg L. D., Maddow-Zimet I., Boonstra H. Changes in Adolescents' Receipt of Sex Education, 2006-2013. *J Adolesc Health*. 2016;58(6):621-627.

Lindberg et al (2016) analyzed historic survey data to identify trends in adolescents' health education, finding significant declines across the board, with most of the effect seen in nonmetropolitan areas. The authors collected data from the 2006-2010 and 2011-2013 National Survey of Family Growth. Participants were chosen by a stratified clustered sample across diverse demographics, and then interviewed using a structured survey. From this data, the authors selected respondents aged 15-19 at the time of interview from both the 2006-2010 and 2011-2013 surveys (females (n = 2,284) males (n = 2,378) and females (n = 1,037) males (n = 1,088), respectively). The respondents were asked about their formal sex education as well as discussions with parents. The analysis revealed significant declines in adolescent females' receipt of formal instruction about birth control (70% to 60%), saying no to sex (89% to 82%), sexually transmitted disease (94% to 90%), and HIV/AIDS (89% to 86%). Males experienced a significant decline in formal instruction about birth control (61% to 55%). Males in nonmetropolitan areas, however, saw significant declines in all areas of sexual education. Across the board for males and females, the declines seen were concentrated in nonmetropolitan areas with very few declines in metropolitan areas. There were some additional disparities due to race, religious attendance, and household income. More research is needed looking into the source, content, and quality of sex education to determine how to best concentrate efforts in improving sex education for adolescent's. An additional question that comes up for the authors is why sex education has decreased when funding for such education has increased.

72. Winters Amanda, Alson Julianna. Development of a Socioecological Adolescent Sexual Health Index and Atlas: A Case Study in Washington State. *American Journal of Sexuality Education*. 2018;1-19.

Winters and Alson (2018) conducted a spatial analysis of sex education needs and access across Washington State to reveal disparities in both need for and access to sexual health education. The authors obtained data from the following sources: WA State Department of Health Surveillance; WA State Healthy Youth Survey; WA State Office of Superintendent of Public Instruction Data; WA State Office of Crime Victims Advocacy; U.S. Census Bureau, American Community Survey, 5-Year Estimates; School District Websites; and Stakeholder Reports of Partner Locations. The authors utilized multiple social determinants for health along with traditional measures (teen pregnancy rate and STIs) to determine health education needs. They found that just looking at traditional measures could leave gaps in need for health education, for example in areas with high levels of racism and racial segregation, and high levels of dating violence, both of which contribute to negative health outcomes. In their analysis the authors found that the areas that had lower priority for health education also had fewer programs operating; districts with the fewest adolescents living in proximity to Title X facilities also had the lowest rates of reported receipt of sexual health education in school; and visual assessment revealed that urban counties tended to be the areas that had both community resources and sex education initiatives, whereas rural areas tended to be the ones without access to community resources and with few sexual health education resources. These compounding effects of high need for education and few resources highlight the disparities in sex education across the state. The data are limited in their scope, as counties with multiple school districts, for example King County, there could be great variation between access and needs between school districts that are not reflected when looking at the county as a whole; more detailed research is needed. The authors recommend a broader range of social determinants of health be taken into account when making decisions on health education policies and programs.

73. Women Committee on Health Care for Underserved. Committee Opinion 586: Health Disparities in Rural Women. Washington, DC: American College of Obstetricians and Gynecologists; 2014 (reaffirmed in 2016).

Rural women have poorer health outcomes and more limited access to health care as compared to urban women. Health care providers, particularly in women's health, are limited in many rural areas. The heterogeneity of rural areas in the U.S. result in there being various problems depending on the specific region and state. It is important for health care professionals to have awareness about health disparities for rural women and advocate for its reduction.

74. Delamater Paul L, Messina Joseph P, Shortridge Ashton M, et al. Measuring geographic access to health care: raster and network-based methods. *International Journal of Health Geographics*. 2012;11(15).

Geographic inequalities to health care can be caused by facility configuration, population distribution, and transportation infrastructure. Although recent studies on this issue have used traditional Euclidean measures of distance, this study used travel distance or time instead. These different underlying data models are one explanation for the differences in raster-based and network-based studies' findings.

75. Sobel Laurie, Rosenzweig Caroline, Salganicoff Alina. Proposed Changes to Title X: Implications for Women and Family Planning Providers. Henry J. Kaiser Family foundation; June 2018 2018.

This Kaiser Family Foundation issue brief provides an overview of the changes to regulations for the federal Title X family planning program proposed by the Trump Administration. Authors highlight that the proposed regulations would: 1) block the availability of federal funds to family planning providers that also offer abortion services; 2) end counseling and referrals to abortion services by Title X providers; 3) eliminate current requirements that Title X sites offer a broad range of medically approved family planning methods and non-directive pregnancy option counseling (e.g., prenatal care, delivery, adoption, and abortion; and 4) direct new funds to faith-based and other organizations that promote fertility awareness and abstinence as methods of family planning.

76. Rayburn W. F., Richards M. E., Elwell E. C. Drive times to hospitals with perinatal care in the United States. *Obstet Gynecol.* 2012;119(3):611-616.

Access to care is an important issue in health care reform. This study evaluated access to inpatient obstetric care by determining the percentage of women of reproductive age living within a 30-minute or a 60-minute drive to the closest hospital with perinatal services. As defined by the 2007 American Hospital Association survey, perinatal centers were level I (uncomplicated obstetric and nursery care), level II (limited complicated care), or level III (full complement of care). The study used geographic information system mapping software to determine drive times from the census block group centroid to the closest perinatal center. In the United States, 2,606 hospitals offered some level of perinatal care for the 49.8 million reproductive-aged women. There was variation in access to perinatal centers within a 30-minute drive depending on the level of care: 87.5% of the population had access within a 30-minute drive to any center, 78.6% to a level II or III center, and 60.8% to a level III center. Access within a 60-minute drive also varied by level of care: 97.3% had access to any center; 93.1% to a level II or III center; and 80.1% to a level III center. The most geographic maldistribution of perinatal services was found in the mostly rural western portion of the US (excluding the Pacific Coast) and Alaska. There was considerable variation in driving time. The study concluded that regional obstetric workforce planning and policy-making regarding access to care should use geographic information system software.

