Reforming Sexual Health Education in Minnesota Schools: An Evidence-Based Approach

Antonia Kurtz

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REFORMING SEXUAL HEALTH EDUCATION IN MINNESOTA SCHOOLS: AN EVIDENCE-BASED APPROACH

Antonia Kurtz

TABLE OF CONTENTS

INTRODUCTION .............................................................................................................................. 34
I. THE EVOLVING PURPOSE OF SEXUAL HEALTH EDUCATION .................................................... 35
   A. The Abstinence Era ............................................................................................................... 35
   B. The Failure of Abstinence-Only Education ................................................................ 38
   C. The Move Toward Comprehensive Sex Education ............................................................... 41
II. THE FUTURE OF SEXUAL HEALTH EDUCATION IN MINNESOTA .............................................. 43
   A. Minnesota’s Current Sexual Health Education Requirements ............................................. 43
   B. Effectiveness of Minnesota’s Current Sexual Health Education Requirements ................... 44
   C. A Proposed Evidence Based Model ..................................................................................... 47
   D. Recommendations ................................................................................................................ 48
      1. Discussion of Abstinence .............................................................................................. 49
      2. Parental Opt-Out .......................................................................................................... 50
      3. District Opt-Out ............................................................................................................ 51
      4. Authority Considered .................................................................................................... 52
      5. Further MDH Involvement ........................................................................................... 53
   E. Overcoming Barriers to Implementing Comprehensive Sexual Health Education Curriculum in Minnesota ........................................................................................................................................... 53
      1. Funding and Time Allocations for Creating a Model Sexual Health Education Program ................................................................................................................................ 54
      2. Partisan Views on Sexual Health Education: Myth v. Reality ...................................... 55
      3. Sources and Stakeholders ............................................................................................. 56
      4. Institutional Distrust ..................................................................................................... 57
      5. Lack of Specificity ......................................................................................................... 59
      6. Criticism of Imposing Value Judgments on Students .................................................... 60
CONCLUSION .................................................................................................................................. 62

* Antonia Kurtz, J.D. candidate 2021 at Mitchell Hamline School of Law. The author is a third-year law student, serves as a Writing Associate for the Mitchell Hamline Law Journal of Public Policy and Practice, a former TEFL teacher and a former legislative assistant for Senator Kevin Dahle. Kevin Dahle is a former member of the Minnesota Senate and former member of the education policy and finance committees.
INTRODUCTION

The conversation around sexual health education has changed. Sexual health education in public schools was once viewed as contentious by policy makers who saw the issue as a political minefield as it implicated religion, morality, and sexuality—all deeply personal and controversial topics.¹ However, policy makers are starting to understand the benefits of a well-structured sexual health education system as evidence consistently shows that comprehensive sexual health education benefits the lives of students and is an important arrow in the quiver of public health initiatives in Minnesota.²

Minnesota policy makers are starting to take note of the importance of sexual health education in Minnesota’s curriculum. During the 2019 legislative session, State Representative Todd Lippert authored a bill that required the Minnesota Department of Education (MDE) to develop, and help school districts implement as statewide curricula, a comprehensive sexual health education plan for public schools in Minnesota.³ While this bill ultimately failed, the conversation around sexual health education surely did not end.⁴ As Minnesota and other states start to fully understand the impact sexual health education can have on children, the role of schools and even the economy, the question remains: how can Minnesota best structure its sexual health education system in order to avoid inadequate and inconsistent public health results?

¹ America’s Sex Education: How We Are Failing Our Students, UNIV. S. CAL. DEP’T NURSING BLOG (Sept. 18, 2017), https://nursing.usc.edu/blog/americas-sex-education/ (“‘It’s hard to get legislators behind comprehensive sex ed,’ said Nash, who explained that campaigning on controversial and sensitive topics can make lawmakers uncomfortable.”).
⁴ Id.
While mandating comprehensive sexual health education in schools has become a popular solution for many states, Minnesota has not yet followed suit. There are barriers to passing a bill mandating comprehensive sexual health education in Minnesota schools, but a need for this type of education continues to exist. Fully educating Minnesota students about the impact that sexual health has on themselves and their communities is more important than it ever has been. While Minnesota must overcome political, religious, and administrative barriers in order to mandate comprehensive sexual health education in schools, if Minnesota policy makers learn from past mistakes, they are well equipped to do so.

I. THE EVOLVING PURPOSE OF SEXUAL HEALTH EDUCATION

A. The Abstinence Era

Since the start of sexual health education, a main purpose has always been to prevent unwanted pregnancy and stop the spread of sexually transmitted diseases. However, traditionally these aims were thought to best be accomplished by abstinence only education—or advocating for the complete refraining of sexual activity outside of wedlock.\(^5\) Much of abstinence only education is based in the students’ character and morality, with underpinnings of conservative culture and religiosity.\(^6\) The religious nature of abstinence only education has been challenged as religion impermissibly being incorporated into public school curriculum.\(^7\)


\(^6\) Id. at § 1.2.

