Advancing Comprehensive, Medically Accurate Sex Education Legislation in Georgia

KEY MESSAGES

THE PROBLEM

While Georgia schools are required to teach sex education and AIDS prevention education, curriculum is not required to be comprehensive or medically accurate.

- The current curriculum is required to emphasize abstinence and include instruction on peer pressure, sexual violence prevention, and healthy relationships, but is not required to include instruction on sexual orientation and gender identity or consent.

As a result of top-down sex education policies, students are often victims of "information inequities which leverage adult control over minors to prevent access to sexual health information."

- Withholding medically accurate and comprehensive sexual health information infringes on students rights to education and information access. The consequences of this failure to provide students comprehensive and medically accurate sex education are "grave."

For instance, states that require sex education to be taught, but do not require the information to be medically accurate, have comparable rates of teen pregnancy and/or chlamydia to states that have no current policy on the curricula taught in their sex education programs.

- This trend clearly highlights the impact of policy on pregnancy and chlamydia rates among youth aged 15 to 19.

Legislative policies that require medical accuracy have the potential to result in lower rates of teen pregnancy and chlamydia in youth aged 15 to 19.

- Medically accurate, comprehensive sex education is an important strategy to reducing the rates of Sexually Transmitted Infections (STIs) and preventing pregnancy among all youth aged 15 to 19.
- Comprehensive sex education should be medically accurate, evidence-based, and age-appropriate and should include the benefits of delaying sexual intercourse, while also providing information about normal reproductive development, contraception (including long-acting reversible contraception methods) to prevent unintended pregnancies, as well as barrier protection to prevent sexually transmitted infections.
- A comprehensive sex education curriculum should include gender equality, identity, and sexual diversity, as well as information about consent, decision-making, teen violence, and establishment of healthy relationships.

POLICY OPTIONS

Georgia law mandates that the state board of education determines minimum guidelines that sex education programs must satisfy. The guidelines created by the board require instruction to "emphasize abstinence from sexual activity until marriage and fidelity in marriage as important personal goals." Local school boards are largely responsible for deciding specific subjects that education must cover, age-appropriate messages, and the grade level in which topics are introduced.

Policy Option 1: Through new legislation and updated state standards, policymakers should enact legislation that requires public school districts to adopt and implement sex education requirements that include medically accurate information and comprehensive sex education and funding to support school districts that adopt and implement medically accurate and comprehensive sex education.

Policy Option 2. Require that the person who administers the sex education curriculum be trained and qualified in HIV/STD Prevention and Comprehensive Sexual Health Education.

ADDITIONAL POLICY CONSIDERATIONS

California, New Jersey, and Oregon have served as model examples of teaching healthy relationships as part of sex education. All three states require educators to use materials that are medically accurate and include instruction related to healthy relationships or consent. Despite the devastating impact of COVID-19, there might be a window of opportunity with most school districts now having the ability to facilitate virtual learning. Partners of Morehouse School of Medicine Prevention Center who are trained in sexual health and HIV/STI prevention education could deliver curriculum to students in at least 2 school districts as a pilot.

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Policy Context

Youth (aged 13-24) are the least likely to know that they have HIV compared to other age groups.[1] HIV risk is increased by: a lack of exposure to sexual education in middle and high school, risky sexual behaviors, low rates of testing, substance use, low rates of condom use, low rates of PrEP use, lack of access to care, and stigma.[1,5-8] Almost 55% of all teens have had sex by age 18.[9] About 46% of all sexually active high school students reported ***NOT*** using a condom the last time they engaged in sexual intercourse.[10] HIV and STD education increases condom use among youth.[11-13] Proper condom use reduces the risk of getting HIV and STDs. Youth must be educated on proper condom use, sexual risk-reduction behavior, and where to seek HIV and STD testing and treatment.