77. Skillman SM, Dahal A. Washington State's Physician Workforce in 2016. Seattle, WA: Center for Health Workforce Studies, University of Washington; February 2017 2017.

The supply of physicians per capita in Washington is comparable to national averages, but there is significant variation in distribution based on whether an area is urban or rural, with there being fewer physicians (both total and for primary care) in the latter. Furthermore, there is a lower per capita supply in the eastern counties as compared to the western ones. One possible approach to this problem would be creating more residencies in these underserved areas and for specialties in which underserved areas are especially affected. It could also help stabilize the workforce to target retention of younger physicians, especially for the rural areas where over half of physicians are 55 years of age or older.

78. **Report to the Legislature | UPDATE: Homeless Students Data.** Olympia, Washington: Washington State Office of Superintendent of Public Instruction; 2018 2018. In 2014, the Washington State Legislature passed legislation (SB 6074) requiring the Office of Superintendent of Public Instruction to report data on students experiencing homelessness to the governor and the legislature every other year beginning in 2015. This report is required to include enrollment data as well as performance outcomes disaggregated by at least the following subgroups of students: White, Black, Hispanic, American Indian/Alaskan Native, Asian, Pacific Islander/Hawaiian Native, low-income, transitional bilingual, migrant, special education, and gender. It also includes additional information regarding student participation in a variety of supportive educational programs. During the 2017-2018 school year, 39,299 students in grades K-12 were identified as experiencing homelessness. Specifically, 18,222 students in grades K-5; 7,935 in grades 6-8; and 13,142 in grades 9-12. Data indicate 29,772 students were sharing housing of other persons due to loss of housing, economic hardship or similar reason ('Doubled-Up'). Additionally, students were living in hotels/motels (2,533), shelters (5,102), and unsheltered (2,958). Race/ethnicity data indicate that 8.4% of the state's Black/African American student population was experiencing homelessness, as were 7.4% of American Indian/Alaska Native students, 7.6% of Native Hawaiian/Pacific Islander students, 4.6% of Hispanic/Latino students, and 4.2% of those of 2 or more races. Additionally, 2.5% of white students and 1.0% of Asian students were experiencing homelessness.

79. **Rice E. , Barman-Adhikari A., Rhoades H., et al. Homelessness Experiences, Sexual Orientation, and Sexual Risk Taking Among High School Students in Los Angeles. *Journal of Adolescent Health*. 2013;52:773-778.**

A supplemental survey about homelessness and sexual health was added to the Youth Risk Behavior Survey in Los Angeles. The supplemental questions were completed by 1,839 high school students (grades 9-12). Rice et al. analyzed the responses to evaluate associations between demographic characteristics, homelessness experiences, and condom use at last intercourse. They cite previous research showing that male adolescents and youth who identify as LGBTQ are more likely to experience homelessness, and "since the 1980s, a large body of work has demonstrated that homeless youth are more likely than housed youth to engage in risky sexual behaviors, such as unprotected and exchange sex." The supplemental questions asked about gender, sexual orientation, and race/ethnicity. Homelessness experience was evaluated by asking, "during the past 12 months, have you spent the night in any of the following places? (1) in a youth or adult shelter; (2) in a public place, such as a train or bus station, a restaurant, or an office building; (3) in an abandoned building; (4) outside in a park, on the street, under a bridge or overhang, or on a rooftop; (5) in a subway or other public place underground; and (6) with someone you did not know because you needed a place to stay." Sexual risk behaviors were determined by asking about any sexual intercourse (vaginal, anal, or oral) and condom use during last sexual intercourse. Approximately 23.8% of youth sampled experienced homelessness in the past 12 months, 40% had experienced sexual intercourse, and 61% reported using a condom at last sex. The authors found that, "younger age (OR= .90; 95% CI: .81-.99), male gender (OR= 1.94; 95% CI: 1.54-2.46), identifying as LGBTQ (OR= 2.18; 95% CI: 1.59-2.99), and identifying as 'other race' (OR= 2.48; 95% CI: 1.67-3.70) were statistically significantly associated with any experience of homelessness in the past year." Youth that identified as LGBTQ and youth identifying as black/African American were more likely to have stayed with stranger. Youth that were older, male, LGBTQ, black/African American, and

experiencing homelessness were statistically significantly more likely to have had sexual intercourse. Among youth experiencing homelessness, "older age (OR= 1.50; 95% CI: 1.24-1.81) and having spent the night with a stranger (OR= 3.36; 95% CI: 1.90-5.93) were significant predictors of being sexually active." Those who stayed with a stranger or in a public place were more likely to have had unprotected sex. The authors concluded that, "schools should work to address the unique needs of LGBTQ youth who may be experiencing homelessness. Moreover, school-based sexual health programs should recognize the prevalence of sexual risk taking among adolescents who experience homelessness. Address the needs of homeless adolescents, especially LGBTQ adolescents, while in school is critical. Discussions of exchange sex should also be included in sexual health education programs. This can be addressed within the context of promoting healthy relationships and power dynamics/balances within relationships."