Urbanization in the late 1800s and early 1900s spurred interest in organized sexual health education. However, sexual health education was not viewed as an important public health initiative until World War I when an increase in young soldiers abroad caused an increase in sexually transmitted diseases. Congress passed The Chamberlain-Kahn Act in 1918 that funded sexual health education geared towards soldiers with an aim of reducing sexually transmitted diseases. Throughout the decades, interest in sexual health education expanded, eventually making its way to college campuses. While sexual health education became more popular in the mid-twentieth century, this education largely consisted of abstinence only education and used scare tactics to educate. Most of this sexual health education was taught through film, popular titles being Damaged Goods and The Gift of Life.

Sexual health education first became commonplace in secondary schools in the 1960s, perhaps because of changing ideas about sex in culture during this era. During this time, whether sexual health education should be taught in schools was fiercely debated with prominent religious organizations remaining staunchly opposed. However, sexual health education gained popularity by the 1980s and it was clear by this point that sexual health education in public schools was here to stay. The first federal support for sexual health education came in the form

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9 Id.
11 Cornblatt, supra note 8.
12 Id.
13 Id.
15 Id. at 7.
16 Id.
of a seven-million-dollar appropriation from the 1981 Adolescent Family Life Act.\textsuperscript{17} This funding was intended to be used to promote premarital abstinence, discourage abortion, and promote adoption.\textsuperscript{18} This program continued to grow into the 1990s.\textsuperscript{19} Federal funding for abstinence only sexual health education was expanded in 1996 in a welfare appropriation act during the Clinton era and continued to increase through various federal programs and appropriations into the 2000s.\textsuperscript{20} However, as funding for sexual health education grew, so did the discord over what content sexual health education in public schools should include. The federal government first allocated funding for comprehensive sexual health education in 2009.\textsuperscript{21} In 2010, funding for comprehensive sexual health education surpassed that of abstinence only sexual health education programs with $50 million being allocated to abstinence only sexual health education programs and $185 million being allocated to comprehensive sexual health education programs, particularly the new Teen Pregnancy Prevention Program promulgated by the Obama administration.\textsuperscript{22}

However, funding for abstinence-only sexual health education appears to be making a resurgence on the federal level. Former President Donald Trump’s proposed 2020 federal budget did not include funding for the Teen Pregnancy Prevention Program at all, with no comprehensive sexual health education program proposed to replace it even though two years

\textsuperscript{18} Kantor et al., supra note 14.  
\textsuperscript{19} Id.  
\textsuperscript{20} Id. at 7–8.  
\textsuperscript{21} Id.  
\textsuperscript{22} Megan K. Donovan, The Looming Threat to Sex Education: A Resurgence of Federal Funding for Abstinence-Only Programs?, 20 GUTTMACHER POL’Y REV. 44, 45 (2017).
remained in the program’s five-year grant. While Trump’s proposal did not become law, it signaled a potential return to the era of abstinence-only sexual health education.

B. The Failure of Abstinence-Only Education

Abstinence is often touted as being one hundred percent effective as a form of birth control and STI (sexually transmitted infection) prevention. However, this information is misleading as many adolescents fail to remain abstinent. A 2017 Centers for Disease Control and Prevention (CDC) study found that an estimated fifty-five percent of male and female teens have had sexual intercourse by age eighteen.

The most compelling argument for ending abstinence-only sexual health education is that study after study shows that it simply does not work. Overwhelmingly, the data shows that teenage pregnancies are positively correlated with abstinence education models. That being said, teenage pregnancy is not the only social harm correlated with abstinence education models.

Additional evidence shows that STIs (sexually transmitted infections) and unplanned pregnancies affect youth more than older demographics. For example, seventy-five percent of pregnancies were unintended among teens aged fifteen to nineteen years. In contrast, only forty-

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five percent of pregnancies in the United States for all age ranges were overall unintended.\textsuperscript{26} Furthermore, evidence shows that twenty-five percent of new HIV (human immunodeficiency virus) cases occur among adolescents less than twenty-two years of age.\textsuperscript{27} An estimated 18.9 million STIs occurred in 2000 in the United States; almost half of these in adolescents and young adults under twenty-five.\textsuperscript{28} Homosexual men and heterosexual minority women are disproportionately infected with HIV.\textsuperscript{29}

Even if eventually treated, the long term consequences of STIs can include infertility, cervical cancer, and chronic pain.\textsuperscript{30} Higher rates of non-white teenagers engage in sexual intercourse, meaning that the failures of sexual health education fall disproportionately on the shoulders of non-white youth.\textsuperscript{31} Unintended pregnancy is one of the earliest identifiable risk-factors for child maltreatment and also has a positive correlation with pre-term birth.\textsuperscript{32}

For the above reasons, many prominent health organizations like the American Academy of Pediatrics, the Society for Adolescent Health and Medicine, the American Medical Association, the American Public Health Association, the National Education Association, the National School Boards Association, and the Minnesota Department of Health have expressed

\begin{itemize}
\item \textsuperscript{27} Santelli et al., \textit{Abstinence-Only-Education, supra} note 25, at 74.
\item \textsuperscript{28} Id.
\item \textsuperscript{29} Id.
\item \textsuperscript{30} Id.
\item \textsuperscript{31} ABMA & MARTINEZ, \textit{supra} note 24, at 5.
\end{itemize}
their disapproval with the efficacy of abstinence-only education and urged policymakers to embrace a comprehensive sexual health education model.\textsuperscript{33}

The far-reaching consequences of inadequate family planning education have only just started to be understood. U.S. taxpayers spend more than twelve billion dollars each year on 1.25 million unintended pregnancies through the funding of the Children’s Health Insurance Program (CHIP), and 103 million dollars is allocated to abortion services.\textsuperscript{34} However, money spent on health interventions for unplanned pregnancy is just the tip of the iceberg.