In 2018, youth aged 13-24 made up 21% of all the HIV diagnoses.[1] Research shows that the disproportionate burden of HIV/AIDS is especially pronounced in the Southern United States, accounting for 52% of new HIV diagnoses (16.1 per 1000) in 2017 (CDC, 2017). Furthermore, approximately 46% of all people living with HIV and 47% of all deaths resulting from HIV are in the South (CDC, 2017). Georgia, located in the Southeastern United States, had an HIV diagnosis rate of 28.6 compared to the national average of 13.6. This rate was the third highest in the United States in 2018 (CDC, 2020). Georgia had the second-highest rate (14.9 per 100,000 population) of HIV diagnoses among adolescents aged 13-19.[2] In Georgia, African American youth in Fulton County are disproportionately affected by HIV (See Tables 1 and 2).[3-4]

Table 1: HIV, STD, and Pregnancy Rates in Georgia and Fulton County

	Georgia	Fulton
Rate of people living with HIV per 100,000 population, 2018	625	1,707
Percent of people living with HIV, by Race, 2018	Black: 68.6% Hispanic/Latinx: 7.5% White: 18.0%	Black: 71.5% Hispanic/Latinx: 6.2% White: 16.9%
STD Rate per 100,000, 2018 (aged 15-19)	3,043.1	3,409.1
Pregnancy Rate per 100,000, 2018 (aged 15-19)	34.7	40.2

Table 2: HIV, STD, and Pregnancy Rates for Non-Hispanic Blacks vs Whites in Fulton County

	Blacks	Whites
STD Rate per 100,000, 2018 (aged 15-19)	3,409.1	148.2
Pregnancy Rate per 100,000, 2018 (aged 15-19)	40.2	4.5

Results from Project HAPPY revealed several positive outcomes. Across all of the interventions, condom use attitudes and HIV prevention attitudes demonstrated significant improvements. Youth reported more positive feelings towards using condoms and had more positive attitudes about HIV prevention behaviors. Condom use self-efficacy improved in two of the intervention arms. Youth felt more confident about using condoms the right way[14].

EVIDENCE-BASED POLICY OPTIONS

Georgia law requires local boards of education to develop and implement a course of study in sex education and HIV/AIDS prevention as part of an accurate, "comprehensive" health education program.[1] Local school boards are largely responsible for deciding the content and grade level at which topics are introduced, but at minimum the instruction must cover: "the handling of peer pressure, the promotion of high self-esteem, local community values, the legal

consequences of parenthood, and abstinence from sexual activity as an effective method of prevention of pregnancy, sexually transmitted diseases, and acquired immune deficiency syndrome (AIDS)".[1] Georgia code states that the sex education courses must include instruction concerning the legal consequences of parenthood, including, the legal obligation of both parents to support a child.[2] The course also includes information about the legal penalties or restrictions upon failure to support a child, including, the possible suspension or revocation of a parent's driver's license and occupational or professional licenses.[2] Sex education must also include annual age-appropriate sexual abuse and assault awareness and prevention education in kindergarten through grade nine.[2] Local school boards that fail to implement these minimum course standards are ineligible for state funding.[2]

Policy Option 1: Through new legislation and updated state standards, policymakers should enact legislation that requires public school districts to adopt and implement comprehensive sex education that requires medically accurate information and funding to support school districts that adopt and implement medically accurate and comprehensive sex education.

Georgia has no standard regarding medically accurate sex education instruction and sex education is not required to be comprehensive. Comprehensive sex education standards would include education about sexually transmitted diseases and infections, other than HIV/AIDS, and education about sexuality and contraception. The National Guidelines Task Force identified six essential concept areas for comprehensive sex education which include medically accurate information on human development, relationships, personal skills, sexual behavior, sexual health, and society and culture.[3] Topics also include decision-making, abstinence, contraception, and disease prevention. As part of the risk reduction approach, comprehensive programs also cover topics such as sexually transmitted infections, human immunodeficiency virus (HIV), and contraceptive methods, including condom use. Additionally, the Future of Sex Initiative developed National Sex Education Standards that also include the principles of reproductive justice, racial justice, social justice.[4] In 2016, Oregon set a high bar by implementing standards that require comprehensive sex education in public schools.[5] The standards emphasize characteristics of healthy relationships, and education about consent, sexuality and identity, and sexual violence.[5] Oregon's standards also include consent and personal boundaries language, beginning in kindergarten.[5]