80. Homeless and Runaway: Physical & Reproductive Health. 2019; Available at: <https://youth.gov/youth-topics/runaway-and-homeless-youth/physical-and-reproductive-health>. Accessed 7/8/2019.

youth.gov, a federal website with information about youth and youth programs, provided an overview of health, teen pregnancy, HIV/STDs, and healthcare access among runaways and youth experiencing homelessness. Overall, they noted that youth experiencing homelessness are less likely to have access to healthcare, including reproductive healthcare, due to a number of barriers (e.g. lack of transportation; need for parental consent; lack of coordinated services). Youth experiencing homelessness are at higher risk for teen pregnancy, early sexual debut, survival sex, lack of access to and inconsistent use of birth control and condoms, multiple sex partners, and drug use. For example, "compared to the national average of 10%, 48% of street youth and 33% of shelter youth have been pregnant or have impregnated someone." Similarly, "runaway and homeless youth are six to twelve times more likely to become infected with HIV than other youth."

81. Pediatrics American Academy of. Health Care for Youth in Juvenile Justice System. *Pediatrics*. 2011;128(6):1219-1235.

This policy statement from the American Academy of Pediatrics identified youth in the juvenile correctional system as a high-risk population, many of whom, "have unmet physical developmental, and mental health needs." Data from 2008 indicate that females comprise about one-third of juvenile arrests in the U.S. Additionally, "although minority youth represent only 39% of the US juvenile population, they represented 65% of the national juvenile custody population in 2006." Authors cite evidence that "overall, poverty is likely to be the underlying factor that most influences trends in juvenile crime." Moreover, "poorer health status is related to lower [socioeconomic status] SES, and lower SES is more likely to be found among minority youth." While AAP reported the categories of health needs are similar for both youth in the correctional system and their peers in the community, they note that "high-risk behaviors such as violence, substance abuse, and sexual activity, which may be more prevalent than those of their peers in the general population" influence certain health categories. Authors cited a 1991 study by the National Commission on Correctional Health Care (NCCHC). "The study included 1801 youth from 39 short-term or long-term correctional facilities in the United States. These youth had higher rates of substance abuse, trauma, unprotected sexual activity, history of sexually transmitted infections (STIs), suicidal ideation, and reported violence than those in a general high school population." As of 2012, the NCCHC study remained one of the best nationally

representative samples evaluating sexual activity and contraceptive use among incarcerated youth. Overall, incarcerated youth reported higher rates of sexual activity, were more likely to report 4 or more lifetime sexual partners, and had much lower self-reported use of contraception or condoms at their most recent sexual intercourse. Data from the Centers for Disease Control and Prevention's (CDC) 2009 Sexually Transmitted Disease Surveillance Report demonstrated that youth ages 12 to 18 years in juvenile detention have high rates of STIs (e.g., Chlamydia: 14.8% of females and 6.6% of males; Gonorrhea: 3.9% of females and 1.0% of males). Additionally, the 2003 Survey of Youth in Residential Placement (SYRP) found that one-fifth of incarcerated youth were currently a parent (14%) or expecting a child (12%). "Males (15%) were more likely to have father a child compared with 9% of females who reported having a child." These rates are disproportionately higher than those of the general population of 12- to 20-year-olds, "in which 2% of males and 6% of females have children." Additionally, national data show incarcerated teens "report higher pregnancy rates than those in the general adolescent population; more than one-third of females report ever having been pregnant." The statement also discusses general physical health issues (i.e., dental, injury, and tuberculosis), mental health, and behavioral health issues. For example, "although [males and females] experience sexual (10-24%) and physical (11-58%) abuse, all forms of abuse, including emotional abuse, are more common in girls." Such abuse contributes to diagnoses of posttraumatic stress disorder in females, more common than males. Longterm outcomes for judicially-involved adolescent females "reveal greater persistence of emotional problems and worse outcomes complicated by relationship and parenting issues, drug problems, and suicidality." SYRP results show that about 20% of youth surveyed reported that they were not enrolled in school at the time they entered custody, which is 4 times higher than the rate for the general population. AAP provided recommendations to address the needs of youth in juvenile detention settings.

82. Barnert Elizabeth S., Perry Raymond, Morris Robert E. Juvenile Incarceration and Health. *Academic Pediatrics*. 2016;16(2):99-110.

This perspective by pediatricians Barnert, Perry, and Morris addresses the health status and needs of incarcerated youth. Authors identify reproductive health as one of three areas of particularly high need, "likely as a result of lower access to care, engagement in high-risk behaviors, and underlying health disparities." Additionally, authors note significant disparities by race/ethnicity and class. For example, they cite evidence that "African American adolescents are 5 times more likely and Latino and American Indian youth 3 times more likely to be incarcerated compared to white adolescents." Incarcerated youth often come from marginalized backgrounds, have high rates of adverse childhood experiences, (ACEs) and have limited financial resources. Additionally, many live in high-crime neighborhoods, which "increases incarceration risk and creates a socioeconomic disparity that is accentuated for black and Hispanic youth." Within this context, "compared to nonincarcerated adolescents, incarcerated youth report high rates of sexual activity and sexually transmitted infections, more lifetime partners, and lower use of condoms and other forms of contraception." In 2011, CDC reported "prevalence of chlamydia infection among detained girls and boys as 13.5% and 6.7% respectively, compared to rates of 3.3% in the general adolescent female population and 0.7% in the general adolescent male population." Additionally, "youth victims of sex trafficking or commercial sexual exploitation have a higher incarceration risk and higher risks of contracting HIV or hepatitis C."