In a 2015 Iranian study, researchers looked at the correlation between comprehensive sexual health education and the economy in response to the Iranian government’s decreased spending on comprehensive sexual health education.\textsuperscript{35} Any working parent with a small child would likely tell you that having a small child negatively impacts their ability to excel in the workplace. Research supports this theory. The Iranian study found that unplanned pregnancies


\textsuperscript{35} Mansureh Yazdkhasti et al., Unintended Pregnancy and Its Adverse Social and Economic Consequences on Health System: A Narrative Review Article, 44(1) IRAN J. PUB. HEALTH 12, 14 (2015).
were positively correlated with a range of negative economic outcomes like labor market challenges and an increasing number of working days lost.\textsuperscript{36}

The study also found that public health interventions to quell unplanned pregnancy had a positive impact on the economy.\textsuperscript{37} Further, state and federal public insurance programs paid for sixty-eight percent of the 1.5 million unplanned births that year, compared with thirty-eight percent of planned births. Federal and state governments together spent an average of $336 on unintended pregnancies for every woman aged fifteen to forty-four in the country.\textsuperscript{38}

While the burden unplanned pregnancies inflict upon society is clear, the problem is also cyclical. There is a strong and positive correlation showing that teenage mothers often had mothers who were similarly teenage mothers themselves.\textsuperscript{39} This means that an unplanned teen pregnancy can lead to a familial cycle of unplanned teen pregnancy which results in a cycle of the personal, social, and economic consequences that follow.

Thus, there is clear evidence that the economy, labor productivity, and population health of a community suffer when unplanned pregnancies increase. Government intervention, like comprehensive sexual health education, can help to prevent economic harm caused by unplanned pregnancies.\textsuperscript{40}

\textit{C. The Move Toward Comprehensive Sex Education}

\textsuperscript{36} \textit{Id.} at 16.
\textsuperscript{37} \textit{Id.}
\textsuperscript{39} Christina S. Meade et al., \textit{The Intergenerational Cycle of Teenage Motherhood: An Ecological Approach}, 27(4) HEALTH PSYCH. 419, 427 (2008).
\textsuperscript{40} SONFIELD & KOST, \textit{supra} note 38.
Given the failure of abstinence-only sexual health education, many states have moved toward a comprehensive sex education model, or programs containing information about ways to prevent unwanted pregnancies and sexually transmitted diseases other than abstinence.\textsuperscript{41} Comprehensive sex education also covers a broad range of issues relating to the physical, biological, emotional, and social aspects of sexuality.\textsuperscript{42} This approach recognizes and accepts all people as sexual beings and is concerned with more than just the prevention of disease or pregnancy.\textsuperscript{43} Comprehensive sex education, as generally understood by policymakers and scholars, includes teachings about gender equality and sexual diversity, provides information on consent and healthy relationships, discusses how the internet and social media interacts with sexuality, and encourages use of birth control implants.\textsuperscript{44} Comprehensive sexual health education has fared better in an overwhelming number of studies that show this type of sex education decreases unwanted pregnancy and “sexually risky” behaviors that result in higher levels of STI transmission.\textsuperscript{45} Minnesota students report that they believe sexual health education should cover a wide range of sexual health topics, including the social and emotional aspects of sexuality and relationships, and that they favor an open, honest, comfortable, and nonjudgmental teaching style.\textsuperscript{46} Each of these preferences is a central focus in comprehensive sexual health education models.

\textsuperscript{41} Sex And Sensibility: Public School Sex Education And The Religious Right, supra note 7.
\textsuperscript{43} Id.
\textsuperscript{45} Leung, supra note 5.
\textsuperscript{46} Maria E. Eisenberg et al., Viewpoints of Minnesota Students on School-Based Sexuality Education, 67(8) J. SCH, HEALTH 322 (1997).
There is currently no federally mandated standard for teaching sexual health education, and state laws mandating sexual health education vary widely. As of May 2020, only twenty-eight states call for sex education, sixteen states mandate instruction on contraception, eight states require schools to provide accurate information if they provide sexual health education and thirty-five states require schools to stress abstinence if they provide sexual health education to students.\textsuperscript{47} Additionally, several states’ sexual health education policies stigmatize homosexuality and only a few states require teaching communication about sexual consent.\textsuperscript{48}

While many states are starting to embrace aspects of a comprehensive model, many states have not changed their policies in the light of evidence that abstinence-only education does not work, and many still have yet to implement statewide policies mandating any sort of model.

\section*{II. The Future of Sexual Health Education in Minnesota}

\subsection*{A. Minnesota’s Current Sexual Health Education Requirements}

In Minnesota, the only current requirements for sex education in public schools are that a sex education curriculum must be taught, it must involve cooperation between school districts and student organizations, and it must be technically accurate and updated.\textsuperscript{49} Minnesota also mandates that the curriculum must help students refrain from sexual activity until marriage.\textsuperscript{50} While Minn. Stat. § 121A.23 states that sexual health education curricula must include “a targeting of adolescents, especially those who may be at high risk of contracting sexually


\textsuperscript{48} William J. Hall et al., \textit{State Policy on School-Based Sex Education: A Content Analysis Focused on Sexual Behaviors, Relationships, and Identities}, 43(3) AM. J. HEALTH BEHAV. 506 (2019).

