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Sexual Consent in Middle School Sex Health Education: An Analysis of Health Education Standards in Minnesota

By:

Ashley Parent

A Thesis Submitted in Partial Fulfillment

of the Requirements of the Degree

Master of Arts

In

Gender and Women's Studies

Minnesota State University, Mankato

Mankato, Minnesota

May 2020

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Sexual consent in Middle School sex health education: an analysis of health education standards in Minnesota

Ashley Parent

This thesis has been examined and approved by the following members of the student's committee.

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Dr. Ana Maria Perez, Advisor

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Dr. Eric Sprankle, Committee Member

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Chapter

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ABSTRACT

Comprehensive sex education is designed to teach sexual health, reproductive health, human sexual anatomy, safe sex, birth control and sexual abstinence. Consent education focuses on sexually transmitted infection (STI), pregnancy prevention, sexual identity, and the risks of sexual violence (Willis, 2019). This qualitative content analysis and survey will explore consent education in middle schools adopted in Minnesota from the past ten years. The research questions for this study are: is consent a part of sex education? How has consent been taught in 8-10 grades in Minnesota over the past 10 years? What frameworks are being used to teach consent to 8-10 grade? Parents and school administrators have opposed comprehensive education in the past in fear that students will have sex at earlier ages, increasing the rates of teen pregnancy and sexually transmitted infection (STIs) among youth.

However, students who receive comprehensive sex education are less likely to have unprotected sex, and experience lower rates of teenage pregnancy and STIs- than students who receive no sex education or abstinence-only (Planned Parenthood, 2019). Not providing this consent education withholds vital information for youth understand consent in friendships and relationships and make empowered choices. According to Willis et al., (2019) "Consent education could in principle develop the ability to identify and subsequently communicate sexual desires, which ties indirectly to communicating consent in relation to sexual acts" (p 231). The bodies of knowledge that will be used in this study are gender-based violence, K-12 education, and public health and health education. I conducted a content analysis to carry out this research and the findings from an anonymous survey. I anticipate that I will find few schools in Minnesota teaching comprehensive sex education that include consent because Minnesota is a state that typically teaches abstinence-only (Planned Parenthood, 2019).

I. Introduction

Comprehensive sex education taught in K-12 schools is meant to teach young people about age-appropriate sexual behaviors, sexual health, reproductive health, human sexual anatomy, birth control, consent and abstinence (Grossman et al., 2014). According to Willis et al. (2019) sexual "consent education could in principle develop the ability to identify and subsequently communicate sexual desires, which ties indirectly to communicating consent in relation to sexual acts" (p 231). The definition of sexual consent, that is used throughout this thesis, is the act of communicating sexual desires, before and during any sexual activity between two or more people. For the purposes of this thesis, I will be using the definition of consent to mean sexual consent. Consent is taught in a wide variety of ways. One variation of how it is taught is called affirmative consent, meaning a knowing and voluntary decision made among all participants in a sexual activity, more commonly known as the "yes means yes" approach ("Definition of Affirmative Consent," 2019). Refusal skills, which is often used in drug and alcohol related workshops, teaches young people to refuse sex or substances. Negotiation skills are also taught when teaching consent, including teaching students to build communication skills and to work on saying what they want and don't in any situation.

Refusal skills place the responsibility of preventing sexual violence on potential victims. It does not require potential abusers to learn about respecting boundaries of other people and how to take no for an answer. Refusal skills teaches the potential victim to refuse sexual activity, and it shifts the responsibility of refusal to the victim. It mainly teach young girls to say no to any sexual activity, no matter if they want it or not. This

culture also teaches young boys to push for sexual activity until a young girl gives in and says yes.

Negotiation skills teach young people to talk about sexual activities. It gives students a set of tools to talk about what they want and don't want in a sexual situation. Affirmative consent gives students the language to say yes to what they want, and no to what they don't want. This form of teaching puts the responsibility of action on the potential perpetrator. This is because there is a clear yes or no from the potential victim and the perpetrator choses to act on whatever they want to do instead of listening for an answer. By using these types of approaches to consent in schools across Minnesota, it shows that there is a culture of consent in the school systems. That culture is largely teaching students how to refuse and abstain from sex, drugs, and alcohol at an early age.

Consent is meant to teach students about what they want to happen to, and with, their bodies and gives them words to express such desires. According to the Minneapolis Department of Health and Family Support, "Sexual health education that begins in high school is reaching students too late" (2019). Students who engage in sex at an early age are at risk for a variety of negative health and educational outcomes. Some of the outcomes include dropping out of school, an increased rate of teen pregnancy, and an increased rate of sexually transmitted infections ("Sexual Health Education," n.d).

Comprehensive sex education promotes healthy behaviors, including delaying the initiation of sexual behaviors and decreasing teen pregnancy and sexually transmitted infection. Abstinence-only sex education broadly teaches students that in abstaining from sex before marriage, students are 100% likely to not transmit and a sexually transmitted

infection (STIs) and will avoid pregnancy. Schools in Minnesota can teach either type of sex education because there is no state standard ("Sex Education in Minnesota", 2019).

For this research, I conduct a content analysis of a set of eight sex education curricula. I found two completed curricula: *Making Proud Choices* and *Be Proud! Be Responsible*. Both curricula are taught in middle and high schools, which are 6-10th grades or ages 11-16, and they are both evidence-based. According to the Minneapolis Department of Health and Family Support, "Evidence-based programs (also called science-based, research-proven, or best practice programs) are considered best practice in sexual health education programming. These programs have been scientifically evaluated and, when taught with fidelity, have been proven to be effective over time in reducing sexual risk-taking behavior related to teen pregnancy" ("Minneapolis Department of Health and Family Support," 2019). For the other six of my curricula, I use summaries of the curriculum provided by the Minnesota Department of Health as well as summaries from etr.org to conduct a content analysis of the curriculum. Etr.org is a distributor of health and sex education curricula, which provides information about who and how the education is taught to.

The Minnesota Health Department and Hennepin County Human Services and Public Health Department created lists of sex education curricula that are promoted for schools to teach students. I use these lists to create my data set and use the descriptions of the curricula to analyze the curriculum. I was able to find two of my curricula online for public use. The other six curricula, I use the Minnesota Department of Health summaries and etr.org to analyze them.

There are many myths and misconceptions about sex and sexuality and how they should be taught in K-12 schools. Many myths that exist about comprehensive sex education that question its effectiveness, have been debunked. The first myth about comprehensive sex education is that it encourages students to have sex. It has been shown in numerous studies that by teaching about safe sex practices and contraceptives, young people are less likely to engage in sex at an early age (Advocates for Youth, 2020). In giving students the tools and knowledge to understand their bodies, students are able to know what they want and make informed decisions about what happens to and with their bodies.

Another sex education misconception is the idea that sex only occurs between a person with a penis and a person with a vagina. This misconception stems from teachings that only include heteronormative sex practices. By discussing LGBTQ sexual practices and relationships, we include other types of sex rather than just teaching about sex between a person with a penis and a person with a vagina. By teaching about a wider variety of sexual practices, gender, and gender identity, educators and authority figures create a safe and encouraging space for students who are not cisgender or heterosexual. Students feel safer to talk to adults who are encouraging of diversity and are inclusive in their teachings.

One more misconception is that people only need to use one form of birth control to have the effective outcome. Many comprehensive sex education programs teach that a person should use two or more types of birth control. For example, using both a condom and being on a form of birth control is more effective for a variety of reasons more than just pregnancy prevention (American College of Obstetricians and Gynecologists, 2020).

Some other reasons that people use multiple forms of birth control is to reduce periods and period symptoms, reduce the risk of ovarian cancer, and to treat certain disorders such as fibroids and endometriosis (American College of Obstetricians and Gynecologists, 2020).

There are also many misconceptions and myths about cisgender female sexual health and sexual practices. Two that were very common amongst my peers were that you cannot get pregnant the first time you have sex, and that your first-time having sex is supposed to be painful and bloody. According to Planned Parenthood, "Any girl who has unprotected vaginal intercourse runs the risk of becoming pregnant, whether it's her first-time having sex or the 100th time" (2019). Pregnancy can happen any time because ejaculate or pre-ejaculate may travel to the vagina or in the vulva ("What happens the first time you have sex?" 2019). Bleeding and pain may occur during a person's first-time having sex, but it is not always true, nor should be expected. Sex education and sexual beliefs that assume pain and discomfort are based on norms and ideas that value sexual purity and traditional gender roles. Planned Parenthood states that some people have a thicker hymen tissue than others, and that there are many ways to stretch the hymen so that it does not hurt or bleed during or after sexual intercourse. There are many other reasons why it may hurt, and one reason is if the vagina or anus is not lubricated enough. ("What happens the first time you have sex?" 2019). Providing age-appropriate sex education that creates a space for young people to debunk these damaging myths is crucial to a well-informed society.

A limiting factor of this research is that Minnesota does not require comprehensive sex education to be taught ("Sex Education in Minnesota," 2019). This means that a

district can teach any type of sex education they deem fit. Not all sex education curricula teach consent, and those that do, teach it in different ways, such as affirmative consent, refusal skills, and negotiation skills.

Throughout my research on this subject, I found that there are very few studies done on sex education in middle school to early high school age. There is one study by Willis et al. that focuses on consent education in middle school. They define consent education as an education that can help youth develop abilities to identify and communicate sexual desires; it ties indirectly with communicating consent in sexual acts (Willis et al, 2019).

This qualitative content analysis explores consent education in grades 8-10 that have been used in Minnesota from the past ten years. I found that many curricula teach in a wide range from 6-8 to 8-10 grades. The research questions that center this research are: 1.) Is consent a part of sex education? 2.) What frameworks are being used to teach consent to 8-10 grade? 3.) How has consent been taught in 8-10 grades in Minnesota over the past ten years? The aim of these questions is to understand what is being taught in 8-10 grades and how are young people learning about consent.

My study looks at Minnesota, which is a culturally rich and diverse state. The total population of Minnesota in 2019 was 5,639,632 people (US Census). The amount of people under the age of 18 in 2019 was 23.2%, and the female populations equaled 50.2% of people in Minnesota (US Census, 2019). In Minnesota, the median income in 2018 was $68,411 and 9.6% of people live in poverty. The breakdown by race in Minnesota is that 84.1% of people are white, 6.8% of people are Black, 1.4% of people are American Indian and Alaska Native, 5.1% of people are Asian, and 5.5% of people are Hispanic or Latino.

Many of my curricula are from the Hennepin County Human Services and Public Health Department. In 2019, Hennepin County had a total population of 1,265,843 people (US Census, 2019). The percentage of people 18 and under was 22% and 50.5% of the total population was female (US Census, 2019). The breakdown of race in Hennepin County was 74.4% white, 13.6% Black, 1.1% American Indian, 7.5% Asian, and 7% Hispanic or Latino.

The breakdown by race is important in the state, and in Hennepin County, because it can dictate what curriculum is taught in which school districts. For example, *Be Proud! Be Responsible!* was created to be taught to young African American boys, *Cuidate* is meant for Latino students, and *Safer Sex Initiative* was created for girls and women who have been sexually active and may not be in school.

I hypothesize that the curriculum will all be different in the ways they teach consent. Some will teach refusal skills, and fewer will teach affirmative consent. This is because Minnesota does not have a standard for sex education ("Sex Education Standard in Minnesota," 2019). I hypothesize that Minnesota is moving in the direction of teaching affirmative consent, but as of now, most schools will teach refusal and negotiation skills.

Finally, I organized this research by addressing the history of sex education in the United States and by my methodology in this research. I will then discuss the literature surrounding this topic and finally discuss the methods of my own research and data analysis that will be added to this topic.

In chapter 2, I conduct a literature review on sex education in grades 6-12. I look at literature on the topics of gender-based violence, K-12 education, public health, and health education. The literature builds a foundation for the importance of teaching sex

education to students in grades 8-10. In chapter 3, I discuss my methodology and methods. The chapter starts by detailing my rationale and the significance of this topic. I then talk about my data collection, and the methods used in my research. I end the chapter by addressing the limitations of doing my research and reflexivity of my position as a graduate researcher.