83. Instruction Office of Superintendent of Public. Washington Migrant Education Program Service Delivery Plan.2018.

In this report, OSPI provided an overview of the Migrant Education Program in Washington State. The Elementary and Secondary Education Act (ESEA) of 1965 (Title I, Part C) is a federal formula grant (based on the number of eligible individuals) and provides funding to states to "meet the unique educational needs of migratory children and their families to ensure that migrant students reach challenging academic standards and graduate high school. Specifically, the goal of state MEPs is to design programs to help migratory children overcome educational disruption, cultural and language barriers, social isolation, health-related problems, and other factors inhibiting migratory children from doing well in school and making the transition to postsecondary education or employment." Washington State has the third largest Migrant Education Program in the U.S. During the 2013-2014 school year, 51 school districts received funds to serve 31,816 migrant students. The largest programs are in Yakima, Kennewick, and Wenatchee, and most students served are in elementary school (37%). An additional 4,607 migrant students were in 116 districts that did not receive funding. Therefore, in 2013-2014, there were approximately 36,423 migrant students across Washington State. Among eligible students, approximately half (46%) move within Washington, 96% identify as Hispanic, and 40% identified as English Language Learners. Many students also begin the school year in Washington, but leave for other locations in November, with the majority moving to California and Mexico. OSPI indicated low participation by Out of School Youth and stated a need to re-evaluate program outreach. They noted one goal to increase the percentage of Out of School Youth, including a strategy to provide referrals to health care providers to increase participation in the program.

84. Gelatt J., Zong J. Fact Sheet: Settling In—A profile of the Unauthorized Immigrant Population in the United States. Migration Policy Institute;2018.

This report by the Migration Policy Institute presents population estimates and sociodemographic characteristics for unauthorized immigrants living in the U.S. The Migration Policy Institute, in collaboration with Pennsylvania State University and Temple University, developed a methodology to estimate whether an individual is authorized to be in the U.S. Their methodology uses a multiple imputation statistical model to compare measures in the Census Bureau's American Community Survey with measures in the Census Bureau's Survey of Income and Program Participation, which asks participants to report whether they have Lawful Permanent Resident status. They compare measures such as country of birth, year of U.S. entry, age, gender, and educational attainment between the two surveys to estimate unauthorized status. Migration Policy Institute presents data for the U.S. overall, for 41 states, and for 135 counties with the largest population of unauthorized immigrants. This factsheet presents information about country of origin, U.S. designations, length of U.S. residence, educational attainment, English proficiency, employment, income, and homeownership. Overall, Migration Policy Institute estimates there are 11.3 million unauthorized immigrants living in the U.S. Nationally, the majority (53%) of individuals who are undocumented arrive from Mexico, and Yakima County, Washington has the highest share of unauthorized immigrants from Mexico (97% of unauthorized immigrants in Yakima County are from Mexico). The majority of individuals who are undocumented in Washington work in agriculture. Washington is also among the top 10 states with children under the age of 18 who have at least one parent who is undocumented. Migration Policy Institute estimates that 88,000 children in Washington State have at least one

parent who is undocumented, and approximately 30% of this group has two parents who are unauthorized.

85. Perez-Escamilla R., Garcia J., Song D. Health Care Access Among Hispanic Immigrants: ¿Alguien esta escuchando? [Is anybody listening?]. *NAPA Bulletin*. 2010;34(1):47-67.

Perez-Escamilla et al. completed a systematic literature review of 77 articles related to health care access for Hispanic immigrants in the United States. Major barriers to accessing health care included lack of health insurance, stigma, fear of deportation, and low English proficiency. For adolescents, parental citizenship and immigration status has also been identified as a barrier to accessing health care, even for children who are U.S. citizens. Eleven articles examined barriers to accessing women's health care. In addition to general barriers, the review found additional barriers specific to access of women's health services like mammography and prenatal care, including: lack of culturally competent services (including outreach practices), low self-efficacy, lack of social support, and mobility. The authors also note that, "deeply rooted cultural beliefs about the origin of health and disease within the context of limited access to health insurance may be associated with more prevalent use of traditional healing...as alternative means to access care." Studies have found that language differences, differences in cultural beliefs about health, and perceived discrimination may limited access to health care in the U.S. Based on their review, the authors note that "programs relying heavily on community health workers, also known as promotoras, have improved health care access."

86. Raymond-Flesch M., Siemons R., Pourat N., et al. "There is no help out there and if there is, it's really hard to find": a qualitative study of the health concerns and health care access of Latino "DREAMers". *J Adolesc Health*. 2014;55(3):323-328.

Raymond-Flesch et al. completed nine focus groups with 61 Latino immigrants in California who qualified for the Deferred Action for Childhood Arrivals (DACA) program. The Affordable Care Act excluded DACA recipients from obtaining Medicaid or private insurance through the Health Care Exchanges. The purpose of the focus groups was to understand DACA recipients' access to health care and current health conditions. The authors also identified evidence-based policy changes to address the health needs of undocumented immigrant communities (including DACA recipients). The study was the first to examine the health needs of DACA recipients. The authors identified a number of barriers to accessing health care generally, including cost of care, competing financial priorities (e.g. food, tuition, rent), lack of knowledge about the health care system, low health literacy, long wait times and delays getting appointments, lack of provider knowledge and sensitivity about immigration status and health needs of immigrants, lack of a consistent medical home, lack of a driver's license, fear of discrimination, and fear of deportation or consequences for future citizenship. The authors recommend training providers in culturally-sensitive and trauma-informed care, educating providers about immigration law and status, strengthening relationships between providers and community-based organizations, creating local health care and insurance options for undocumented individuals, and educating DACA-eligible youth about health care options.

87. Lee Y., Dancy B., Florez E., et al. Factors Related to Sexual Practices and Successful Sexually Transmitted Infection/HIV Intervention Programs for Latino Adolescents. *Public Health Nursing*. 2013;30(5):390-401.