\textsuperscript{49} MINN. STAT. § 121A.23 (2017).

\textsuperscript{50} Id.
transmitted infections and diseases, for prevention efforts;” the statute does not note whether this
aim has to be accomplished by anything other than abstinence-only education.51 Notably, the
statute is void if any mandate that pregnancy or STI prevention be accomplished by anything
other than abstinence-only sexual health education.52 Because of the indistinct nature of the
statute, sexual health education is allowed to vary widely from district to district with little
oversight or direction from MDE, the Minnesota Department of Health (MDH) or any other
competent governmental body. There is no oversight beyond the district level in the sexual
health education curriculum process as long as Minnesota schools meet the vague components of
the statute.53 The last time Minn. Stat. § 121A.23 was substantively amended was in 1998 when
the statute was modified to mandate districts that provide sexual health education include
information “that includes helping students to abstain from sexual activity until marriage.”54

B. Effectiveness of Minnesota’s Current Sexual Health Education Requirements

While nationwide statistics show a correlation between abstinence-only sexual health
education, teenage pregnancies and sexually transmitted diseases, the data regarding this
correlation in Minnesota is less clear.55 In Minnesota, both pregnancy and birth rates are at
historic lows.56 Since 1990, the pregnancy rate has declined seventy-two percent and the birth
rate has declined sixty-seven percent.57 From 2016 to 2017, the number of pregnancies among

51 Id.
52 Id.
53 Id.
54 Id.
55 Santelli et al., Abstinence-Only-Until-Marriage, supra note 25, at 278; Stanger-Hall & Hall, supra note 25, at 6;
Santiago-Taylor, supra note 25, at 177; Santelli et al., Abstinence-Only-Education, supra note 25, at 73.
56 2018 Minnesota Health Statistics Annual Summary, MINN. DEP’T OF HEALTH (Dec. 31, 2019),
57 Id.
adolescents fifteen and younger decreased thirty-nine percent and the number of births decreased twenty percent. Experts believe that recent declines have in part been caused by increased use of highly effective contraceptive methods like IUDs (Intrauterine Devices) and implants.

However, Minnesota adolescents experience a disproportionately high rate of sexually transmitted infections. Although they account for only 6.4% of the population in Minnesota, adolescents aged fifteen to nineteen accounted for twenty-five percent of chlamydia and seventeen percent of gonorrhea cases in Minnesota in 2018. Rates of chlamydia and gonorrhea in Minnesota youth are at an all-time high, suggesting that although long-term birth control options are widely used, traditional barrier methods are currently underused.

Although the numbers of pregnancies and births are larger in the Twin Cities metropolitan area, the rates of pregnancies and births are higher in Greater Minnesota. STIs are widespread throughout the state. In rural areas, access to sexual health care clinics is more

58 Id.
61 STD Surveillance Report Data Tables, supra note 60; American Community Survey—Minnesota, supra note 60.
63 Id.
64 Id.
limited than access to these clinics in urban areas. There are large geographic disparities in sexual health clinics’ hours of availability and distance to services. For example, there are eighteen sexual health clinics in Hennepin and Ramsey Counties with services available five days per week.65 In contrast, almost half of rural counties in Minnesota have no clinic specifically focused on sexual health.66 From 2015 to 2017, teen pregnancy rates decreased among adolescents who identify as White, Asian and or Pacific Islander, Black, or Hispanic while birth rates increased among adolescents who identify as American Indian, evidencing a racial disparity among Minnesota youth’s sexual health.67 Even for Black and Hispanic populations, birth rates did not decrease substantially compared to the birth rate of White teens.68

Further, while rates of sexual abuse and sexual assault in Minnesota youth are overall trending downward, girls, transgender, non-binary, gay, lesbian, bisexual, students with disabilities, socio-economically diverse, and non-white students report significantly higher rates of sexual abuse than their counterparts.69 While it could be argued that these populations tend to live in urban areas and therefore their urban status is more causal of experiencing sexual abuse than their minority status, this argument is most likely dispersed because statistics of sexual assault are self-reported, meaning that perhaps rural and suburban youth experience comparable

66 FARRIS ET AL., supra note 65.
68 Id.
rates of sexual abuse but are not aware these actions are abusive because of their lack of education about sexual abuse.

While Minnesota may have decreased teen pregnancy rates because of the rise in popularity of more effective birth control options, Minnesota’s STI rates and racial and geographic disparities in the area of teen sexual health and safety are concerning issues that call for a state-wide solution.