Chapter 4 is the data analysis chapter, and in it I review the national sex education standards, as well as Minnesota's state standards for sex education. I follow up with discussion of the curricula I looked at. and then review my findings from the research. I recommend a curriculum for Minnesota to use more often and to create more like it. I conclude by discussing, in which I discuss the entire research process and close with recommendations for further research.

II. Literature Review

In this literature review, I discuss the intersections of gender-based violence, K-12 public school health education and adolescent studies, to establish trends in sex education curriculum in the grades 8-10 over the past ten years. In the first section, I review the history of sex education. Next, I review the findings linking gender-based violence intersections with consent education. Then, I explore the importance of teaching sex education in grades 8-10. Finally, I discuss health education in the public sector and relate it to how consent education is taught in sex education.

A. History

Feminism- The pill- The Sexual Revolution

The sexual revolution era brought with it new contraceptive technologies and larger debates over abstinence only education (AOE) and comprehensive sex education (CSE). This era, “Appeared to be where the chasm between the belief systems became the most prominent and the AOE/CSE controversy became a moral, political, religious, and education debate” (Herrman et al 2013, p. 143). In 1964, the Sexuality Information and Education Council of the United States (SIECUS) was founded. At the time, their goal was to provide information and resources to those who were teaching sex education and to promote CSE in schools (Herrman et al 2013, p. 143; "The CSE's National Sex Ed Conference", 2015). Partly because of SIECUS, during this time we saw more schools implementing sex education into their curriculum for adolescents. Sex education became more politicized, and parents protested the addition of sex education in schools ("The CSE's National Sex Ed Conference", 2015).

The sexual revolution brought with it a new sexual freedom. This new sexual freedom brought about, "swing clubs, open nudity, gay bathhouses, and pornographic movies" that shocked much of the American public (Huber et al., 2014, p. 37). Opponents of the birth control pill warned that it would create a culture of casual sex. The landmark case of Roe V. Wade (1973) legalized abortion as a matter of privacy between patient and doctor. In 1977, Carey V. Population Services International allowed for minors to gain access to contraceptives without parental consent or knowledge (Huber et al.,2014).

It wasn't until Nixon in 1971, and the White House Conference of Youth, that sex education was implemented in public elementary and secondary schools. At the time, "the goal was not as much to prevent teens from engaging in sex, but rather to prevent pregnancy as a consequence for their experimentation" (Huber et al., 2014, p. 39).

The increased rate of teen pregnancy and rise of HIV in the late 1970s and early 1980s led to an emphasis on contraception and safe sexual behavior in public sex education (Herrman et al., 2013). The HIV and AIDS crisis brought more education surrounding sexually transmitted disease (STDs) in sex education. This period only strengthened the arguments made by sex education activists that sex education needs to be taught in schools (Harris, 2015).

The Modern Sex Education Era (1980s- present)

The Adolescent Family Life Act (AFLA) was passed in 1981, and the primary was to prevent "premarital teen pregnancy through abstinence-only education, promoting adoption, and providing services for pregnant and parenting teens" (Herrman et al., 2013,

p 144). The AFLA restricted sex education programs from, “Including references to religious doctrine, [were] required to be medically accurate, mandated to demonstrate respect for individual autonomy regarding referrals for contraceptive services, and prohibited from using church facilities or parochial schools for presentations during school hours” (Herrman et al., 2013, p. 144).

Title V of the Welfare Reform Act of 1996, signed by President Clinton, gave tens of millions of dollars to support abstinence-only sex education programs (Harris 2015; Huber et al 2013; Herrman et al., 2014). At the time of this act, the majority of the public supported comprehensive sex education programs and were outraged (Herrman et al., p. 2013). This bill called for a specific definition of abstinence-only sex education. The bill was known as, “The ‘A-H Guidelines’ because of their location within the legislation, they mandated that all programs funded under the act teach the benefits of abstinence until marriage, reestablishing this behavior as the expected standards for school-age youth” (Huber et al., 2014, p. 42).

In 2008, George W. Bush provided equal funding for abstinence-only sex education and comprehensive sex education. He made it known that he supported abstinence-only sex education, and believed it offered a practical approach (Huber et al., 2014). In 2000, Bush and other lawmakers passed the Special Projects of Regional and National Significance - Community Based Abstinence Education that added $31 million to abstinence-only sex education (Harris 2015, Herrman et al., 2013, Huber et al., 2014). The bill “required programs to discuss contraception only in terms of failure rates, refrain from providing young people with information about accessing contraception and omit content on sexual orientation or gender identity” (Herrman et al., 2013, p. 144). To

reach more people, comprehensive sex education rebranded their approach as abstinence-plus, rather than comprehensive, to demonstrate that they teach abstinence but also teach accurate information.

During the Obama Administration, there was a shift in policy regarding comprehensive sex education. President Obama signed the Consolidated Appropriations Act of 2010, which was the first federal funding, for comprehensive sex education in public sex education and it included the Teen Pregnancy Prevention Initiative (Herrman et al., 2013). The Consolidated Appropriations Act provided funding to public and private schools to teach medically accurate and age-appropriate programs. The main goal of this act was to reduce teen pregnancy. There were many attempts to eliminate abstinence-only sex education funding and one was the introduction of the Repealing Ineffective and Incomplete Abstinence-Only Program Funding Act. Although this act was unsuccessful, its goal, like many like it, was to, "Reprogram funding to evidence-based CSE" (Herrman et al.,2013, p. 146).

B. Gender-Based Violence

Gender-based violence mainly affects young girls and women. However, scholars in masculinity studies have demonstrated the ways that hegemonic masculinity harms boys as well as men (What is Healthy Masculinity? 2012; Connell, 2005). On average, about 246 million children globally are victims of some form of gender-based violence every year (Comprehensive Sexuality Education to Prevent Gender-Based Violence, 2018). According to UNESCO, "Educating young people is the only true, long-term solution to gender-based violence" (2019). Few children are provided age-appropriate sex education.

In education that is age-appropriate and comprehensive, young people learn how to recognize and identify forms of gender-based violence, to prevent it, and to seek help when needed (Comprehensive Sexuality Education to Prevent Gender-Based Violence, 2018). UNESCO's mission statement is to, "Seek to build peace through international cooperation in Education, the Sciences and Culture" (Comprehensive Sexuality Education to Prevent Gender-Based Violence, 2018). Part of their work relates with sex education, and their "primary goal of sexuality education is to equip children and young people with the knowledge, skills and values to make responsible choices about their sexual and social relationships in a world affected by HIV" (Gordon, 2011, p 175). By withholding information about HIV, consent, and the workings of the reproductive organs to young people, institutions are contributing to the roots of gender-based violence. One way to prevent violence is to teach comprehensive sex education in schools to children in K-12.

Affirmative consent is one way to teach students about their agency to their bodies. Without teaching consent, students are left without the proper language to describe what they want and don't want to happen to and with their bodies. Teaching affirmative consent is one of the many ways that we can fight sexual violence. The primary goal of sex education, according to Gordon, is to give children the correct knowledge and skills to make responsible choices about their sexual and social relationships (2011). By teaching consent to young people, we are giving the tools to make informed decisions about consent and their bodies.

From its inception, sex education has been taught to prevent STIs, and later it taught about avoiding teen pregnancy (Kolenz, 2019). Teaching consent sex education to

teenagers helped them make informed decisions about consent (Kolenz, 2019). This study is focused on consent education and the ways it has been taught. The definition of consent I am using is “Knowing our bodies and desires and knowing what we like-or don’t-in sexual situations with sexual behavior they are engaging in and how to be safe” (Kolenz, 2019, p 576). Consent education is part of a comprehensive model of sex education that teaches about reproductive anatomy, healthy relationships, communication, pregnancy and birth, reasons for abstaining from sex, STIs, sexual orientation, sexual abuse, and pregnancy prevention. Schools can provide young people the tools and language to make decisions about their bodies and know when they are ready to engage in safe sexual behaviors. In understanding consent, teens can make informed decisions about sex and can learn strategies to ensure that they understand their agency and what they want to do with and to their bodies. According to Kolenz, “This knowledge helps us recognize rape by de-normalizing sexual coercion” (2019, p. 576). By giving teens knowledge about sexual consent, they can understand sexual coercion, how to avoid it, and have the language to say no.

In teaching sex education, before puberty, we are communicating to students that sex is not taboo, rather, it is something to be thought about and not taken lightly (Grossman et al., 2014). Sex and consent being taught together in age-appropriate ways, gives students an opportunity to make informed decisions (Kolenz, 2019). With comprehensive sex education, students can consent to sex if they want to engage in it, and they are able to notice the signs, coercion, or sexual assault and stop it before it happens (Hollander, 2004). Teaching affirmative consent is one of the best ways to teach young people about the relationship between sexual violence and comprehensive sex education.

There are many approaches on how to teach sex education to middle school and high school students. Sex education is taught in either abstinence-only sex education or comprehensive sex education. Abstinence-only sex education, which teaches about abstinence from sex until marriage, does not have to be medically accurate when talking about STIs, and emphasizes that abstinence is the only way to avoid teen pregnancy and STIs. (Grossman et al., 2014; Hollander, 2004). Comprehensive sex education, on the other hand, includes teachings about abstinence as the most effective way to prevent teen pregnancy and STIs (Hollander, 2004). Comprehensive sex education also addresses contraception, consent, and in some cases queer sexuality. (Kolnez 2019 et al.; Hollander, 2004; Wood et al., 2019; Eisenberg et al., 2008). By teaching sex education through a comprehensive sex education lens, educators can help students understand their bodies and their rights to their bodies.

In Hollander's study, she demonstrated that when offered access to contraception, people were willing to pay a lot of money in order to obtain it (2004). When offered information and access by a pharmacy, 53% of participants stated that if they had pharmacy access to birth control, they would be more likely to use it. Overall, 65% reported that they would be more likely to use birth control, in this case the Pill, if their doctor had given them information about it (Hollander, 2004). This shows that when people are given information and access to birth control. or any other kind of contraception, they are willing to use it. Hollander found that Minnesotan teens taught about abstinence-only sex education were more likely to engage in "risky sexual behaviors" (2004). Furthermore, 12% of students in three Minnesota middle schools reported that they were sexually active after taking an abstinence-only course. That

number is twice that of the responses given before taking the course (Hollander, 2004). The author also notes that by teaching abstinence-only, people are more likely to engage in risky behavior, this is because they do not have the proper knowledge to decide what are safe and risky sexual behaviors. Hollander's study demonstrates evidence that there is a trend of ineffectiveness using an abstinence only sex education approach (2004).

Students of abstinence-only sex education are more willing to participate in risky sexual behaviors because they are not introduced to topics such as consent and how to safely engage in sex (Grossman et al., 2014). For example, "two evaluations in the 'It's Your Game: Keep It Real' curriculum demonstrate its effect of delayed sex for both boys and girls" (Grossman et al., 2014, p 811). "It's Your Game: Keep It Real" is a comprehensive sex education program designed for middle school students and was developed by the Planned Parenthood League of Massachusetts. This program includes nine lessons in grades 6, 7, and 8, "and provides culturally sensitive and age-appropriate information, focusing on relational skill-building as a means to make healthy choices regarding sexual behavior" (Grossman et al., 2014, p 811). Over 2,000 students were surveyed at the beginning of three years on ten categories, including sexual activity, age, race/ethnicity, two-parent family, median household income, grades in school, parent/guardian closeness, social desirability, Get Real dosage, and Get Real family activity participation (Grossman et al., 2014). Over the course of three years, they found the program included, "developmentally appropriate, comprehensive sex education programs that include parent involvement [which] can be effective in delaying sex for middle school students" (Grossman et al., 2014, p 813). This study shows that by

providing age-appropriate sex education that focus on skill-building, students are less likely to engage in risky behaviors because they understand safe sexual practices.