Georgia's State Board of Education requires that sex education must "emphasize abstinence from sexual activity until marriage and fidelity in marriage as important personal goals."[1] States that receive federal abstinence-only-until-marriage grants (e.g., Adolescent Family Life Act, Community-Based Abstinence Education, Title V) must spend those funds on abstinence-only education.[6] Local school boards *may choose* to adopt an "abstinence-plus" curriculum that emphasizes abstinence and covers medically accurate information regarding contraception and disease-prevention methods.[6] The local control of sex education curriculum has resulted in disparities in the quality of sex education that students receive.[6] While some Georgia school districts teach the comprehensive FLASH curriculum, many others use an abstinence-only curriculum, called Choosing the Best.[6] This curriculum "stigmatizes sexually active youth through shame and fear-based messaging, fails to include instruction relevant to LGBTQ youth, and includes biases about gender, sexual orientation, and pregnancy options".[6]

The state regulations in New Jersey, California, and Oregon ensure that sex education is comprehensive, and they require sex education to be uniform and consistent across school districts. We propose that legislators reintroduce and expand House Bill 133. House Bill 133 sought to require schools to establish a medically accurate sex education and HIV/AIDS prevention instruction requirement. Additionally, legislators need to propose funding to support this effort. In addition to limited curriculum requirements, advocates report that a lack of funding creates significant barriers toward advancing sex education.[6]

Category of Finding	Summary of Key Findings
Benefits	● Research shows that sex education programs can help youth delay onset of sexual activity, reduce the frequency of sexual activity, reduce the number of sexual partners, and increase condom and contraceptive use.[7,8,9] ● Providing sex education helps students achieve academic success. [10]

	• Health programs, including health education, can help reduce health disparities and assist youth to succeed in school.[9]
Potential Harms	Independent evaluators and critics state that comprehensive sexual education exposes youth to pornographic images, increases teen pregnancy, increased sexual initiation, and increased number of sexual partners (*Protect Student Health Georgia Coalition*). Potential loss of Federal funding if teaching more than abstinence.
Resource Use, Costs and/or Cost Effectiveness	Although cost-related research on this topic is limited, one study estimated the cost-effectiveness and cost-benefit of a comprehensive sex education program. That study found that for every dollar invested in the Safer Choices Program, $2.65 was saved in medical and social costs by preventing pregnancy and sexually transmitted infections.[11]
Stakeholders' Views and Experience	A teen shared "I believe sex education should be enforced in all school districts, despite what many other may think. I also like the second policy. It is imperative that the curriculum about teaching students to practice abstinence rather than teaching them proper sex education needs to be changed." A faith-based leader stated "I agree that abstinence should be practiced. But the reality is, that it is not. So we have to educate our youth. I noticed that the age limit is 14-19. In my opinion, it should start at 11 because the questions and the sexual appetite start at the start of adolescence . Also, Children are so much more advanced due to television and social media. While peer pressure, sexual violence prevention and healthy relationships are great topics to teach but children, especially children in the public sector and the low-income areas, need to be fully educated when to comes to sexually transmitted diseases, what they are and how to prevent them. They also need to know about teen dating abuse. Some of our children, young girls and boys, are being abused by their boyfriends/girlfriends. They also need to what preventative measures to take to avoid sexually transmitted diseases and pregnancy…" A parent shared "Benefits of providing medically accurate sex education legislation in Georgia is crucial for adolescent decision making. While all teens have some level of access to the internet Facebook, Instagram, porn websites, and a peer-based environment where information about sexual intercourse, pregnancy prevention is widely available. This information can be dramatized in a way that persuades sexual intercourse instead of deterring. Medically accurate and comprehensive sex education provides each teen with facts that may not be readily accessible via a smartphone or peers. Facts such as long-term effects of sexually transmitted diseases, testing procedures for male and female, treatment methods, birth control options, and ramification of infections that go untreated and undetected." Another parent stated "While the topic of sex is necessary, information provided should provoke thought and reasonable deduction in our teens. Information that makes them think first and react later. The emotional and financial ramifications teens place on already strained households. Lessons they inadvertently teach younger brothers/sisters and underlying generational curses that can be broken with better decision-making skills." Another parent shared "Education in the black community, especially in the lower income communities is unequal if compared to ANY education that a child gets in a middle-class neighborhood. Specifically, distribution of educational resources for core subjects such as math and reading, laptops, books, or tutorial sessions online or in person. If core requirements resources are inconsistently provided, sex education may be treated as an elective, not to be taken serious by those being asked to fund such program. Without access