C. A Proposed Evidence Based Model

Representative Lippert’s 2019 bill, H.F. 1414, would have mandated comprehensive sexual health education throughout school districts across Minnesota. Specifically, H.F. 1414, if implemented, would have mandated that MDE create a model program for elementary and secondary school students that provided training and resources to educators. Substantively, the bill mandated that sexual health education curriculum cover medically accurate instruction that is age and developmentally appropriate on human anatomy, reproduction and sexual development; consent, bodily autonomy, and healthy relationships, including relationships involving diverse sexual orientations and gender identities, as well as abstinence and other methods for preventing pregnancy and STIs and the relationship between substance abuse and sexual behavior and health. Additionally, if implemented, H.F. 1414 would have mandated that sexual health programming respected community values and encouraged students to communicate with trusted adults about sexuality and intimate relationships, responded to culturally diverse individuals, families and communities in an inclusive, respectful, and effective manner, and provided

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71 Id. § 1 subdiv. 1(a)–(b).
72 Id. § 1 subdiv. 1(b)(1)–(4).
students with information about local resources where they may obtain medically accurate
information and services related to sexual and reproductive health, dating violence, and sexual
assault.\textsuperscript{73}

The bill also set forth a procedure for school districts opting out of the statewide sexual
health education plan in lieu of a district’s preferred program and mandated that MDE produce a
report including a description of how a model program was identified, assistance provided to
schools in implementing a comprehensive program, the number of school districts that adopted
the model program, and a list of Minnesota districts that implemented their own program.\textsuperscript{74}

However, this bill’s proposals still do not go as far as some other states. For instance,
H.F. 1414 mandates a discussion of abstinence with few parameters about how to discuss
abstinence.\textsuperscript{75} If made law, the bill would include the option for parents to opt out of sexual health
education altogether.\textsuperscript{76} H.F. 1414 would also allow school districts to opt out of the model
program created by the MDE in lieu of a district-created program.\textsuperscript{77} Further, H.F. 1414 lacks a
provision mandating involvement from the MDH in the content, method, and mode of
instruction.\textsuperscript{78}

While the change to a comprehensive sexual health education model in Minnesota is
welcome because of the evidence discussed in Section I, H.F. 1414 still would fail Minnesota
students in several key ways.

\textit{D. Recommendations}

\textsuperscript{73} Id. \textsection 2.
\textsuperscript{74} Id.
\textsuperscript{75} Id. \textsection 1 subdiv. 1(b)(3).
\textsuperscript{76} Id.
\textsuperscript{77} Id. \textsection 1 subdiv. 2(b).
\textsuperscript{78} Id.
Regardless of the imperfect nature of this bill, H.F. 1414 would have been a step in the right direction for improving Minnesota students’ sexual knowledge and health. However, some of the provisions in the bill meant to appease conservative legislators may have created more political issues than they resolved. Additionally, several provisions in the bill meant to create flexibility for districts either substantially watered down the bill or allowed legislators to make assumptions regarding the content taught, which was vehemently expressed during a lively discussion of the bill on the floor of the Minnesota House of Representatives.79

1. Discussion of Abstinence

While a discussion of abstinence in itself is not necessarily unwise considering many youth decide to stay abstinent during high school, H.F. 1414 only mandates that “[t]he model program must include medically accurate instruction that is age and developmentally appropriate on . . . abstinence . . . ”80 H.F. 1414 does not mandate whether abstinence must be stressed, dissuaded, or what precisely Minnesota youth should be taught about abstinence, beyond that the information taught must be “medically accurate.”81 H.F. 1414 does not require that abstinence not be the central teaching of the individual district’s sexual health education program or even that students not be asked to sign “virginity pledges” or take part in other abstinence-centric, value based teachings.82 Moreover, H.F. 1414 does not dictate that students be given information about the number of youth who attempt and fail to maintain abstinence or the sexual health

80 H.F. 1414, 91st Leg., Reg. Sess. § 1 subdiv. 1(b)(3).
81 Id. § 1 subdiv. 2(a)(3).
82 Id.; Hannah Bruckner & Peter Bearman, After the Promise: The STD Consequences of Adolescent Virginity Pledges, 36(4) J. ADOLESCENT HEALTH 271 (2005) (“[Virginity pledgers] STD infection rate does not differ from nonpledgers. Possible explanations are that pledgers are less likely than others to use condoms at sexual debut and to be tested and diagnosed with STDs.”).
outcomes of this group. Considering the immense failure of abstinence-only education, efforts in a future proposal should delineate what percentage of time should be spent discussing abstinence—ensuring that Minnesota students are given accurate, impartial information regarding their decision to remain sexually abstinent—and discussing both advantages and disadvantages of committing to remain abstinent throughout high school and beyond.

2. Parental Opt-Out

H.F. 1414 mandates that a school district must allow parental review of the sexual health education curriculum and an option for parents to choose alternative programming, including allowing parents to provide the instruction in lieu of the school district. This effectively allows parents to entirely opt out of comprehensive sexual health education curriculum altogether, regardless of the merit of their concerns. Presumably, this provision of the bill would disproportionately affect rural areas whose residents are more conservative, and are less open to comprehensive sexual health education being taught in schools, and more likely to choose to opt out of a comprehensive sexual health education program. While mandatory statewide comprehensive sexual health education would increase the sexual health and safety of Minnesota youth overall, if rural districts had a high parental opt-out rate, this bill overall would only exacerbate the existing divide between rural, suburban and urban sexual health education and

84 Santelli et al., Abstinence-Only-Until-Marriage, supra note 25, at 278.
85 H.F. 1414, 91st Leg., Reg. Sess. (Minn. 2019); see also MINN. STAT. § 120B.20.
86 H.F. 1414, 91st Leg., Reg. Sess. (Minn. 2019); Leslie Kantor & Nicole Levitz, Parents’ Views on Sex Education in Schools: How Much Do Democrats and Republicans Agree?, 12(7) PLoS ONE 1, 5 (2017) (“[T]here were differences in support by political affiliation for two topics: sexual orientation and birth control. For sexual orientation, 92.0 percent of Democrats said it should be included in high school sex education programs compared to 74.9 percent of Republicans. For birth control, 97.9 percent of Democrats said it should be included in high school sex education compared to 89.3 percent of Republicans.”).
resources. Thus, a parental opt-out provision should not be included in a future bill mandating comprehensive sexual health education in order to improve sexual health and safety proportionately state-wide.