In teaching comprehensive sex education, another topic that is sometimes addressed is pleasure. The pleasure imperative, "Reinforces social and cultural norms that position pleasure as something that young people must or should achieve in their sexual lives" (Wood et al., 2019, p 1). This study interviews ten young people about sex and pleasure based on conferences or courses that the participants attended. Importantly, concepts of pleasure in sex education potentially reduce sexual violence. Pleasure is about the right to the body and knowledge of what a person does and does not like. Wood suggests a rights-based approach that broadens "content to include such issues as gender norms, sexual orientation, sexual expression and pleasures, violence, and individual rights and responsibilities in relationships" (Wood et al., 2019, p 5). To incorporate pleasure, educators need to include that sex is not always pleasurable.

C. K-12 education

Sex education typically starts in late elementary, continues throughout high school and in some cases universities (Grossman et al., 2014). In late elementary school, children are taught about puberty, and later in middle and high school, they are taught about sex and reproduction (Grossman et al., 2014). Middle school is an important time to focus on sex education because it is the time when children typically are beginning puberty and are curious about their bodies. According to Grossman, middle schools are important role players in students' lives, "As beginning sex education *before* teens have sex is critical in effectively reducing risky sexual behavior" (Grossman et al., 2014, 745).

In teaching comprehensive sex education to middle school students, we have seen lower rates of STIs and teen pregnancy (Carter, 2012; Hollander, 2004; Grossman et al., 2014).

The United States is the only developed country that has not created a national standard for sex education (Carter, 2012). According to the National Conference of State Legislators, each state can decide what policies they have in place for sex education ("State Policies on Sex Education in Schools," 2019). As of March 1, 2016, "24 states and the District of Columbia require public school teach sex education", and of that, only 21 mandate sex education and HIV education ("State Policies on Sex Education in Schools," 2019).

There are small differences between public and private school education. According to the National Center for Education Statistics, nearly 10% of students attend private school in the U.S., while over 50 million students go to public school ("State Policies on Sex Education in Schools," 2019). Private schools are independently funded and usually parents or guardians of private school students pay tuition for their children to attend school. One advantage and disadvantage of private school is that they can choose their own curriculum, whereas public schools are more limited ("Private School Vs Public School Breakdown," 2019).

Since many private schools are religious institutions, and that can play a factor in what type of sex education is taught in the school. According to the National Association of Independence Schools, some of the main contributors to the literature of sex education in private schools are, "Teacher(s), author(s), consultant(s), [and the] sexuality education" (Marshall, 2017, p 11). Deborah Roffman stated that, "It is through parents

that children acquire their most basic attitudes and feelings about themselves as sexual people" (Marshall, 2017, p 11). Sex education was the role of parents, and with the shift in the 1970s of parents going to work full time, schools are teaching sex education to children. (Marshall, 2017).

There has been a shift in what has been taught in private schools regarding sex education. In the World War II era, the natural rights viewpoint looked at the moral sage-guard of sex, which promoted no sex before marriage (Marshall, 2017). The liberal viewpoint was sex is a pleasurable experience and that can, and should, happen outside of marriage (Marshall, 2017). In the 1980s, with the onset of the HIV epidemic across the globe, sex education saw a shared interest and emphasis on education to young people. The education that was being taught was about HIV and pregnancy prevention (Marshall, 2017). Twenty years later in the 2000s, the liberal viewpoint brought about an emphasis on making informed choices and talking about consent to young people (Marshall, 2017).

In public schools, there are more rigid standards of what is being taught to young people. There are laws in many states that determine what is to be taught in the public schools. According to Planned Parenthood, only, “24 states and the District of Columbia mandate sex education, and 34 states mandate HIV education” (2019). The final decisions about what is going to be taught are left up to school districts, which explains how in one state, such as Minnesota, we see a wide range of sex education curriculum being taught (“State of Education in the USA,” 2019). This means that students across the state are being taught different things at different times. Minnesota argues that abstinence is the only way to absolutely prevent STIs and pregnancy, and educators that must teach

about STIs (“Sex Education in Minnesota,” 2019). According to Planned Parenthood, “Minnesota has no statewide standard for sex education” (“State of Education in the USA,” 2019). Without having a state standard, students across the state get an education that can be vastly different from one another.

While Minnesota has no standard for sex education. there are national standards for health education across the United States. According to Advocates for Youth and the Future of Sex Education, there are National Standards of Sex education or NSES. This standard guide covers standards in K-12, and covers topics such as, anatomy and physiology, puberty and adolescent development, identity, pregnancy and reproduction, STIs and HIV, health relationships, and personal safety. The standards are broken down by grade groups, K-2, 3-5, 6-8 and 9-12.

The core concepts from the NSES cover, a lot of ground that should be taught to students during their time in K-12. The Anatomy and Physiology topic, “provide(s) a foundation for understanding basic human functioning” (“National Sex Education Standards,” 2019). Puberty and adolescent development include physical, social, and emotional development. Identity addresses who students are as people. Pregnancy and Reproduction chapter introduce the ways in which pregnancy could happen, and how students can avoid unwanted pregnancies through safer sex behaviors. The topic about STIs and HIV covers the signs and symptoms of HIV and STIs and how to prevent them. Healthy Relationships includes information on how to successfully navigate relationships with peers and significant others. Personal Safety emphasizes personal growth and creation of safety in all environments. The core concepts that students should be learning in schools are listed below in the table.

Core concepts

	End of 8th grade	End of 12th grade
Anatomy and physiology	Know reproductive systems Know the body parts and their functions	Know the human sexual response cycle Know how hormones play a role
Puberty and adolescent development	Know how physical, social and emotional changes affect the body during puberty and adolescence	Analyze how brain development impacts physical, social, and emotional changes in the body
Identity	Understand the differences between gender identity, gender expression and sexual orientation Explain gender roles	Understand the differences between biological sex, sexual orientation, and gender identity and expression

Pregnancy and reproduction	Be able to define sexual intercourse, sexual abstinence, emergency contraception Explain the risk and benefits of using contraceptives Known the signs of pregnancy Identify ways to contribute to a healthy pregnancy	Analyze the advantages and disadvantages of abstinence versus using birth control methods Know the laws related to reproductive and sexual health
STIs and HIV	Be able to define STIs and how they transmit Analyze abstinence Know the signs, symptoms and impact of STIs, including HIV	Know the common symptoms of STIs Know the signs of pregnancy Know prenatal care to ensure a healthy pregnancy Know the laws about pregnancy, adoption, abortion and parenting
Health relationships	Know the difference between a healthy relationship and an unhealthy one	

Personal safety	Be able to identify and discuss bullying, sexual harassment, assault and dating violence Understand sexual agency Understand that a person who has been raped is not at fault	Be able to analyze bullying, sexual harassment, assault and dating violence Know the laws related to bullying, sexual harassment, assault and dating violence

D. Public Health and Health Education

Sex education is frequently framed under health education and is taught in health education classes as a section of the class. The debates over whether comprehensive sex education or abstinence-only should be taught, have been around since the early days, when sex education was introduced into schools. How and at what age it should be taught are still debates that students, teachers, parents and policymakers are having today. This debate is still happening because it has long been that parents know best and should teach their own children. The debate also happens because people believe that children are too young to understand the natures of sex and sexuality.

In a study conducted in 1997 on high school aged teenagers in Minneapolis and St. Paul, questions were asked to students about how they want their sex education to be taught. This study was conducted using five focus groups and used participants in 9th-12th grade. These students were mainly white female students. The research gathered information from these students concerning what they liked and disliked about classes and instructors, the appropriateness of the sex education, and the impacts sex education in

their own lives (Eisenberg et al., 1997). The study's main objective was to ask students about ways to improve sex education curriculum. The results are similar to those found in Eisenberg et al., which was a study of 2008 conducted with parents. Students wanted comprehensive sex education. Students wanted comprehensive sex education and believes it should start as early as elementary school. Teachers or presenters should be qualified and not just coaches of sports teams. Students also asked for the peer education discussions, and that teachers should create an open and honest environment and that related to student's lives.

Students want their instructors to be qualified to teach sex education and to be open and honest with answers to awkward questions. Erkut et al's., study asked if using the "Get real: Comprehensive Sex Education that Works" curriculum is a good strategy for teaching sex education to students in order to prevent early teen pregnancy and reduce 'early starters' for sexual behavior" (2013, p 483). This study's methods were to assess behavioral impact at the beginning of 7th grade, relative to data obtained at the beginning of 6th grade of a comprehensive sex education intervention called, "Get Real: Comprehensive Sex Education that Works.*"* They divided schools into control groups, with the abstinence-only sex education that was currently being taught, and comprehensive sex education curriculum, and gave students surveys about their sexual behavior. The researchers found that participants who reported having had sex before the study were 4x more likely as others to report having sex at follow up.

Furthermore, they found that teaching comprehensive sex education to those students that had not already engaged in sex, helped students to made decisions to not engage in risky sexual behaviors. In the Eisenberg study, students reported that they wanted

education before they heard it from their friends, the media, or tried it themselves (2008). By teaching students about sex education before they start having sex, they can properly assess the risk of having sex and take steps to make it less risky if they are to engage in sexual behaviors.

Another study carried in 2019 by Brinez et al., asked the question, “How should I teach sex education in middle school?” Brinez was a teacher at the time of this study and had wanted to assess the way she was teaching sex education in her middle school classroom. She used an action research approach which is, “A way of exploring a social situation with the purpose of improving it. Those involved in this research are inquirers, including teachers and students, with the aim of improving the quality of action” (Brinez et al., 2019, p 410). She asked, **“**How do I improve my teaching practices using ICT in order to encourage self-care behaviors around sexual and reproductive health in my students?” (Brinez et al., 2019, p 412). She was able to find that by using an ICT-Informational and Communication Technologies based, approach which included, “Good digital presentations and access to relevant digital resources”" (Brinez et al., 2019, p 407). Her findings are that students’ knowledge of sex education improved relative to the number of class hours dedicated to each subject (Brinez et al., 2019).

Sex education, and how it is taught, is a collective issue that spans globally (“Global Review Finds Comprehensive Sexuality Education Key to Gender Equality and Reproductive Health,” 2019). It is a global public health issue that needs to be addressed in many ways and there is no one size fits all approach to it. Willis et al., in 2019 did a study that focused on K-12 health education standards in the United States.

Willis et al., described consent education that, “Could in principle develop the ability to identify and subsequently communicate sexual desires, which ties indirectly to communicating consent in relation to sexual acts” (Willis et al., 2019, p 231). They collected data from 18 states health education standards in the United States. The health education standards, “Specifically, we ranked all fifty states on nine relevant demographic factors (e.g. population under eighteen, teacher salary, federal aid) and selected the two states that were closest to each division’s median on these characteristics" (Willis et al., 2019, p 228). They found that in teaching about consent in sex education in schools, teenagers showed less taboos regarding affirmative consent. Their study was limited because few state education standards require consent education curriculum, in their education so the number of students who are receiving this consent education is limited (Willis et al., 2019).

There are many studies that have been conducted to find what type of sex education is best to teach young people. In all the research above, it has been shown that comprehensive sex education is best practice as it teaches about anatomy, sexual relationships, healthy relationships and consent. Sex education is a widespread issue that expands far beyond the scope of the research being done in the United States. The research that I conduct is based in Minnesota and looks at curricula that taught to 8-10 grades over the past ten years. In the past ten years, we have seen a shift towards using more comprehensive sex education, and teaching sex education to younger students using age-appropriate teaching methods.

III. Methodology

In this research, I identify a key sample of eight sex education curricula to serve as the data set for this research. These curricula consisted of sex education curricula offered in Minnesota that are promoted by the Hennepin County Human Services and Public Health Department and the Minnesota Department of Health. These curricula are limited to Minnesota in order to focus on the health standards of the state, and national sex education standards of the United States. I chose sex education curricula that are deemed to be medically accurate and evidence based.

Rationale and Significance of the Research

According to The Minneapolis Department of Health and Family, grades 8-10 is a time of rapid changes in self-identity and development. It is an ideal time to educate students about their health and encourage healthy behaviors (Grossman et al.,2014). Based on my research questions, I am interested in the ways that consent is introduced and how it is taught to students ages 13-16. A limiting factor of this research is that Minnesota does not require comprehensive sex education curriculum to be taught in K-12 ("Sex Education in Minnesota," 2019). I am also interested in the application of health standards in Minnesota specifically to grades 8-10, and the inclusion of consent in sexual education curriculum.