Lee et al. completed a review of literature to determine what factors are successful in STI/HIV intervention programs designed for Latino adolescents. They state that STI rates continue among Latino adolescents, despite declines in other racial/ethnic groups. For example, 24% of newly diagnosed cases of HIV are among Latino youth. Their review included 17 articles published between 1990 and 2012, including results from five STI/HIV intervention programs that met review inclusion criteria. Their review identified five factors that “can promote understanding of sexual practices among Latino adolescents: familialism; religion; gender roles; level of knowledge and information on sex and STIs; and protection of privacy and confidentiality.” For example, the authors explained that, “strong Roman Catholic roots may deter many Latino adolescents from protecting themselves if they are sexually active.” They cite previous research showing that Latino adolescents were less likely to use contraception than their black and white counterparts. Approximately 31.2% of Latino youth said they had never used contraception during sex compared to 23.3% of blacks and 17% of whites. In addition, traditional cultural gender roles of marianismo and machismo put Latino youth at greater risk of STIs and HIV. The authors explained that, “machismo is strongly associated with early initiation of sexual intercourse and multiple partners, and is negatively associated with condom use among Latino men.” The authors also noted that, “Latino adolescents have relatively fewer reliable sources of information on sexuality and contraception than other populations,” including in school-based or community-based settings. Among the five STI/HIV interventions programs that met inclusion criteria, the authors concluded that, “only STI/HIV knowledge and gender roles were found as common factors across the five successful STI/HIV intervention programs...therefore, healthcare providers need to understanding culturally related gender roles and their impact on sexual practices to provide culturally sensitive and appropriate sex education about STIs and HIV for Latino adolescents.”

88. Graham J. Christopher. Washington State DCYF Racial Disparity Indices Report (2018) Olympia, Washington Washington State Department of Children, Youth, and Families;2019.

This report from the Washington State Department of Children, Youth, and Families summarized trends in racial disparities for children referred to Washington State Children's Administration (CA) and children placed in out-of-home care by CA for cohorts from calendar year (CY) 2011 through CY 2017. This report compared population rates and describes racial disproportionality relative to the general population of Washington State and presented indicators of racial disparity relative to the CA population at intake or placement. "The purpose of the [Disparity Index After Intake] DIAI and [Disparity Index After Placement] DIAP is to control for whatever disproportionality (of reports) or disparity (within the system) may be present as a legacy of the earlier stages in the process by which children/youth come to the attention of, and may become involved with, Child Protective Services (CPS) and move through the system." Disparity Index (DI) of All Intakes (screened out or screened in) data from 2011 through 2017 indicate that American Indian/Alaska Native (AI/AN) children/youth and Black children/youth were more likely to be reported to CPS as were white children/youth. In 2017, AI/AN children/youth were 69% more likely to be reported to CPS as were white children/youth, and Black children/youth were 55% more likely to be reported to CPS than white children. While reductions compared to previous years, both are disproportionate. From 2011 to 2017, disproportionality of all intakes among multiracial children/youth reduced "until they were no more likely to have an intake than were white children/youth (DI = 1.0), which is the culmination of a decreasing multi-year trend

in disproportionality that goes back to 2007 (at which time there was a DI of 1.68 for multiracial children/youth)." Asian/Pacific Islander children/youth and Hispanic children/youth were less likely than white children/youth to be reported to CPS across the reporting period. At the stage of screening of intakes, no more than a slight degree of any such disparity is not apparent. In contrast, the DIAI for children entering placement within 12 months shows obvious disparity, most so for the three multiracial groups (multiracial AI/AN, multiracial Black, and multiracial other) and AI/AN. The DIAI for the 2015 and 2016 AI/AN cohorts was 1.66 (66% higher than for white children/youth). The report notes that "the Placement DIAI for both AI/AN and, even more dramatically, multiracial AI/AN increased from the 2015 to 2016 cohorts [...] both of which are at the maximum for the entire period of 2006 through 2016 cohorts (the only data point slightly more extreme was DiAI of 1.68 for the AI/AN 2012 cohort)." Overall, "[r]elative to the degree of disparity evident at the other stages of decision making considered in this report, disparity of removal/placement is the clearest, and also removal is the key early stage of children's/youth's involvements in the CPS system."

89. Health Department of. Maternal and Child Health Data Report: Teen Pregnancy and Childbearing.2014.

In this report, Department of Health presents the teen pregnancy rate per 1,000 women aged 15-17 by race/ethnicity. Hispanic youth had the highest teen pregnancy rate of 36.7 pregnancies per 1,000 women aged 15-17. American Indian/Alaska Native youth experienced 31.1 pregnancies; Pacific Islander youth had 20.0; black youth had 11.9; white youth had 7.5, and Asian youth 3.6 pregnancies per 1,000 women aged 15-17.

90. Moya E. M., Chavez-Baray S., Martinez O. Intimate partner violence and sexual health: voices and images of Latina immigrant survivors in southwestern United States. *Health Promot Pract.* 2014;15(6):881-893.

Moya et al. assessed the relationships between IPV and sexual health among Latina immigrants in southwestern United States. Researchers used photo-voice methodology and a community-based participatory research approach to gather and assess data from a convenience sample of 22 Latina survivors of IPV and 20 community stakeholders in El Paso, Texas. Participants reported "feelings of hopelessness, humiliation, loneliness, fear, and isolation from resources and services due to physical, sexual, and verbal abuse." Similarly, the majority of participants reported STIs from their partners and shared they were afraid to seek medical treatment because of their status (e.g., HIV/AIDS) for fear of being stigmatized or discriminated against. Study participants also described limited/no access to health services, fear of deportation and separation from children, limited English proficiency, and lack of health insurance as barriers to sexual and reproductive health. They explained that stigma, discrimination, humiliation, oppression, economic control, and fear act as barriers to sharing struggles and health concerns with health providers, family members, employers, and policy officers. Authors note, "[t]he inability to access physical and mental health services interfered with their ability to prevent, screen, and address IPV and adequately fulfill sexual and reproductive health needs." Participants came to a consensus and recommended the use of promotoras (community health worker) "to better reach and address IPV and sexual and reproductive health concerns in the U.S.-Mexico border region and beyond." Promotoras can disseminate information on IPV and connect affected women to resources. Participants expressed the need for community engagement and community-based organizations

to moderate structural and social barriers and promote access to IPV, sexual, and reproductive health services.