3. District Opt-Out

While the district-created program would still need to be approved by MDE, this provision of the bill allows every school district choose their own sexual health education program and renders the proposed statutory mandate less of a mandate and more of a recommendation. Additionally, H.F. 1414’s “opt out” provision allows districts to implement their own plan, if approved by MDE, regardless of the content of the plan. This renders the strides made in the bill effectively null as long as MDE is willing to allow the district a variance. Proponents of the bill might argue that this provision builds in flexibility by allowing more conservative districts in Minnesota the option to write their own abstinence-only sexual health curriculum. However, the failure of these abstinence-only programs will affect all of Minnesota’s economy. Conservative districts in Minnesota are largely rural. This means that rural children, who already bear the brunt of sexual health issues in Minnesota and lack of access to sexual health resources, will disproportionately suffer the social costs of abstinence-only education explored in Section I of this article. Thus, a district should not be permitted to opt-out of a comprehensive sexual health education model.

87 See discussion supra Sections I.C, II.C.
89 Id.
91 See discussion supra Section I.
4. Authority Considered

While stressing the importance of accurate sexual health education, H.F. 1414 does not note what authority should be considered in providing accurate sexual health education.\textsuperscript{92} The bill does state that the model program should be created “in consultation with the commissioner of health and other qualified experts.”\textsuperscript{93} However, the bill notably does not mandate how much or which parts of the instruction should come from MDH. The bill also lacks a provision mandating any concrete involvement or cooperation with MDH.

A parallel bill—perhaps more appropriately introduced through the Health and Human Services Committees of the Minnesota Legislature—should mandate MDH to publish updated recommendations annually regarding sexual health education in Minnesota schools and the education bill should read that MDE should implement these recommendations into their curriculum. While MDE is arguably better tasked with determining modes of instruction, assessments, and age-appropriate learning, MDH specializes in public health education and better understands the sexual health needs of the community than MDE, and therefore is a better resource for the content of a state-wide sexual health education program. MDH is a crucial resource for MDE in terms of determining the validity of the sexual health information taught in these programs, aligning instruction with the current sexual health issues facing Minnesotans, and understanding what sexual health information is needed at different ages. MDH also has the impetus to provide useful, unbiased information likely to prevent sexual health issues because MDH is the agency that grapples with the fallout when sexual health education, and other

\textsuperscript{92} H.F. 1414, 91st Leg., Reg. Sess. (Minn. 2019).
\textsuperscript{93} Id. § 1 subdiv. 1(a).
preventative sexual health interventions, do not prevent sexual health issues in Minnesota communities.

5. *Further MDH Involvement*

Finally, H.F. 1414 does not mandate when sexual health education should be provided, who should teach it or what exactly should be taught. DE should follow evidence-based recommendations from the Centers for Disease Control and Prevention, MDH, and other credible, empirical government sources regarding when sexual health information should be introduced to children, how many hours of sexual health education is optimal, and what type or training sexual health teachers should have to best prevent unplanned pregnancy and sexually transmitted diseases. Because concrete recommendations by MDH are scarce regarding sexual health education in schools, perhaps because of the lack of willingness on behalf of policy makers to adopt recommendations, MDH should study and publish recommendations on when, how, and who must provide sexual health education.

E. *Overcoming Barriers to Implementing Comprehensive Sexual Health Education Curriculum in Minnesota*

While evidence shows a comprehensive sexual health education is good for Minnesota’s community and economy, several barriers stand in the way of passing a mandatory comprehensive sexual health education bill into law. Not all disdain for comprehensive sexual health education can be avoided through strategic approach and careful drafting because of the personal, moral, and religious nature of the objections that have traditionally been raised to comprehensive sexual health education.94 However, some of the main concerns expressed by

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94 *America’s Sex Education*, supra note 1.
conservative legislators can be addressed in a way that preserves the bill’s purpose of improving Minnesotan’s public health.

1. Funding and Time Allocations for Creating a Model Sexual Health Education Program

While creating an entire new curriculum could be criticized as costly and time consuming, MDH already has several model curricula options available for school districts, faith communities, and others to use to educate Minnesota youth about sexual health.\(^\text{95}\) Each of these eight model programs are geared toward different ages and populations, one geared in a culturally appropriate way toward Native American youth, another geared toward youth in juvenile detention facilities, and even a more general sexual health education curriculum geared generally toward adolescents.\(^\text{96}\) While the existing model programs might need to be altered to fit a state wide model program that is adaptable for schools with different resources and schedules, it is not necessary for MDE use new resources and start from square one in creating a model sexual health education program.