I selected grades 8-10 because this age group is a developmental milestone since the period of the beginning of puberty is in grade eight. Willis et al. (2019) states that, "Formal education in schools is not the only source of sex and sexuality education; young people likely learn about consent from other sources" (p. 227). When young people are going through puberty, they have questions that are not always answered in the school

system. When students are not given proper education in the classroom, they start to look at other sources to gain knowledge. These other sources can be the internet, peers, and family.

Using a qualitative content analysis approach in this research, I began data collection by using the set of eight curricula and the executive summaries. I looked for what modules or subjects they taught, the theoretical framework, concepts they teach, how and if they teach consent, unique features of the curriculum, and some evaluation. For evaluation, I looked for the intended audience of the curriculum, and how has it been adapted to fit different groups of students over time.

Using the full curriculum, I looked for how many times they use certain keywords. The keywords I used in this content analysis are in the curriculum being used throughout: “consent,” “refusal skills,” “negotiation skills,” and general “skills. Consent, for the purposes of my research, is the agreement to engage in sexual activity between two or more people. For the purposes of this thesis, I refer to consent in place of sexual consent. I looked for ways the curriculum frames topics of sexual activity, behavior, and abstinence. I wanted to know if the curriculum is teaching abstinence-only education, or abstinence as well as a form of consent. I chose to use the method of feminist content analysis because I wanted to know if consent was being taught in 8-10 grades in Minnesota over the past 10 years. The data I am analyzing is sex education curriculum taught in 6-12 grades and focusing on 8-10 grades.

Content analysis as a method is a good fit to answer my research questions. Patricia Leavy argues that, “Content analysis offers feminist researchers a flexible and

wide-ranging method for engaging in this intellectual and political process" (Leavy, 2007, p.224). By using this method, I have more flexibility in the data set I chose, and what I analyzed from the data sets. The nature of data garners two unique qualities, "1.) the data are preexisting and thus naturalistic, and 2.) the data are non-interactive" (Leavy, 2007, p. 227). The unique feature about using content analysis is that the data is independent from the research.

Consent is important to study and teach because it provides language to young people about what they want to happen with and to their bodies. Consent is emphasized in United States in colleges and universities. A few universities have created legislation surrounding consent in their policies in higher education (Willis et al., 2018). Willis et al., states that, "by the time many young people in the USA reach college, it is likely that they have already engaged in sexual behavior" (2018, p. 227). The first sexual encounter ranging around 16 years old (Willis et al., 2018). According to Willis et al.'s study, college is too late to teach students about consent. By teaching sex education to students at an earlier age, around 6th grade to begin, we are providing young people with the tools and agency to talk about their wants and bodies.

By refusing to teach students about their bodies and consent, the education system is letting students down. By not teaching consent to young people, they are left without the tools to negotiate what they want and need from a partner. By not giving them tools to say what they want and need, we are allowing for sexual violence to occur. One reason that sexual violence is rampant is because people do not know how to communicate their wants and needs. This leads to misunderstandings and more severe, can often lead to rape. When a person has the tools to say what they want and need, they are better able to

communicate a rejection or affirmation to sexual encounters. This is not to say that teaching consent is the only way to end sexual violence. Affirmative consent is just one way of better understanding how young people can understand the relationship between sexual violence and comprehensive sex education.

Data Collection

The criteria for the selection of curriculum focuses on those that identified as Minnesota evidence-based programs. According to The Wing Institute (2019), which is an independent non-profit that promotes evidence-based education practices to K-12 education, evidence-based curriculum, “Consists of practices that have been vetted through rigorous research” (para 1). The Wing Institute suggests curricula should align with health and sex education standards, have enough research using both qualitative and quantitative approaches, have levels of competency that are well defined. They suggest that curricula also have high rates or responses to the curriculum, have adjustments to the curriculum based on feedback, have the scope of the curriculum lead to increasing levels of difficulty and have assessment be specified (“Evidence-Based Curriculum,” 2019, n.p.). These match state and national health standards.

This age range, between 13-16, is a critical age group in which the spread of misinformation and sex education myths occurs most often. According to Grossman et al., (2014) middle school education is important because it teaches students about sex education before, they engage in sex. This provides them the tools and language they need to understand, and to make the best decisions to any sexual act done with another person or persons. It also allows them to make informed decisions about what they want and do not want to happen to and with their bodies.

My research includes curricula that are promoted by Hennepin County Human Services and Public Health Department and the Minnesota Health Department. I began with eight curricula that are listed in table 1.1. My criteria for the selection of curriculums were: 1.) Taught in the past ten years, 2.) Had to be taught in 8-10 grades or to people ages 13-16, and 3.) Had to be taught in Minnesota. I selected these curricula because the Hennepin County Human Services and Public Health Department and the Minnesota Health Department stated that these curricula are promoted by the county and the state. The eight curricula I looked for, and analyzed, are listed in the table below.

Table 1.1 Data Collection of Curriculum

Name of Curriculum	**Year of Publication**	**Is it taught to ages 13-16?**
Making Proud Choices!	2015	Yes
All4You!	2000-2001	Yes
Be Proud! Be Responsible	2014	Yes
Reducing the Risk	2011	Yes

Safer Sex Initiative	2011	Yes
Teen Outreach Program	2017	Yes
Sexual Healthy and Adolescent risk prevention		Yes
Live it	2017	Yes

The first step of data collection was to compile a list of curricula that are taught in 8-10 grades in Minnesota. I found that many of the curricula are taught either to grades 6-8 or grades 8-10 and I look at all that incorporate 8-10 grades. I used data from the Hennepin County Health Services and Public Health Department and Minnesota Health Department to gather a working list of curricula that are promoted for schools to use. I looked at eight curricula. I chose to focus on these two public health organizations because they serve a large portion of the Minnesota population.

The breakdown of race and ethnicity in Minnesota is important because some of the curriculum I examine is specific to race and ethnicity. For example, *Taking Care of Yourself or Cudiate* is designed for Latino youth whereas, *Be Proud! Be Responsible!* is designed for young African American boys. It is important to know what racial or

cultural identity a curriculum is addressing, because in addressing certain groups, we can break down some of the myths and stereotypes surrounding them.

Methods

This content analysis, using discourse analysis, will be guided by three research questions. These three research questions investigate the current sex education health standards for the presence of consent education in Minnesota. See below for the main research questions that guide this study:

Table 1.3 Research Questions

Research Questions
1. Is consent a part of sex education curriculum?
2. What frameworks are being used to teach consent to 8-10 grade?
3. How has consent been taught in 8-10 grades in Minnesota over the past 10 years?

In the next step of data gathering, I looked at two complete curricula, *Making Proud Choices* and *Be Proud! Be Responsible!* As I read through these curricula, I used my research questions to help guide the data analysis. I found the curricula by searching online and only two were available to the public. After, I read the curriculum and highlighted where, and if, they discussed consent. I examined theoretical framework of the curriculum, inclusion of consent, how they taught consent, and the unique factors to the curriculum.

The next step of data collection was to use the Minnesota Health Department and Hennepin County Human Services and Public Health Department lists and summaries of curricula to conduct a content analysis of the rest of the curricula that are not readily available to the public for free. I used the summaries of the curricula, as well as the information on the website etr.org, which is a distribution website of health and sex education related curriculum, to analyze the curriculum based on my units of analysis. The main categories of analysis in this study is, consent and how it is taught (consent, refusal skills, negotiation skills, etc.), theoretical framework, if it is taught in grades 8-10 in Minnesota, and unique factors of the curricula.

After identifying my central categories of analysis from my curriculum set, I began to analyze the data. I applied a qualitative content analysis approach in organizing themes and patterns for data analysis. This is a spiral approach to data gathering and analysis rather than a list approach, according to Patricia Leavy. In this study, the representation is the sex education curricula that are being taught in 8-10 grades in Minnesota. The next step is to analyze additional data and decide what am I looking for within the data set. After, I generated codes and units of analysis, for example, looking for key term's "consent" and "refusal skills." The next step is to create memo notes that help to re-analyze the data and find more themes and patterns from the data set. Next is to generate codes from the reanalysis and to analyze that subset of data. To analyze this data, I asked questions about when the curricula were made and what type of consent it teaches. This all leads to a topical area that is the center of the research': the inclusion of consent in each curriculum (Leavy, 2007).

According to Patricia Leavy, “Content analysis is the systematic study of texts and other cultural products or nonliving data forms” (2007, p. 227). In content analysis research, the researcher’s first step is to identify a body or bodies of content or material to analyze. The second step of content analysis for a researcher is to create a system for recording specific pieces of the content. The final step of the researcher is to measure the information found as numbers or data (Leavy, 2007).

This is a standard definition of content analysis. For my research, I will be conducting a feminist content analysis on sex education curricula. What makes my research feminist in nature, is that I am analyzing the content from a feminist perspective. According to Leavy, a feminist researcher uses content analysis to examine issues such as women’s issues or gain a feminist perspective to explore a medium. Leavy continues to state that feminist researchers critically analyze and interrogate texts that, “Comprise culture to resist patriarchal understandings of their culture and social interpretive processes” (2007, p 224). A feminist lens brings feminist concerns such as equality, social justice, and women’s status to the research. Using a feminist lens, I analyze sex education curriculum and identify consent as a key aspect in my research. I also focus on what theories the curriculum uses to teach from, and what demographic the curricula were made to teach to.

My research looks at the curricula that are promoted in 8-10 grades across Minnesota. Leavy says that feminist content analysis is an analysis of culture and, “Culture is a site where struggles over meaning are played out and later embedded into a host of cultural artifacts such as texts or products” (Leavy, 2007, p 224). Curricula are a text in culture, and they create cultures of consent and rape culture. By not providing

adequate information about sex and sexuality, we as a society are allowing rape culture to flourish. This is because without the proper knowledge and tools to know what healthy relationships and healthy sexuality looks like, students start to act on what they have seen before.

The lens I am bringing to the research is consent education and how that creates a healthy and safe space for people to practice their sexuality and relationships. Leavy states, that, "By bringing a feminist lens and feminist concerns such as women's status, equality, and social justice to the study of the material culture (products), and symbolic culture (multimedium images and representations), feminist researchers employ content analysis in very unique ways and ask questions that would otherwise go unexplored" (Leavy, 2007, p 224). The product of my research is sex education curricula and the symbolic culture of this research is the relationship between consent and sexual behavior that is being taught to students.

By studying sex education curricula, I gained an understanding of the climate of sex education in Minnesota over the past ten years. Each of these curricula have been made or revised sometime in the past ten years and demonstrate the standards of teaching youth about sex and their bodies. By using a qualitative content analysis approach, I was able to look at most of these documents as a whole and then analyze them in multiple parts. By looking at the data sets as a part, and a whole, I can use the theory approach to analyze them and situate them within a social and political context.

Research Limitations and Reflexivity

The limitations to this study are that I could not access the curriculum in their entirety. Thus, I am limited in data that is available to me as a graduate student researcher. I was able to gain access to two complete curricula out of the eight curricula in their entirety. Without a research budget, I was unable to acquire six of the curricula. The cost of sex education curriculum runs from $200-$700 per curriculum ("Minneapolis Department of Health and Family Services," 2019). In order to acquire some of the curriculum, I would have had to purchase student copies, as well as the instructor's copies. Some limitations were that I did not have access to instructors' copies of six of the eight sex education curricula and was unable to afford the expense of buying them outright.

A limitation of doing a content analysis approach alone to this study is that I am unable to know if these curricula that are promoted are taught in the classroom. I did not have access to the schools in order to ask them what they are teaching to students. This is limiting because Minnesota does not have any standards or requirements for sex education, which means schools have choices in what they teach and in what combination they are teaching it to students.