91. **Park J., Nordstrom S. K., Weber K. M., et al. Reproductive coercion: unclocking an imbalance of social power. *Am J Obstet Gynecol.* 2016;214(1):74-78.**

Park et al. provide an overview of reproductive coercion (RC), a type of intimate partner violence (IPV) that involves exerting power and control over contraceptive and/or pregnancy choices and outcomes. Authors define and discuss the most common forms of RC: birth control sabotage (deliberate interference with or inhibition of a woman's ability to obtain contraception); pregnancy pressure (pressuring a female partner to become pregnant when she does not want to); and pregnancy coercion (threats or acts of violence if partner does not comply with desired pregnancy outcome--terminate or continue pregnancy). While the predominant form of RC involves a male partner's dominance over a woman, women, same-sex partners, and intergenerational relations (i.e., parents or in-laws) can also engage in RC. Authors cite evidence that suggests building awareness of RC among providers, adolescents, and the general public can help to identify at-risk individuals. They recommend all females be universally assessed for IPV, regardless of perceived risk because evidence shows that RC can affect women of any age, race, sexual orientation, or sociodemographic group. Clinic signage can help normalize private interviews with patients as a routine part of appointments. Additionally, using a wallet-sized screening card to verbally assess patients has been proven effect. One study found a 71% reduction in the odds of pregnancy coercion among women in the intervention arm when compared with standard care at the follow-up 12-24 weeks later. The National Health Resource Center on Domestic Violence partnered with ACOG to create a Safety Card for Reproductive Health available online. Patients who are not comfortable speaking with their provider can take the card home for more information.

92. **Miller E., Jordan B., Levenson R., et al. Reproductive coercion: connecting the dots between partner violence and unintended pregnancy. *Contraception.* 2010;81(6):457-459.**

Miller et al. discuss evidence of the association between partner violence and unintended pregnancy and how it relates to the need for providers to consider reproductive coercion when counseling women regarding pregnancy prevention options (e.g., form of contraception). For example, teens may benefit from education and harm reduction strategies that focus on healthy relationships as they may not recognize controlling behaviors as abusive or coercive. Therefore, when working with teens who inconsistently use contraception (i.e., non-adherent), providers should consider assessment for partner violence and reproductive coercion rather than assuming the patient lacks motivation and education. The author also recommends comprehensive sexuality education curricula that discusses partner violence, reproductive coercion, and the contrast with healthy relationships as a strategy. This may support girls and women negotiate contraception and seek help for an unhealthy relationship. Similarly, prevention program directed at boys and men are necessary to promote healthy, respectful, gender-equitable relationships.

93. **US Committee on the Commercial Sexual Exploitations and Sex Trafficking of Minors in the. Press TNA.Confronting Commercial Sexual Exploitation and Sex Trafficking of Minors in the United States.Washington, D.C.2013.**

This Committee on the Commercial Sexual Exploitations and Sex Trafficking of Minors in the US report reflects a collaboration between the Committee, the U.S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention, the National Research Council, Institute of Medicine, and other experts in the field. Authors identify insurance status as a barrier to young victims and survivors of commercial sexual exploitation and sex trafficking accessing health care services. Authors note that the Affordable Care Act (2010) improved aspects of health care accessibility for former foster care youth (who disproportionately experience sexual violence and exploitation). As of 2014, states are required to extend Medicaid eligibility for young people formerly part of the foster care system until age 26 years. However, maintaining eligibility in Medicaid and CHIP can require frequent interactions with state or local agency, a process that may be challenging for young victims/survivors. The report discusses other structural barriers which limit young victims and survivors access to health care services and other social services, including: the requirement of personal identification documents (commonly held by trafficker); procedural challenges associated with independently applying for health insurance (e.g., Medicaid, Children's Health Insurance Program [CHIP]); distance, travel time, and availability of public transportation to services (e.g., for rural areas and Tribal communities). Authors cite evidence that local, state, and federal policies may limit the discussion of sexual health and risk of sexual exploitation in school-based programs, thereby acting as a barrier to safety and healthy relationship education for youth and adolescents. Additionally, fear of justice-involvement (e.g., prostitution charge) acts as a barrier to accessing health services in jurisdictions in which individuals 16-18 years of age can be tried in criminal courts as adults. Moreover, in clinical settings results from two U.S. based studies and one Canadian study indicate that the majority of providers did not feel confident in their ability to identify and assist victims/survivors of domestic sex trafficking. Evidence suggests that educational interventions can successfully increase knowledge and confidence in identifying and treating victims, yet further research is necessary to identify evidence-based effective training models. Language access can also act as a barrier to identifying victims and providing necessary services. To limit this barrier, researchers recommend conducting at least one portion of the appointment one-on-one with the patient with a culturally competent interpreter in the individual's preferred language rather than speaking through an English speaking family member. The report identifies various social barriers which also limit young victims and survivors access to health care, including: intimate partner violence; reproductive coercion; physical or sexual violence; confidentiality/privacy concerns; fear of criminal justice-involvement; etc. Additionally, provider bias, fear of discrimination and stigmatization, provider attitudes and beliefs, and provider fear of mandatory reporting can all influence an individual's access to necessary health services. For example, provider stereotypes and misperceptions can affect the likelihood of screening a patient. One study by the Department of Health and Human Services found that some health care providers stereotypically view commercial sexual exploitation and sex trafficking as primarily affecting young foreign adolescent girls. This may influence whether the screen for or recognize victims who are U.S. citizens, or who are male, or transgender as at risk of sexual exploitation and trafficking. Additionally, minors born in the U.S. but whose parents lack documented legal status in the U.S. may not seek care or assistance for fear of causing family deportation (e.g., parents). The complex intersectionality of identities can further limit access to health services.