Additionally, even if creating a model program used by every school in Minnesota would involve significant resources and time on behalf of MDE, the creation of this one model program would save each district significant amounts of time creating their own program from scratch. Unlike other subjects that might need a specific curriculum geared toward their geographic area, sexual health is a universal, biological issue with largely universal solutions that does not require a district centered approach.

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\(^\text{96}\) Id.
Also, even if creating a model program meant increased cost to MDE and/or MDH, the long term, tangential socioeconomic consequences of schools failing to teach comprehensive sexual health education would perhaps surpass that of allocating funding on the front end to address sexual health.97

Thus, in contrast to the argument that creating a sexual health education system would mandate extra resources and time on the part of government agencies, streamlining the sexual health education curriculum process by mandating a state-wide solution instead of each district creating their own curriculum would effectuate a more efficient use of government resources.

2. Partisan Views on Sexual Health Education: Myth v. Reality

Generally, Republican legislators more often oppose passing bills mandating statewide comprehensive sexual health education than Democratic legislators.98 While conservative legislators might worry that there would be pushback in their districts by passing a comprehensive sexual health education bill, research shows otherwise. A 2017 study found that more than 93 percent of parents of children aged nine to twenty-one place high importance on sex education in both middle and high school.99 While Democratic parents have a higher rate of support for various sexual health education topics like sexual orientation, a majority of Republicans support puberty, healthy relationships, birth control, sexually transmitted diseases, and sexual orientation being taught about in both middle and high school. When controlling for

97 See Yazdkhasti, supra note 35, at 5.
99 Kantor & Levitz, supra note 87.
race/ethnicity, income, employment, marital status, gender, and education, the difference between sexual health education opinions between Democrat and Republican parents move close to zero.  

Perhaps if Republican legislators understood the true opinions and beliefs of the constituents they serve, they would feel less beholden to a vocal, minority group that opposes comprehensive sexual health education in their districts, and they would more objectively consider the evidence in favor of comprehensive sexual health education.

3. Sources and Stakeholders

A major criticism from conservative policy makers about H.F. 1414 was that language from the bill was similar to language found on Planned Parenthood’s website. Representative Lippert notes that conservative policy makers in Minnesota tend to draw associations between sexual health education and Planned Parenthood and, ultimately, to the expansion of abortion services. However, studies have shown that there is a positive correlation between how much abstinence-only sexual health education a teen girl experiences and her likelihood of receiving an abortion as compared to comprehensive sexual health education models.

Regardless of the facts behind the analysis, policy makers still struggle, perhaps politically and morally, with supporting a bill endorsed by an organization with which they are fundamentally opposed. The politics of political division and stakeholder affect on the passage of a bill are much bigger problems outside of the scope of this narrow issue. However, a possible solution to the divisive and political nature of comprehensive sexual health education is to ensure

100 Id. at 5.
101 Video, supra note 80, at 2:19:00.
102 Telephone Interview with Todd Lippert, State Representative, Minn. H.R. (Sept. 11, 2020) (notes on file with author).
103 See Stranger-Hall & Hall, supra note 25, at 4.
neutral stakeholders that are trusted in the community, such as researchers at the University of Minnesota or non-profit groups that do not actively support abortion, work alongside policy makers to develop an evidence-based comprehensive sexual health education policy. Policy makers working in tandem with these neutral organizations helps to get ahead of the argument that the bill is driven by left-wing organizations. Neutral organizations vocally supporting a future bill is a step towards legislators and the general public approving mandatory comprehensive sexual health education legislation.

4. Institutional Distrust

Representative Lippert notes that Minnesota Republicans’ confidence and trust in governmental institutions like MDE and MDH are at an all time low, partially because of an inherent distrust that the party has with government itself but especially because of the ongoing COVID-19 epidemic.104

Republican state legislators have been vocal opponents of Minnesota Governor Tim Walz’s handling of the COVID-19 epidemic in regards to mandating business closures and restrictions.105 This criticism extends to MDH, an executive agency that has worked closely with Governor Walz to develop COVID-19 mandates and to inform the public about COVID-19 mandates and recommendations.106

104 Telephone Interview with Todd Lippert, supra note 106.
Additionally, MDE has drawn the ire of many Minnesotans who criticize the fall 2020 distance learning plans many school districts chose in the wake of the COVID-19 pandemic.\(^{107}\) While distance learning plans, and hybrid distance learning plans, have been justified as necessary to comply with the Centers for Disease Control and Prevention’s guidelines, surveys of Minnesota parents show that a majority would feel comfortable sending their children back to school.\(^{108}\) Over half of Minnesota parents surveyed felt spring 2020 distance learning was a bad experience.\(^{109}\) The criticism of distance learning disproportionately comes from Minnesota Republicans, who argue that reopening schools is best for students.\(^{110}\)

Even though the handling of the COVID-19 pandemic is an issue substantively unrelated to comprehensive sexual health education, MDH’s management of COVID-19 has eroded the trust of Minnesota Republicans, who blame MDH for what they deem a mishandling of COVID-19. Consequently, Minnesota Republicans may be less likely to rely upon recommendations of MDH or MDE when making future policy decisions. While buy-in from MDE and MDH is needed to create a workable program, relying on neutral organizations outside of MDE and MDH to inform the program could help Republican legislators trust a comprehensive sexual health education plan.


\(^{108}\) Id.

\(^{109}\) Id.