By doing this research from a Gender and Women's Studies lens, I engaged in a practice of reflexivity and reflecting on my own identity as a queer, disabled, white person, from the South. In looking back on my own sex education, I notice that I was not given much of a sex education and that has led me to having a lot of questions over some time. For instance, in the 5th grade, girls and boys were split into groups by sex and each had to watch a video about puberty for their respected sex. After the video, young girls received a gift bag with a stick of deodorant and a panty liner. The video showed a young

girl getting her period for the first time at a sleepover, and the friend's mother explaining what a period was. It went onto describe what the reproductive organs are and why girls get a period every month. From then on, I was left on my own to figure out my sex education. It was in high school that I looked online and found Laci Green, who taught me about sexuality and gender. I was in college when I first heard about consent. I had heard about consent in a Gender and Women's Studies class and then again in a student organization about sexual. It was there that I learned about gender-based violence, and how many people are not taught about consent or given medically accurate sex education.

Sex education is significant to teach to young people because it provides a basis of what healthy and unhealthy behaviors look and act like. By teaching consent to young people, we can give students a foundation of healthy sexual behavior. This behavior and knowledge provide students with tools to say yes or no to sexual activity according to what they want. It allows students to notice healthy and unhealthy relationship behaviors and help each other if someone is in an unhealthy situation. By looking at what education is being promoted by the state of Minnesota, I was able to see what the state believes should be taught to students based on public participation and legislation. Using a content analysis research method, I was able to discover what types of content is being promoted and notice how they relate to one another.

IV. Data analysis

The National Health Education Standards (NHES), are standards that all public schools across the United States should meet in their health and physical education of students in K-12. The NHES are a list of eight expectations and benchmarks for health education by the end of grades 2, 5, 8, and 12 ("National Health Education Standards," 2019). For this research, I focused on sex education by the end of grades 8 and 12, and I focused on standards 2, 5, 7 and 8. I selected these NHES standards that are most related to sex education and consent.

Table 1: Selected National Health Education Standards

Standard 2	Students will analyze the influence of family, peers, culture, media, technology, and other factors on health behavior.
Standard 5	Students will demonstrate the ability to use decision-making skills to enhance health.
Standard 7	Students will demonstrate the ability to practice health-enhancing behaviors and avoid or reduce health risks.
Standard 8	Students will demonstrate the ability to advocate for personal, family, and community health.

For the second health standard, students are expected to analyze the influence of family, peers, culture, media, technology, and other factors on health behavior. At the end of 8th grade, students should be able to understand and examine how family influences and culture affect the health of adolescents. Students are expected to describe how influence from their peers affect both healthy and unhealthy behaviors. Students should be able to analyze how their schools, media and technology, and community could influence their personal health behaviors. Students should explain how the perceptions of norms can influence healthy and unhealthy behaviors in youth., so that they can understand how the influence of personal values and beliefs affect healthy and unhealthy behaviors. They should be able to explain how schools, communities, and public health policies can influence health promotion. By the end of 12th grade, students should be able to do all the above and understand how family, peers, culture, media and community affect healthy and unhealthy behaviors ("Standard 2," 2019).

The fifth standard expects that students will demonstrate the ability to use decision-making skills to enhance health. By the end of 8th grade, students should be able to identify situations that could help, and hinder, healthy decision-making as well as use the decision-making process to make decisions on situations about health-related topics. Students should be able to determine when and if to use individual decision making or collaborative decision-making. Students should be able to find alternatives to healthy and unhealthy issues or problems. They should be able to predict the short-term impact of each alternative related to themselves or others involved, and be able to choose healthy alternatives when making decisions ("Standard 5," 2019).

Students, by the end of 12th grade, should be able to examine barriers that could prevent healthy decision-making. They should be able to predict the long-term impact of health alternatives related to the self and others involved. Students should also be able to defend the healthy choice when making health-related decisions and evaluate the effectiveness of that decision.

The seventh National Health Standard states that students should be expected to demonstrate the ability to practice health-enhancing behaviors and avoid or reduce health risks ("Standard 7," 2019). By the end of 8th grade, students should be able to explain the importance of being responsible for personal health. They should be able to demonstrate healthy practices and behaviors that will maintain or improve health for themselves or others and avoid or reduce health risks. By the end of 12th grade, students should be able to do all of the above, as well as analyze their role of being responsible for enhancing their health. They should be able to show a variety of healthy practices that will maintain or improve their health and others and avoid risk ("Standard 7," 2019).

The eighth and final National Health Standard states that students will demonstrate the ability to advocate for personal, family, and community health ("Standard 8," 2019). By the end of 8th grade, students should be able to take a health-enhancing position on a topic and support it with valid and accurate information ("Standard 8," 2019). Additionally, they should be able to influence and support others to make positive healthy choices. Students should be able to work in groups to advocate for healthy individuals, families and schools, and to identify the ways in which health messages can be changed to fit different audiences. By the end of 12th grade, students should be able to do all of

those from 8th grade, as well as use peer and society norms to create a health-enhancing message and adapt health messages to target a specific audience ("Standard 8," 2019).

National Sex Education Standards

The National Sex Education Standards (NSES) have been revised in 2020, and they cover topics of Consent and Healthy Relationships, Anatomy and Physiology, Puberty and Adolescence, Sexual Development, Gender Identity and Expression and Sexual Orientation and Identity, Sexual Health and Interpersonal Violence ("National Sex Education Standards," 2020). The National Sex Education Standards use a theoretical framework of personalization, susceptibility, self-efficacy, social norms, and skills. The NSES breaks down the information students should know by grades K-2, 3-5, 6-8, 9-10 and 11-12. I will be focusing on grades 6-8 and 9-10.

Table 2: NSES Core Concepts

NSES Standard Core Concepts	**Grades 6-8**	**Grades 9-10**
Consent and Healthy Relationships	Identify characteristics of health and unhealthy relationships Understand power relations Define sexual consent and sexual agency	Describe importance of sexual consent Explain impact of media on personal health
Anatomy and Physiology	Understand human reproductive system	Describe human reproductive system
Puberty and Adolescent Sexual Development	Define medically accurate information about puberty,	Describe cognitive, social, and emotional change in adolescent development

	adolescent development and sexual health	
Gender Identity and Expression	Analyze how peer, family and individual identities influence attitudes and beliefs	Understand the differences between sex assigned at birth, gender identity, and gender expression
Sexual Orientation and Identity	Recall definition of sexual orientation and explain	Differentiate sexual orientation, sexual behavior and sexual identity
Sexual Health	Define vaginal, oral and anal sex Know methods of long- and short-term contraceptives Know the signs of pregnancy	analyze the differences between several types of contraception and identify risks of unintended pregnancy and STDs
Interpersonal Violence	Define and know signs of interpersonal violence and sexual violence Explain why someone who is assaulted is a victim Define sex trafficking, sexual exploitation and gender-based violence	Define and know signs of interpersonal violence and sexual violence Explain why someone who is assaulted is a victim Define sex trafficking, sexual exploitation and gender-based violence

All the standards of the NSES have certain learning outcomes that are expected. Consent and Healthy Relationships (CHR) outline the knowledge and skills needed to successfully navigate changing relationships among peers, family, and partners. There is an emphasis placed on personal boundaries, bodily autonomy, sexual agency, and consent. Anatomy and Physiology (AP) focuses on basic human functioning. Puberty and Adolescent Sexual Development (PD) emphasize skills students need to understand the impact of milestones correlating with physical, social, and emotional development. It also emphasizes that sexual development is normal and healthy (NSES). Gender Identity and

Expression addresses the framework of who a person is and how that relates to their, "Gender identity, gender roles, and gender expression" ("National Sex Education Standards", 2020, p 15) as well as how community, media, and peers influence attitudes and beliefs about safety and equity. Sexual Orientation and Identity (SO) emphasizes an understanding of who people are, as it relates to sexual orientation and identity. Sexual Health (SH) discusses STIs and HIV, how they are spread, prevention methods, and signs and symptoms. It also discusses pregnancy and decision-making to avoid an unwanted pregnancy. Interpersonal Violence (IV) helps students understand interpersonal and sexual violence and emphasizes prevention, intervention, and local resources ("National Sex Education Standards," 2020).

The NSES breaks down learning objectives and core concepts from each subject by grades. I will be focusing on NSES standards that apply to grades 6-8 and 9-10. Under Anatomy and Physiology, by the end of 8th grade, students are expected to be able to describe and understand the human reproductive system, and when concluding 10th grade, they should be able to describe the human reproduction and sexual systems. Under Puberty and Adolescent Sexual Development 8th graders, should be able to define medically accurate information about puberty, adolescent development and sexual health. Upon the completion of 10th grade, students should be able to describe cognitive, social, and emotional changes of adolescence and early adulthood. Under Gender Identity and Expression, students in 8th grade should be able to analyze how peers, family, and an individual's intersecting identities can influence attitudes and beliefs.

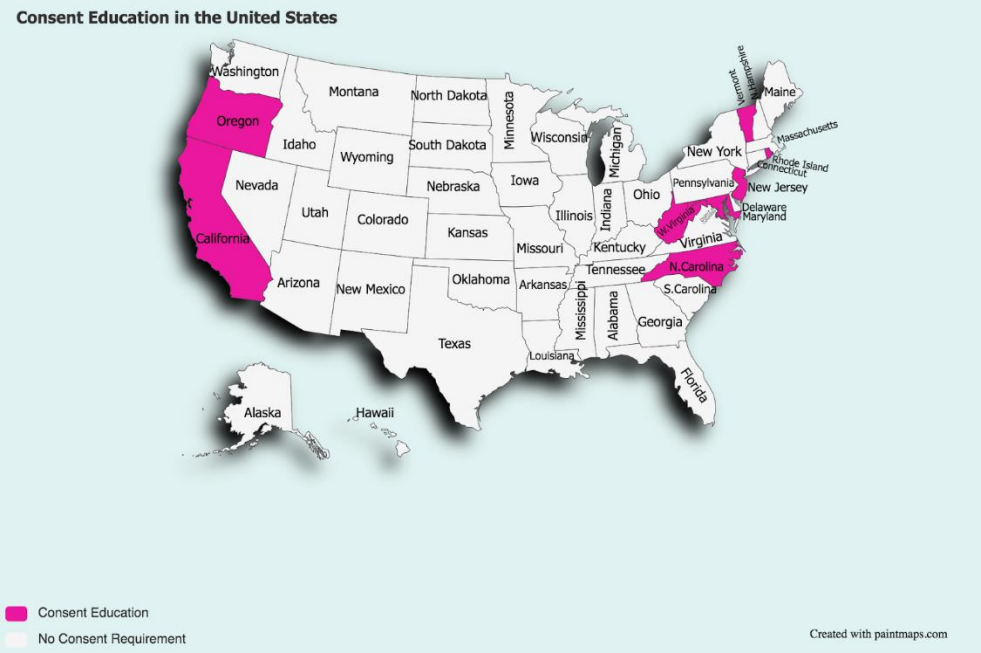
Upon resolution of 10th grade, they should be able to understand the differences between sex assigned at birth, gender identity, and gender expression. Under Sexual

Orientation and Identity, students upon the completion of 8th grade, should be able to recall definitions of sexual orientations and be able to explain them to others. Additionally, upon resolution of 10th grade, students should be able to differentiate between sexual orientation, sexual behavior, and sexual identity. By the end of 8th grade, sexual health students should be able to define vaginal, oral, and anal sex, as well as explain the methods of short- and long-term contraceptives. Students should also know the signs and symptoms of pregnancy. By the end of 10th grade, students should be able to analyze the differences between several types of contraception and identify risks of unintended pregnancy and STDs. Under Consent and Healthy Relationships, students upon completion of 8th grade, should be able to identify characteristics of healthy and unhealthy relationships, understand power relations, and define sexual consent and sexual agency. Upon resolution of 10th grade, students should be able to do all of the above and describe the importance of sexual consent, as well as explain the impact of the media on personal health. Upon the end of 8th grade, under Interpersonal Violence, students should be able to define and know the signs of interpersonal violence and sexual violence, explain why a person who has been sexually abused or assaulted is a victim, and be able to define sex trafficking, sexual exploitation and gender-based violence.