	to accurate information, our children are not being adequately prepared for adulthood and interpretation is left up to teenage literacy or understanding."
Additional Considerations for Policy Making	Georgia school districts should review their existing scope and sequence on a regular basis to confirm that it still appropriately matches locally identified health priorities and any relevant standards, benchmarks, and requirements, both of which may change over time. However, there is no standard for how often the committee should be convened to review the curriculum. The State Board of Education requires each local school board to establish a committee to periodically review sex and HIV/AIDS education instructional materials and make recommendations to the board regarding the most appropriate ages for instruction. The committee must be composed mainly of non-teaching parents with children enrolled in the local schools, in addition to educators, health professionals and other community representatives. The committees must also include a male and a female student currently enrolled in the 11th or 12th grades in the local public schools. Additionally, every state and local education agency that accepts federal funding from the Centers for Disease Control and Prevention must have an HIV Materials Review Panel. A poll was conducted by SIECUS that found that 88% of parents of junior high school students and 85% of parents of high school students believe information on how to use and where to get contraceptives is an appropriate topic for sexuality education programs in schools. Schools officials - teachers, social workers, nurses, guidance counselors, and graduation coaches – may discuss teen pregnancy prevention with students and refer them to local health departments for family planning counseling. A system for providing, linking or referring students to sexual and reproductive health services is needed.

Policy Option 2. Require that the person who administers the sex education curriculum be trained and qualified in HIV/STD Prevention and Comprehensive Sexual Health Education.

Given the unique nature of sex education, ongoing professional development is critical. Typically, physical education teachers teach sex education, and they are not always trained to deliver the content. Some states have professional development requirements specifically related to sex education and/or HIV/AIDS prevention education (e.g., California, Maryland, Michigan) but most states do not.[12] Others require a minimum number of professional development hours (e.g., Colorado, Indiana, Georgia, New Jersey) for license renewal or professional recertification but do not specify topic areas.[12] In recent years, however, these requirements have been eliminated or suspended due to budget cuts in some states.[12]

There are also requirements for outside consultants who deliver sexual health education in the classroom. Policies may require outside consultants to present a sample lesson and/or be approved by a curriculum review committee or school health advisory council. The Georgia Campaign for Adolescent Power & Potential (GCAPP) has been working statewide to advance school-based sex education since 2009.[13] GCAPP identifies schools with readiness and capacity and works with districts to identify their goals and objectives relative to sex education. They have also devised a training program to support schools wherever they may be in the process of achieving their goals.[13]

Category of Finding	Summary of Key Findings
Benefits	● Teacher training can influence educators' knowledge and perceptions about the importance of teaching health as well as their comfort level, intentions for teaching in the discipline, and actions for implementing sexuality education.[14]

	• Teacher training is the most significant indicator in determining the comprehensiveness of the sexuality education instruction and the number of sexuality topics taught within any curriculum.[15]
Potential Harms	Requirements to teach a more comprehensive sex education curriculum may overwhelm already overwhelmed, busy teachers.
Resource Use, Costs and/or Cost Effectiveness	Funding and time for teachers or other professionals to be trained and deliver the curriculum.
Stakeholders' Views and Experience	A parent shared "Legislation is the optimal path as funding will be needed for resources to provide. But if that path is unavailable due to an already strained budget option 3 a trained medical professional to administer the program would provide a much-needed educational foundation that our children (our future leaders) need and deserve." A faith-based leader stated "In my opinion, a medical professional and a child advocate/psychologist would be the best choice to teach our children, especially in the low-income public sector, about sex education and unplanned pregnancy. These subjects need to be approached holistically. Not only is the body being affected but the mind and spirit as well. The benefits of this would be that we would set up our children up for success and not failure because they will be in a position to make more intelligent choices when it comes to sexual relationships. When our children become educated they make better choices. They become educated adults, and educated adults build and create strong communities."
Additional Considerations for Policy Making	Federal and state funding for initiatives like GCAPP's WISE Initiative should be considered to take the burden off of local education budgets for training of teachers.

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