While trust in MDE and MDH is low among conservatives, trust in medical doctors and medical research scientists is high among both Republicans and Democrats.\textsuperscript{111} Relying on the medical recommendations of neutral medical science organizations who have publicly supported comprehensive sexual health education, like the American Academy of Pediatrics, the American Medical Association, and the American Public Health Association could help persuade conservative lawmakers.\textsuperscript{112}

5. \textit{Lack of Specificity}

H.F. 1414 does not note any specific curricula that must be used to achieve the aims sought by the bill.\textsuperscript{113} While in theory this gives MDE the opportunity to develop a plan and community members the chance to weigh in on this decision, the lack of specificity in the bill could instead be seen as an unknown to some legislators who fear the “worst” in terms of a liberal agenda being imparted through the bill. If a model program was developed before the passage of the bill, or if one of the existing MDH programs were adopted through the bill, legislators would be informed about the actual contents that would be taught to students and could debate the contents of the curriculum instead of assuming a hypothetical extreme outcome. This approach would quell arguments from Republican legislators that the purpose of a comprehensive sexual health education bill is to promote Planned Parenthood’s initiatives and

\textsuperscript{111} Cary Funk et al., \textit{Trust and Mistrust in Americans’ Views of Scientific Experts}, PEW RSCH. CTR. (Aug. 2, 2019), https://www.pewresearch.org/science/2019/08/02/americans-often-trust-practitioners-more-than-researchers-but-are-skeptical-about-scientific-integrity/ (“There are no significant differences by political party in views of medical researchers, medical doctors or dietitians.”).

\textsuperscript{112} Breuner, \textit{supra} note 33; see also Hauser, \textit{supra} note 33; APHA Policy No. 200610, \textit{supra} note 33.

\textsuperscript{113} H.F. 1414, 91st Leg., Reg. Sess. (Minn. 2019).
would lend some certainty and clarity to what initiatives comprehensive sexual health education actually includes.114

6. Criticism of Imposing Value Judgments on Students

One of the most pressing concerns for opponents of mandatory comprehensive sexual health education is that it imposes liberal value judgments about sex and sexuality onto Minnesota youth, without the consent of their parents.115 Particularly, comprehensive sexual health education is criticized for implicitly supporting casual sex by teaching students how to prevent the spread of STIs and unintended pregnancy.116

While opponents of comprehensive sexual health education argue that it imposes a value judgment onto Minnesota’s youth, these opponents ignore the value judgments that abstinence only sexual health education imposes. While the arguments surrounding sexual health education are admittedly laden with value judgments and moral discomfort on both ends of the political spectrun, the only way to provide value-neutral sexual health education to Minnesota students is to provide facts in a manner that produces results.

Representative Lippert believes this moral discomfort stems from sexuality being regarded as a generally controversial topic and the religious undertones that surround conversations around sexual health.117 He notes that there is a “deep visceral disgust among many conservative Christians around moving away from conservative sexual norms, even when data shows we can have healthier outcomes if we do so.”118 However, the antidote to policy

114 Video, supra note 80, at 2:18:30.
115 Id. at 2:23:07.
117 Telephone Interview with Todd Lippert, supra note 106.
118 Id.
choices based on a legislator’s moral or religious value judgments is following the science and research regarding what policies get the best results for common aims.

A broader idea of the purpose of sexual health education is necessary for policy makers, parents, and instructors to understand the importance of the impact this type of education has on students. While the impact of sexual health education is largely measured in the effect it has on teen pregnancy and STI rates, the knowledge imparted unto students during sexual health education is likely to follow them into adulthood. Just as math and science education is meant to lay a foundation of knowledge for a student’s future education or career, sexual health education is necessary to lay a foundation for a student’s future sexual relationships. While it is true that not all teens engage in sexual acts, the vast majority of adults will eventually engage in sexual activity.119 Equipping students with evidence-based information to enter into a sexual relationship, including a marital sexual relationship, is likely to help adults make informed decisions about whether or not to use contraception, how to prevent STIs, and how to have consensual sexual experiences.

Closely tailor curriculum to evidence-based information prevents moral judgments from passing on through the instructor and instead, helps students understand facts about sexual health through the lens of their own moral and religious values. Like teaching about different cultures and religions in social studies, the goal of sexual health education should not be to adopt others’ choices as their own, but to have a broader, evidence-based understanding of sexual health as a

whole. Even for those few students who will not ever engage in sexual activity, it is important for them to understand the reality that sexual health and activity are important issues facing Minnesota communities and be able to make informed choices to support community sexual health.

CONCLUSION

Sexual health education should be structured around new evidence regarding how to prevent unplanned pregnancy and sexually transmitted diseases. While barriers to passing a comprehensive sexual health education bill in the Minnesota legislature, these barriers can be overcome by implementing existing curricula, helping Republican legislators better understand their constituents’ opinions about comprehensive sexual health education, distancing proponents of the bill from controversial stakeholders, relying on trusted, neutral stakeholders, mandating specific curricula be taught, and emphasizing the lack of value judgments being imparted to students. Minnesota must mandate and standardize a single, comprehensive, evidence-based sexual health education system in order to adequately educate Minnesota’s youth and prevent the far reaching economic and social consequences of unwanted pregnancy and sexually transmitted diseases both in Minnesota’s youth and adult populations.