State of Minnesota

Although there are national standards for sex and health education, each state can adopt its own set of standards. Minnesota does not currently have its own set standards for health or sex education. According to the Minnesota Department of Health, Minnesota recommends that schools use the National Health Education Standards. There are 39 states, as well as the District of Columbia, that mandate sex education ("Sex and

HIV Education," 2020). Out of those 39, 27 and Washington D.C., mandate both sex education and HIV education. Additionally, 2 states only mandate sex education and 12 states only mandate HIV education ("Sex and HIV Education," 2020). Only 17 states require program content to be medically accurate, and only 9 states require sex education to have consent education. The states that require consent education are Oregon, California, North Carolina, West Virginia, Maryland, New Jersey, Rhode Island, Vermont, and D.C. (Fay, 2019).



Minnesota does not require that consent is taught, nor does it require for sex education to be medically accurate (Fay, 2019). Minnesota does not have any standards for sex education (“Sex Education in Minnesota,” 2019), and because of this, school districts are able to identify and select the curriculum they use in their schools. There is a list of curricula that is promoted by the Minnesota Department of Health. Those included in the list are *Teen Outreach Program (TOP)*, *Making Proud Choices!*, *Be Proud, Be*

Responsible! Be Productive, Take Care of Yourself, Sexual Health and Adolescence Risk Prevention, Safer Sex Initiative, All4You, and Live it! (“Minnesota Evidence-Based Prep," 2019).

Discussion

The Minnesota Department of Health promotes a list of sex education programs. Although some curriculums are promoted, this does not mean that schools must teach from only that list. There are advantages and disadvantages to having mandated sex education health standards in the state. One advantage is having a state standard in which a state curriculum is used, and laws and bills are in place to make changes to that curriculum. For example, California is a state that has a state standard for sex education, and it has laws in place to keep the standard of education at a certain level. Minnesota does not have a state standard, and because of that, schools are able to choose which curriculum to use in the classroom. In being able to choose a curriculum, schools are better able to have curriculums specific to their school demographic.

There are 39 states, and the District of Columbia, that mandate sex education and/or HIV education ("Sex and HIV Education," 2020). States that require sex education and HIV education are California, Delaware, DC, Florida, Georgia, Hawaii, Iowa, Kentucky, Maine, Maryland, Minnesota, Mississippi, Montana, Nevada, New Hampshire, New Jersey, New Mexico, North Carolina, North Dakota, Ohio, Rhode Island, South Carolina, Tennessee, Texas, Utah, Vermont, Virginia, and West Virginia ("Sex and HIV Education," 2020). Although these states require that sex education and HIV education be taught, it does not necessarily mean that the state has a standard for teaching this

material. Minnesota does not require sex education to be medically accurate, age-appropriate, and culturally appropriate, and does not require parental consent. When HIV is taught, it must include abstinence education ("Sex and HIV Education," 2020).

Findings

Table 3: Curriculum Analyzed Based on Summaries

Name of Curriculum	Consent Taught?	Other Terms used to Teach Consent	Theoretical Framework	Unique Factors
Cuidate	Yes	Skills, Risk Reduction, Negotiation Skills, Refusal Skills	Risk Reduction	Address cultural beliefs related to sexual risk behaviors in Latino community
All4You	Yes	Refusal Skills, Negotiation Skills	Social Cognitive Theory, Theory of Planned Behavior, Social Development Theory	Youth in alternative schools; Service learning component
Sexual Health and Adolescent Risk Prevention	Yes	Refusal Skills Negotiation Skills	Risk reduction; Motivational Enhancement Therapy	HIV Risk reduction among detained youth
Teen Outreach Program	Yes	Refusal Skills		Offered for a wide range of students and ages Must become a partner in order

				to obtain curriculum
Safer Sex Initiative (SSI)	Yes	Negotiation skills	Risk Reduction	Female led Aimed for sexually active young women between ages 13-23
Live It	Yes	Risk Avoidance	Risk Avoidance	American Indian Youth age 11-18

All the curricula above address consent in different ways. *Be Proud! Be Responsible* uses the term, "Negotiation and refusal skills" to teach about consent. In *Making Proud Choices!* the authors use the term "affirmative consent." Affirmative consent is most commonly recognized with the phrase "yes means yes" and is defined as, "Saying yes to what you want to do, and listening for a yes before engaging in an activity with someone else" ("Making Proud Choices," 2016,). Affirmative consent can be given by words or actions, and a lack of resistance or saying no does not mean a "yes" or willingness to engage in sexual activity. Negotiation skills are taught as a way of addressing aspects of consent into everyday conversation. *Making Proud Choices!* offers students a skillset to learn how to negotiate condom usage and activities they like and do not like. Refusal skills are skills taught to students about saying no to sexual activity and drugs. Affirmative consent, negotiation, and refusal skills are ways to encourage students to learn about verbal and non-verbal aspects of consent. *Making Proud Choices* is

different in its approach to teaching it. The concept of affirmative consent is a tool to provide agency to students and allows them to say, “yes, I want this, but no I don't want this,” whereas refusal skills are on the other end of the spectrum teaching students to refuse sexual advances.

Curriculum Theoretical Frameworks

The theoretical frameworks used in the selected curriculums span various disciplines and practices. Some of the most common are risk reduction, Social Development Theory, Theory of Planned Behavior and Reasoned Action, Social Cognitive Theory, and Motivational Enhancement Therapy.

Risk reduction means that the curriculum or educators take measures to reduce the amount of risk students are taking, typically regarding reduction of HIV. The Theory of Planned Behavior comes from social psychology and is an extension of the theory of reasoned action by Fishbein and Ajez who were social psychologists in the 1970s (Ryan, 2010). Social Cognitive Theory was made well known by Canadian psychologist Albert Bandura in 2001 (“Origins of SCT," n.d,). He stated that Social Cognitive Theory could be used, “To analyze how symbolism is able to influence human thought, affect and action” (“Origins of SCT," n.d.). Social Development Theory was brought about by Soviet psychologist Lev Vygotsky in the 1970s (“Social Development Theory," 2020). Motivational enhancement therapy was developed in the 1980s by William R. Miller who was a clinical psychologist (“Motivational Interviewing and Enhancement Therapies,” n.d.).

Social Cognitive Theory is the theory that focuses on learning as the interconnection between personal factors, behavior, and environmental factors. Personal factors that interact with environmental factors involve belief and cognitive competency. Environmental factors that influence behavior and that behavior that interacts with personal factors influences a person's thoughts and actions (“Core Concepts," 2020). An example of Social Cognitive Theory is, student A does well on a test, and by doing well it leads student B and C to want to do well on the next test, so they study harder. *All4You!* and *Making Proud Choices!* uses this theory in its curriculum.

Theory of Planned Behavior looks at attitudes, subjective norms, and perceived behavioral control (“Theory of Planned Behavior," 2010). This theory used to be called the Theory of Reasoned Action. In 1980 theory of reasoned behavior was used, “Predict an individual’s intention to engage in a behavior at a specific time and place” (“Theory of Planned Behavior," 2010). This predicts actual behaviors and it is used to predict deliberate or planned behavior. It is used in sex education to predict what students will do, and to teach them to reduce the risk of HIV and unplanned pregnancies. An example of this theory in practice is when people try to quit smoking, they have intentions to quit smoking but just because of having intention based, on the time and place, they might not actually quit. This theory is used in *All4You!* and *Making Proud Choices*!.

Social Development Theory developed by Lev Vygotsky, explains how socialization can affect the learning process on an individual level (“Social Development Theory," 2020.). This theory tries to explain awareness and consciousness as a result of socialization. This theory means that, “When we talk to our peers or adults, we talk to them for the sake of communication” (“Social Development Theory," 2020). For

example, this theory is used in schools, when the teacher gives information to the students, they believe it has educational value (“Social Development Theory," 2020). When teaching sex education, students listen to the teacher. This can sometimes lead to misinformation when a teacher is referring to the worst possible STIs, and students take the information as normal because the teacher is stating the information as fact. *All4You!* uses this theory throughout its curriculum.

Motivational Enhancement Therapy is a counseling technique that helps people resolve their ambivalence about engaging in treatment, in order to help stop their drug or alcohol use. This treatment helps people overcome their feelings about quitting drug and alcohol use and getting treatment to stop. It does so by taking an approach of internal motivated change. Participants must want to receive treatment in order to successfully get help for drug and alcohol use. It aims to, “Evoke rapid and internally motivated change,” instead of using a steps program method. (“Motivational Enhancement Therapy," 2018). This therapy is used in *Sexual Health and Adolescent Risk Prevention,* when talking about drug and alcohol use. This curriculum is used for youth who are in the juvenile system, and who are using drugs and alcohol. It is used to help youth stop using, and to want to stop using so they do not go back to it after they are released from the juvenile system.

The first set of curricula that I evaluated curricula, I located online without purchasing the entire curriculum. I used summaries, for these five curricula, from the Minnesota Evidence-Based PREP Curriculum website and the descriptions from the etr.org website. A list of the curricula I used in this method is listed below in the following table.

Content Analysis based on Summaries

Cuidate, which translates to, “Take care of yourself” is a curriculum that is adapted from *Be Proud! Be Responsible!* Its, adaptation is designed for Latino children developing knowledge, skills, and attitudes in order to reduce the risk for HIV (“¡Cuídate!,” 2020). This curriculum is aimed at children in the age group of 11-18 or grades 6-12. It helps teens build skills to negotiate and practice abstinence and condom use. This curriculum teaches negotiation and refusal skills as their form of consent education (“¡Cuídate!,” 2020). This curriculum uses a risk reduction form of theoretical framework.

All4You! is a curriculum that focuses on, “Reducing the number of students who have unprotected sexual intercourse” (“Minnesota Evidence-Based PREP Curricula," 2019). This curriculum is aimed at teaching students ages 13-16 or grades 8-10. Its key determinants that relate to sexual risk are, attitudes, beliefs, and perceived norms. *All4You!* teaches refusal and negotiation skills as their form of consent (“All4You," 2019). This curriculum uses Social Cognitive Theory, the Theory of Planned Behavior, and Social Development Theory as their theoretical approaches (“All4You," 2019).

Sexual Health and Adolescent Risk Prevention, formally known as HIV Risk Reduction Among Detained Adolescents, are a single-session, group-based curriculum designed to reduce sexual health risks among high-risk youth that are in juvenile detention facilities (“SHARP," 2020). Some unique factors from this curriculum is that it covers risk reduction of sexual behaviors and substance use. This curriculum also teaches refusal and negotiation skills. This curriculum uses risk reduction and Motivational

Enhancement Therapy as its theoretical frameworks (“SHARP," 2020). This curriculum is meant to be delivered in small groups of ten or less, and aims to increase condom use, and reduce alcohol-related sexual risk behavior (“SHARP," 2020). This curriculum teaches refusal and negotiation skills as their form of consent (“SHARP," 2020).

There has been some research done on *Teen Outreach Program (TOP)* from 1997 to 2019. The 1997 study by Allen et al. studied 695 high school teens in 25 schools and community-based sites across the United States (“TOP," 2019). These schools and community-based sites were randomly assigned to either receive TOP, or programming that was regularly offered by the site. Allen et al. found that *Teen Outreach Program* showed a lower risk of course failures compared to the control groups. They also found that teens completed the Teen Outreach Program showed a lower risk of pregnancy and school suspension compared to the control groups. This study compared to the 2019 experimental study by Daly et al., in 26 Florida high schools that were randomly assigned to either use Teen Outreach program during the school day or a control that did not (“TOP," 2019). The sample size of this study was about 4,000 teens. Daley et al. found that the teens in Teen Outreach Program were less likely than the control to report recent sexual activity, and lowered intention to have sex in the next year (“TOP," 2019). Daley et al. also found some long-term outcomes during a one year follow up that teens who received *Teen Outreach Program* education were less likely to have been pregnant in high school, not ever (“TOP," 2019).

For the next two curricula, there was not much written about them. The *Safer Sex Initiative* has goals to reduce sexual risk behaviors, increase condom use, and prevention STIs (“Minnesota Evidence-Based PREP," 2019). This curriculum does teach consent as

negotiation skills, and is aimed at teaching young, sexually active women, who have been diagnosed with an STI about risk reduction. *Safer Sex Initiative* is a female led curriculum that is used in clinics and community-based organizations ("Minnesota Evidence-Based PREP," 2019). This curriculum is unique because it is an intervention that is one-on-one and is a single 30-50 minutes session with a female health educator ("Safer Sex Initiative," 2019).