94. **Schneider M., Hirsch J. S. Comprehensive Sexuality Education as a Primary Prevention Strategy for Sexual Violence Perpetration. *Trauma Violence Abuse*. 2018:1524838018772855.**

Schneider et al. examined the potential of K-12 comprehensive sexuality education, developed using the National Sexuality Education Standards, to be an effective strategy to reduce sexual violence perpetration. Historically, efforts to prevent sexual violence have focused on addressing risk factors that make someone likely to be victimized, rather than on the role of the perpetrator in violence. The authors argue that, "in order to achieve measurable reductions in violence, perpetration needs to be the focal point of intervention," but there are relatively few programs with demonstrated effectiveness in reducing perpetration behavior. They evaluate the potential of comprehensive sexual health education to reduce sexual violence perpetration. The authors provide an overview of the current state of sexual violence prevention efforts. They outlined nine characteristics of successful prevention efforts, including: comprehensiveness, varied teaching methods, sufficient dosage, theory-driven, fosters positive relationships, appropriately timed, sociocultural relevance, well-trained staff, and outcome evaluations. They note that comprehensive sexuality education programs based on the National Sexuality Education Standards meet these characteristics for successful violence prevention efforts. For example, "they emphasize age-appropriateness of topics covered, spanning kindergarten through 12th grade, with different learning objectives in each grade level, thereby ensuring that students are reached before the onset of any risk behaviors...[they also] recommend preserve teacher training, professional development, and ongoing mentoring to ensure that staff are well trained." They noted the importance of comprehensive sexual health education beginning in kindergarten to prevent child sexual abuse and because the formation of gender roles begins in early childhood. Specifically, "intervention beginning in kindergarten, before children have engrained gender norms that guide their self-concepts, motivations, and expectations of others, could mitigate the potential harm that comes from rigid- and hypermasculinity. Furthermore, early instruction to address gender stereotyping might create safer climates for LBGTQ and gender nonconforming students as they grow up."

95. **Niolon Phyllis Holditch, Kearns Megan, Dills Jenny, et al. Preventing Intimate Partner Violence Across the Lifespan: A Technical Package of Programs, Policies, and Practices. Atlanta, Georgia: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention; 2017.**

This technical package from the Centers for Disease Control and Prevention presents a select group of strategies based on the best available evidence to help communities and states prevent intimate partner violence (IPV) and its consequences across the lifespan. Strategies discussed include, "teaching safe and healthy relationship skills; engaging influential adults and peers; disrupting the developmental pathways toward IPV; creating protective environments; strengthening economic supports for families; and supporting survivors to increase safety and lessen harms." Strategies presented "focus on preventing IPV, including teen dating violence (TDV), from happening in the first place or to prevent it from continuing, as well as approaches to lessen the immediate and long-term harms of partner violence." Data from the National Intimate Partner and Sexual Violence Survey (NISVS) indicate that many racial/ethnic and sexual minority groups are disproportionately affected by IPV. For example, data indicate "the lifetime prevalence of experiencing contact sexual violence, physical violence, or stalking by an intimate partner is 57% among multi-racial women, 48% among American Indian/Alaska Native

women, 45% among non-Hispanic Black women, 37% among non-Hispanic White women, 34% among Hispanic women, and 18% among Asian-Pacific Islander women. The lifetime prevalence is 42% among multi-racial men, 41% among American Indian/Alaska Native men, 40% among non-Hispanic Black men, 30% among non-Hispanic White men, 30% among Hispanic men, and 14% among Asian-Pacific Islander men." Evidence indicates sexual minorities are also disproportionately affected by IPV victimization; "61% of bisexual women, 37% of bisexual men, 44% of lesbian women, 26% of gay men, 35% of heterosexual women, and 29% of heterosexual men experienced rape, physical violence, and/or stalking from an intimate partner in their lifetimes." Additionally, evidence shows that people living with a disability have nearly twice the lifetime risk of IPV victimization. Authors cite evidence which "indicates that IPV is most prevalent in adolescence and young adulthood and then begins to decline with age demonstrating the critical importance of early prevention efforts." Moreover, IPV is connected to other forms of violence, and research suggests that "boys and girls who experience TDV are at greater risk for suicidal ideation." Adverse health consequences of IPV include physical health outcomes (e.g., physical injury, death, and a range of cardiovascular, gastrointestinal, reproductive, musculoskeletal, and nervous system conditions, many of which are chronic); mental health outcomes (e.g., depression and posttraumatic stress disorder [PTSD]); and health risk behaviors (e.g., binge drinking and HIV risk behaviors). The strategies and approaches included in this CDC technical package represent "current best practices in the primary prevention of IPV and supporting survivors with the after effects of IPV." As evidence suggest that "acceptance of partner violence, poor emotional regulation and conflict management, and poor communication skills put individuals at risk for both perpetration and victimization of IPV," the CDC recommends teaching safe and healthy relationship skills. Specifically, "social-emotional learning programs for youth promote expectations for mutually respectful, caring, non-violent relationships [...] and help them develop social-emotional skills such as empathy, respect, and health communication and conflict resolution skills." Coupled with skills-based practice, this approach has the potential to: increase the use of health relationship skills; reduce perpetration/victimization of physical, sexual, and emotional IPV and stalking; reduce perpetration of peer violence (e.g., bullying); reduce high-risk sexual behaviors; reduce attitudes that accept violence in relationships; increase relationship satisfaction and well-being; reduce substance abuse; and reduce weapons-carrying. Safe Dates, a school-based program focused on the promotion of healthy relationships and prevention of TDV, was evaluated in a randomized controlled trial. Results showed a reduction of both perpetration and victimization of physical and sexual dating violence and were sustained at four-year follow-up, into late-adolescence. "Students exposed to the program reported between 56% and 92% less perpetration and victimization, respectively, at four-year follow-up when compared to control students, and program effects were consistent across gender, race, and baseline experience with TDV." Another program, The Fourth R: Strategies for Healthy Teen Relationships focuses on personal safety and injury prevention, healthy growth and sexuality, and substance abuse. It was evaluated in a randomized controlled trial, and results showed that boys in the intervention were nearly three times less likely to report perpetration than boys in the control condition 2.5 years after baseline. There was no significant effect on girls' perpetration. Meanwhile, Expect Respect Support Groups (ERSG) is a socio-emotional learning approach designed for teens who are in an abusive relationship or who have experienced any form of violence or abuse. Weekly sessions are led by trained facilitators. An evaluation of the 24-session curriculum found "beneficial effects for both boys and girls in regard to reactive and proactive aggression, but is most