Live It, is a curriculum that was born out of the Health Teen Initiative. The goal of the Healthy teen initiative is to "Target populations experiencing the greatest disparities in teen pregnancies, and STIs" ("Healthy Teen Initiative," n.d., para 1). They use medically accurate, evidence-based information, and programs to promote healthy youth development ("Healthy Teen Initiative," n.d.). *Live It* is designed specifically for American Indian Youth. The age range for this curriculum is 11-18 or grades 6-11. According to the Healthy Teen Initiative, this curriculum is culturally specific for American Indian youth in Minnesota. This curriculum teaches risk avoidance as its form of consent and uses risk avoidance as its theoretical framework. Risk avoidance is the avoidance of hazards and risky situations ("Grossu, et al., 2020). It is similar to risk reduction however, the main difference is that the risk avoidance approach attempts to eliminate the hazards that put students at risk instead of reducing the hazards ("Healthy Teen Initiative," n.d.). For example, sex education curriculum would teach students to abstain from sex to avoid risky outcomes such as unwanted pregnancy or contracting HIV or an STI.

Something I found throughout my research was that not all curricula aligned with my initial scope of grades 8-10 or ages 13-16. *Making Proud Choices!* was aimed for youth

aged 11-13, while *All4You* is meant to be taught to aged 13-16. All the curricula I found are taught somewhere in between grades 8-10. *Safer Sex Initiative* is aimed at young people ages 13-23 and is the broadest range of grades for a curriculum that is in my data set. This curriculum is meant for women who have been sexually active, in or out of school. Most of my data set teaches a broad range of ages being taught. Some of the curricula are meant for a younger audience in middle schools, while others are meant for high school.

Risk Reduction versus Risk Prevention

Risk reduction and risk prevention are similar and are both used in talking about business approaches and diseases. When sex education uses these terms, they are talking about the risk of HIV and STIs. Four out of eight of my curricula data set use risk reduction as a part of their teachings to students. Five of my curricula use refusal skills in their teachings, and five use negotiation skills in their teachings.

Risk avoidance is the act of not performing any activity that may carry risk ("Risk Avoidance Vs. Risk Reduction," 2020). Using risk reduction tries to minimize vulnerabilities that may be of threat ("Risk Avoidance Vs. Risk Reduction," 2020). In sex education, risk avoidance teaches about abstinence. The curriculum *Live it,* uses this approach in teaching students to reduce their risk of HIV and STIs, as well as alcohol and drug abuse. This method, used in sex education, would be considered abstinence and if taught on its own as in *Live It,* it would be an abstinence-only curriculum. *Live It* might have a bias about teaching from a risk avoidance perspective because they are trying to get youth out of the juvenile detention system and keep them out.

Using risk reduction tries to minimize vulnerabilities that may be of threat ("Risk Avoidance Vs. Risk Reduction," 2020). Risk reduction teaching would involve teaching students to use condoms and other forms of contraception in order to minimize the risk of HIV and STIs. The curricula, *Sexual Health and Adolescent Risk Prevention, Safer Sex Initiative*, and *Be Proud! Be Responsible!,* all use this form of teaching. Risk reduction gives students the tools to make decisions about using contraceptives and talks about abstinence as the only 100% way to avoid HIV, STIs, and pregnancy.

Be Proud! Be Responsible! has a bias about teaching risk reduction because the curriculum was meant to be taught to young African American boys. There are stereotypes that African American men are more sexually aggressive, so the curriculum is trying to teach away from this stereotype. *Sexual Health and Adolescence Risk Prevention* might have a similar bias as Live *it,* but they are taking a different approach and believe that youth are going to engage in sexual activities. They are teaching students how to avoid HIV risk. *Safer Sex Initiative* teaches young women who have already had an STI about ways to avoid getting another one.

Risk prevention is the process of avoiding risk and lessening the probability of risk ("8 Examples of Risk Prevention," 2020). Both risk avoidance, and risk reduction are a part of risk prevention methods. Risk prevention is avoiding risk, and risk reduction is taking the steps in order to avoid risk and lower the chances of risk. Risk avoidance is avoiding risk as much as possible. In a sex education perspective, risk avoidance is abstinence-only. On its own, risk reduction teaches about abstinence, and when it includes information about contraceptives, it is comprehensive sex education.

I would recommend a curriculum using a risk reduction method. Most of the curricula I looked at use a risk reduction method, and they encourage students to use abstinence and contraceptives. It is not reasonable to expect that students will not be having sex at young ages, but by giving them the tools to practice it safely, educators are allowing for a reduction of HIV and STI rates as well as lower teenage pregnancy. Risk reduction aims to reduce the amount of risk a person confronts in a situation, and by providing students with knowledge, we are reducing the risk.

Five of my curricula use refusal skills to teach consent. Refusal skills fall under risk avoidance. The curricula that use refusal skills are *Be Proud! Be Responsible!*, *Cuidate, All4You!*, *Sexual Health and Adolescent Risk Prevention,* and *Teen Outreach Program. Cuidate, All4You, Be Proud! Be Responsible!, and Teen Outreach Program.* All teach about condoms and contraceptives. Refusal skills are another way to talk about abstinence. Depending on if the curricula teaches about ways to avoid risk, that will decide if the curricula is abstinence-only or comprehensive.

Complete Curriculum Evaluation

Table 4: Complete Curriculums Evaluated

Name of Curriculum	**Consent Taught?**	**Other Terms used to Teach Consent**	**Theoretical Framework**	**Unique Factors**

Making Proud Choices!	Yes	Affirmative Consent	Social Cognitive Theory; Theory of Planned Behavior	Community and family approach
Be Proud! Be Responsible!	Yes	Negotiation skills Refusal Skills	Risk reduction	Designed for small groups; Designed for African-American boys

The next step of data analysis was to evaluate two complete curricula and collect data from the above table. Two of the curricula that are promoted by the Department of Health in Hennepin County are *Making Proud Choices!* and *Be Proud! Be Responsible!* and both are comprehensive sex education curriculums. They both teach about consent, but in different ways. *Making Proud Choices!* teaches about affirmative consent or "yes means yes," while *Be Proud! Be Responsible!* teaches refusal and negotiation skills. *Making Proud Choices!* takes a comprehensive and inclusive approach to sex education.

Be Proud! Be Responsible! aims to reduce HIV and STIs as well as teen pregnancy. In module 3, one of the goals is to increase participants' understanding of their responsibility for safer sexual behavior. This curriculum uses negotiation and refusal skills as consent and those are taught in, "Module 6: building negotiation and refusal skills" ("Be Proud! Be Responsible!," 2014). The goal of this module is to increase students' communications and negotiation skills and to enhance the student's ability to resist risky situations such as sexual behaviors or drug and alcohol related behaviors ("Be Proud! Be Responsible!," 2014). *Be Proud! Be Responsible!* aims to increase a sense of pride and responsibility in students who demonstrate these skills. Finally, it reviews HIV, STI, and pregnancy facts and skills introduced in the other modules.

Be Proud! Be Responsible! uses a risk reduction theoretical framework in order to help students learn about risky behaviors and how to avoid them or reduce their chances of contracting HIV or an STI (“Be Proud! Be Responsible!,” 2014). Some of the core elements that this curriculum teaches are medically accurate information about HIV, STIs and pregnancy prevention, they address behavioral attitudes and outcomes of choices made, build negotiation and problem-solving skills, and build self-efficacy in youth. Self-efficacy is an, “Individual's belief in his or her capacity to execute behaviors necessary to produce specific performance attainments” (“Teaching tip sheet," 2019, para 1).

In their introduction to the curriculum *Making Proud Choices!,* authors state that they teach from a perspective that is age-appropriate, trauma informed, LGBTQ inclusive, culturally inclusive, medically accurate, and teaches affirmative consent (“Making Proud Choices," 2016). They offer lesson plans about non-heterosexual relationships and use gender pronouns throughout the curriculum to be inclusive to all genders. In an alternative version of the curriculum with the Latino Network, *Making Proud Choices!* teaches culturally specific sex education to Latino students. Throughout the curriculum, they ask questions such as, how do other cultures talk and think about sex? What might the best response to engaging in sexual activities be in culturally specific ways?

Making Proud Choices! frames consent as affirmative consent and it is in Module 3, activity A that they give a definition of it. *Making Proud Choices!* says that affirmative consent, “Is about saying yes to what you want to do and listening for a yes before engaging in an activity with someone” (“Making Proud Choices," 2016, p 111). This curriculum uses consent outside of sexual activity and covers consent in any given situation. This curriculum uses the Tea consent video that uses tea as a metaphor for

consent (“Making Proud Choices," 2016). It gives different examples about someone wanting tea or not wanting tea and what someone should do in the circumstances that the other party does not want tea.

Later in Module 4, Activity A, the curriculum teaches a model of consent called, “Stop, think and act: an introduction to problem solving” (“Making Proud Choices," 2016, p 123). The curriculum teaches students to stop what they are doing and collect themselves, think about what they are doing and the consequences of their actions, and act by asking for consent and listening for a yes.

Making Proud Choices! is meant for ages 11-13 or grades 6-8. It was designed for small group settings of African American boys originally and added in girls later (“Making Proud Choices," 2016). This curriculum uses theories, like All4You, Social Cognitive Theory, Theory of Planned Behavior, and Theory of Reasoned Action, also known as the Theory of Planned Behavior throughout its curriculum. Some unique factors of this curriculum are that it teaches consent as affirmative consent, it takes a family approach and brings in family values to the course, and teaches consent (“Making Proud Choices," 2016).

All of my curriculum, except *Making Proud Choices!,* taught refusal and negotiation skills as consent. This shows that the current attitude of sex education in Minnesota is that students should be taught and know how to refuse sexual and drug related activities. *Making Proud Choices!* teaches about affirmative consent and shows that there is beginning to be a shift in attitudes about sex education in Minnesota. The shift is going from refusing sex, to listening for a yes, and actively listening to your partner in a sexual

situation. All eight curriculums are medically accurate and teach about HIV and STIs. Some teach about pregnancy and how to use condoms and other birth control methods to avoid unwanted pregnancy. Five out of eight of the curricula stated that they taught condom use and abstinence together. By teaching about both, they are giving students tools to prevent unwanted pregnancy and the spread of STIs and HIV. All of my curricula abided by the national sex and health education standards.

My recommendations for sex education are that it should be medically accurate, as it is in Minnesota. According to Planned Parenthood, “15 states require instruction to be medically accurate” (para 1). There is a bill that failed that is called the, “Medically-Accurate sex education act” or HB2721 that requires sex education curriculum to be medically accurate in Oklahoma. Many states are also trying to create bills to require sex education to be medically accurate.

Consent should be taught in all sex education curriculums, and with the revised National Sex Education Standards it will have to be included. Some pros about teaching consent to children and teens in middle school and high school is that it gives students agency to their bodies. It allows students to say yes to what they want to happen to and with their bodies in sexual manners, as well as other situations including drug and alcohol related activities. Students at a young age learn consent in ways of good touch, bad touch, and as well as learn the proper names for parts of the body. The goal of teaching consent education is to create an enjoyment about sex being a positive and enjoyable experience when someone is ready to experience it. Consent allows a person to say yes or no to what they want and don’t want with the situation in every step of a sexual encounter, as simple as a high five or a hug.