effective for at-risk boys in regards to TDV perpetration and victimization." Other strategies discussed include, engaging influential adults and peers; disrupting the developmental pathways toward partner violence; creating protective environments; strengthening economic supports for families; and supporting survivors to increase safety and lessen harms. The strategies and approaches reviewed represent the best available evidence to address IPV and have demonstrated impact on rates of IPV or on risk and protective factors for IPV.

96. Smith Sharon G., Zhang Xinjian, Basile Kathleen C., et al. The National Intimate Partner and Sexual Violence Survey: 2015 Data Brief – Updated Release. Atlanta, Georgia: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention; 2018.

In 2010 the CDC's National Center for Injury Prevention and Control launched the National Intimate Partner and Sexual Violence Survey (NISVS) an "ongoing, nationally representative survey that assesses sexual violence, stalking, and intimate partner violence victimization among adult women and men in the United States." Authors report, "[s]exual violence, stalking, and intimate partner violence are serious public health problems affecting millions of people in the United States each year. These forms of violence are associated with chronic physical and psychological adverse health conditions, and violence experienced as a child or adolescent is a risk factor for repeated victimization as an adult." This brief report presents the highlights from the 2015 data year of NISVS. The estimates presented in the report are based on a total of 10,081 completed interviews (5,758 women and 4,323 men) conducted between April and September 2015. Respondents were English- or Spanish-speaking persons aged 18 years and older, and surveys were conducted in all 50 states and the District of Columbia. Results indicate that during their lifetime, "1 in 5 women experienced completed or attempted rape; 1 in 6 women were stalked; and 1 in 4 experienced contact sexual violence, physical violence, and/or stalking by an intimate partner and reported some form of intimate partner violence-related impact." Additionally, findings indicate that violence often begins early in life. For example, "[a]mong female victims of completed or attempted rape, 43.2% (an estimated 11.0 million victims) reported that it first occurred prior to age 18, with 30.5% (about 7.8 million victims) reporting that their first victimization occurred between the ages of 11 and 17, and 12.7% (an estimated 3.2 million victims) at age 10 or younger." Moreover, 1 in 4 female victims (25.8% or approximately 11.3 million victims) of intimate partner violence reported their first experience occurred before the age of 18. Results from male survey respondents indicate that "during their lifetime, 1 in 14 men were made to sexually penetrate someone else; 1 in 17 men were stalked; and 1 in 10 experienced contact sexual violence, physical violence, and/or stalking by an intimate partner and reported some form of intimate partner violence-related impact." Like female respondents, male respondents also reported victimizations early in life. For example, "[a]mong male victims of completed or attempted rape, 51.3% (about 1.5 million victims) first experienced such victimization prior to age 18, with 25.3% (718,000 victims) reporting that their first victimization occurred between the ages of 11 and 17 and 26.0% (738,000 victims) at age 10 or younger." Furthermore, 25.9% (an estimated 2.0 million victims) of male victims of completed or attempted made to penetrate reported their first victimization occurred before the age of 18, and 19.2% (1.5 million victims) reported that it first occurred between the ages of 11 and 17. Specific to intimate partner violence, 14.6% of male victims (5.4 million victims) first experienced such victimization before age 18. Noted survey limitations include: challenges associated with random-digit-dial telephone surveys; the design as a household survey did not reach those who

are institutionalized or residing in healthcare facilities, shelters, military bases, etc.; a likely underestimate of the true prevalence; the vulnerability of self-report data to recall bias and telescoping (report incidents occurring more recently than they actually did); the design of the IPV impact questions capture context of victimization with specific perpetrators and cannot assess impacts of specific types of violence; and not always able to determine the age at first victimization for specific types of violence. See further discussion on page 12 of the CDC brief. Researchers noted that CDC published technical packages for sexual violence, intimate partner violence, and etc., which include prevention strategies based on the best available evidence.

97. **Breuner Cora C., Mattson Gerri. Sexuality Education for Children and Adolescents. *Pediatrics*. 2016;138(2).**

This clinical report from the American Academy of Pediatrics provided updated research on evidence-based sexual and reproductive health education. It discusses the role of pediatricians in educating their patients and their parents about developmentally appropriate stages of sexual development. Furthermore, it outlines the complementary roles parents (primary sexuality educators) and schools (formal comprehensive sexual health education) play. Authors also cite evidence to demonstrate the importance of sexuality education. For example, 2011 National Survey of Family Growth data show that 11% of female and male subjects aged 18 to 24 years who had first intercourse before age 20 years reported unwanted first sexual encounters. Additionally, authors note that those who reported first sex at age 14 years and younger were more likely to report that it was nonvoluntary, compared with those who were age 17 to 19 years at sexual debut. "Unwanted sexual encounters may include dating violence, stranger assaults, and intrafamilial sexual abuse/incest."