My suggestion is a curriculum such as *Making Proud Choices!* should be taught in middle and high schools across the nation. *Making Proud Choices!* teaches affirmative consent, and they teach it as a "yes" before engaging in activities with someone consent ("Making Proud Choices," 2016). The modules that this curriculum teaches are 1.) Getting to know you and the steps to make your dreams come true 2.) HIV and student health centers 3.) Attitudes about sex, STIs and condom use 4.) strategies for promoting sexual health, stop, think and act 5.) preventing sexually transmitted infections, preventing unintended pregnancy 6.) developing condom use and negotiation skills, and 7.) enhancing communication skills ("Making Proud Choices," 2016). These modules teach students how to communicate and negotiate things such as condom use, wants and needs, and other safe sex practices. It teaches about what your options are if you are experiencing and an unintended pregnancy and ways to avoid it happening. *Stop, think and Act* is one of the skills the curriculum teaches students to use when engaging in sexual activity ("Making Proud Choices," 2016). The curriculum uses a mix of videos, role-plays, and lectures to help students learn and develop skills to communicate their needs and desires effectively with a partner.

Some of the unique factors of *Making Proud Choices!* is that they use a community and family approach, meaning they engage in the family at home in the assignments and teach about community resources ("Making Proud Choices," 2016). This curriculum teaches students about sexual responsibility and accountability, each student is responsible for their part in a sexual activity and is accountable to try to make it as safe as possible. It teaches abstinence, but also encourages for safer sex practices if a student is going to be engaging in sexual activities.

The limitation of using *Making Proud Choices!* in my study is designed for students who are 11-13 years old or 6-8 grade (“Making Proud Choices," 2016). It builds a good foundation for students going into high schools and should be continued after 8th grade. This study was originally done in a small group setting with African American boys and girls. The students were split into small groups of 6-8 students and were led by an African American adult or two peer African American co-facilitators. Throughout this curriculum there are questionnaires given to students that are immediately before the curriculum starts, and three, six and twelve months after the curriculum has started.

V. Conclusion

Sex education is important because we need teach students about their bodies and give them the tools to be able to consent to sexual activity when, and if they are ready. By teaching reproductive anatomy, healthy relationships, communication, pregnancy and birth, reasons for abstaining from sex, STIs, sexual orientation, sexual abuse, and pregnancy prevention, we can give middle and high schoolers the tools and language to make decisions about their bodies. Then they will know when they are ready to engage in safe sexual behaviors.

Consent education is a new idea that Willis et al. began to research in 2019. Consent education is parallel to discussions of affirmative consent. Consent is missing in many sex education curricula. It may be taught using other names, and in ways that are not explicit, such as refusal skills or negotiation skills. Minnesota does not have any state standards for sex education, because of that, students are being taught a wide variety of education. By giving students the tools and language for sex and consent in their sex education, they can make informed decisions and know what is happening to, and with their bodies.

There isn’t much literature surrounding sex education in middle and high school, and even less in Minnesota. The literature centered around the frameworks of gender-based violence, K-12 education, and public and health education. Research shows that sex education started out by being taught about STIs to soldiers, and then later was brought into schools to teach to students (Kolenz, 2019). A common finding in research is that the earlier we teach consent, the more likely students will wait to have sex until

after high school (Kolnez 2019 et al.; Hollander, 2004; Wood et al., 2019; Eisenberg et al., 2008).

This research analyzed a set of eight sex education curricula in Minnesota over the past ten years in grades 8-10. The questions that guided my research were as follows: 1.) Is consent a part of sex education? 2.) What are the main frameworks of teaching consent? 3.) How has consent been taught in grades 8-10 in Minnesota over the past 10 years? I wanted to know more about what type of consent was being taught in Minnesota, if any were being taught at all. I chose ten years because there has been a shift from abstinence-only sex education, to comprehensive sex education in the past ten years and I wanted to know if that had been reflected in the curriculum being taught. From my research, I found that curricula are moving to more consent being taught and, in some cases, it is affirmative consent that is being taught.

Through my research, I found that consent is taught in a variety of ways including affirmative consent, refusal skills and negotiation skills. Older curricula, made in 2000-2014, are teaching a mixture of refusal and negotiation skills. *Making Proud Choices!*, made in 2015, teaches affirmative consent. By introducing a new way of teaching consent, we are seeing a trend of affirmative consent becoming a norm. Affirmative consent laws started showing up more and more in states across the nation in the early 2010s ("Affirmative Consent Laws," 2020). These laws showing up allow for affirmative consent curricula to be developed and used in schools. This shows a shift in attitude about how sex should be addressed and when it should be taught to students. From my research, I have found that we are seeing affirmative consent in sex education in Minnesota.

The method of this research was a content analysis of the eight curricula that I had found through the Minnesota Department of Health. I looked online for all the curricula and found two whole curricula, *Making Proud Choice!* and *Be Proud! Be Responsible!*. For the other six curricula, I used the summaries from the Minnesota Department of Health website, as well as the information from etr.org in order to gain knowledge of what kind of consent they taught, and what grades they were taught to. These curriculum are *All4You!, Cuidate, Sexual Health and Adolescent Risk Prevention, Teen Outreach Program, Safer Sex Initiative,* and *Live it.*

I analyzed the theoretical frameworks that were used in each curriculum. I found that risk reduction was the main framework used. *All4You!* and *Making Proud Choice!* used both social Cognitive Theory and the Theory of Planned Behavior. Social Cognitive Theory focuses on learning as an interconnection between personal factors and behaviors ("Core Concepts," 2020). The Theory of Planned Behavior is used to predict the actions of a person based on time and place ("Theory of Planned Behavior," 2010) *All4You!*. The only curriculum to use Social Development Theory, explains how socialization can affect the learning process of a person ("Social Development Theory," 2020). *Sexual Health and Adolescent Risk Prevention* is a unique curriculum because it isn't taught in the school system, rather it is taught in the juvenile detention system. This curriculum uses Motivational Enhancement Theory in order to help the youth want to quit alcohol, drugs, and risky sexual behaviors. Motivational Enhancement Theory is a counseling technique to help people want to quit alcohol and drugs and do it because they want to, not because they must.

Throughout my research, I found that *Making Proud Choices!* was the most inclusive in teaching about cultural differences. This curriculum has a revision for Latino students and talks about gender identity and gender expression. I would recommend for schools to shift their teachings to using *Making Proud Choices!* in their teachings in 6-8 grades and then using a curriculum similar to it throughout high school to increase students' knowledge about consent and gender. I would recommend this curriculum because it talks about STIs and pregnancy in a way that gives choice to the individual. Students are encouraged to stop, think and act when making decisions about sexual or personal behaviors ("Making Proud Choices," 2016).

When teaching and introducing concepts of consent, I found that most of my curricula used a combination of refusal and negotiation skills, except one. *Making Proud Choices!* was the only curriculum that taught affirmative consent. *Live it* used risk avoidance as their consent; this teaches students to avoid all hazards such as risky sexual behavior, drugs and alcohol. *Teen Outreach Program* only teaches refusal skills, which is saying no to risky sexual behavior, drugs and alcohol. *Safer Sex Initiative* only teaches negotiation skills, which is a way to make consent into an ongoing conversation rather than yes or no only.

Some of the limitations of this research are that I did not have access to school districts. This research data set was found from the Minnesota Department of Health website; because of this, I am unable to answer which school districts are using the curriculum. Another limitation is that I had a short amount of time to conduct the research and was unable to create a survey or other data gathering method in order to get access to districts. If I would have been able to interview or survey schools, they might

not have told me what curriculum they use. The information that I am seeking is sensitive information because it is dealing with the teaching methods to minors.

Another limitation of this research was that I did not look directly at the district in Minnesota. If I were to change something about the research, I would add a survey sent out to districts asking them what curriculum they use and how consent is being taught. Without doing a mass survey across Minnesota or looking further into each district, I was unable to determine my second research question. I asked, how many school districts include consent in their sex education curricula. I was able to find what curricula Minnesota and Hennepin County recommend. I found eight curricula that all teach consent but was unable to determine which school districts use these curricula.

For my research, I gathered data on Minnesota, which has not been widely researched. I looked at the state over the past ten years and saw a trend of refusal and negotiation skills being taught to students in late middle school and early high school. I was able to find out which curriculums taught consent and how they taught it based on summaries; in two cases the curriculum itself.

One study that helped shape and inform my study was *Sexual consent in K–12 sex education: An analysis of current health education standards in the United States* by Willis et al. In their study, Willis et al., introduces consent education as, “Consent education could in principle develop the ability to identify and subsequently communicate sexual desires, which ties indirectly to communicating consent in relation to sexual acts” (Willis et al., 2019, p 231).

The study then focused on 18 states, including Minnesota, and gathered data about states' health education standards. In their findings, they found that by teaching about consent education, teenagers showed less taboos regarding affirmative consent. Their study was limited because few state education standards require consent education in their education, so the number of students who are receiving this education is limited. (Willis et al., 2019).

For someone continuing this research I would recommend creating a survey over a longer time period. I would suggest creating a survey or a focus group of districts in each county. This method would be able to directly reach the sources of information to find out what they use and how they teach consent to students. Another suggestion would be to conduct a yearlong study on the students to see how they are being taught consent, and how the methods of teaching influence the reactions and actions of the students.

The terms most commonly used for sex education are comprehensive and abstinence -only. The types of skills for consent used are refusal, negotiation and consent. I recommend for Minnesota to push for more use of negotiation, and affirmative consent in their curricula. The trend with *Making Proud Choices!* shows that Minnesota is moving in the direction to teach affirmative consent. The majority of curricula that I analyzed used negotiation skills as well.

In order to make changes in the curricula, there needs to be more research done on how teaching consent can affect student behaviors and choice. In order to do more research, people must advocate for a change. Talking to local governments and local resource centers to talk about the ways we teach children is a step in the right direction.

These resources can make a change, and they provide the research in order to encourage schools to make the switch from refusal skills to affirmative consent and negotiation skills.

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Appendix

Table 1 Making Proud Choices

Modules	Theoretical Framework	Concepts	Consent	Unique features	Evaluation
Module 1: Getting to know you and steps to make your dreams come true	Social Cognitive Theory	Self-efficacy /perceived behavioral control beliefs	Stop, think Act	Community and family approach	11-13 year olds
Module 2: HIV and Student Health Centers	The theory of reasoned action	Outcome expectancies or behavioral beliefs	Affirmative consent - saying yes to what you want to do and listening for a yes before engaging in activities with someone	Sexual responsibility and accountability	Small group setting with African=American male and female students
Module 3: Attitudes About Sex, STIs and condom use	Theory of planned behavior		Tea consent video - compares tea to consent	Making proud choices with safer sex in their choice	3 different middle schools Randomly assigned abstience only, safer sex or a health promotion curriculum (Control is health promotion)
Module 4: Strategies for promoting sexual health, stop, think and act					Students split up into small groups of 6-8 students

Module 5: Preventing Sexually Transmitted Infections					Led by an African-American adult or two peer African-American co-facilitators
Module 6: Preventing Unintended Pregnancy					Questionnaires before, immediately after, and 3, 6, and 12 months after
Module 7: Developing Condom Use and Negotiation Skills					
Module 8: Enhancing Communication Skills					

Table 2 Be Proud Be Responsible

Modules	Core elements	Consent	Unique features	Evaluation
Module 1: Introduction to HIV, STDs and Pregnancy	Teach correction information about HIV, STDs and Pregnancy and prevention	Negotiation and refusal skills		11-14 year olds
Module 2: Building Knowledge about HIV, STDs and Pregnancy	Addresses behavioral attitudes/outcomes	Resist situations that place them at risk for unwanted pregnancy or contracting an STD, including HIV infection		6-12 teens in a group
Module 3: Understanding Vulnerability to HIV, STDs and Teen Pregnancy	Build negotiation skills and problem-solving skills			In schools on saturdays
Module 4: Attitudes and Beliefs about HIV, Condoms use, and safer sex	Build self-efficacy in adolescents			6 sessions of 50 min or 3 1 hour 40 min sessions
Module 5: Building Condom Use Skills				Led by two African-American adults

Module 6: Building Negotiation and Refusal Skills				Questionnaires before, before and after program
				African American boys

Table 3 Teen Outreach Program

Modules	Theoretical Framework	Concepts	Consent	Unique features	Evaluation
Healthy relationships	Evidence-based	Adolescent development	unknown	In school After school Community-based organizations In systems and institutional settings	Ages 12-18 Middle and high school
Communication and assertiveness		Sexuality	"Life skills"		Designed to accommodate a wide range of ages
Critical thinking and external influences		communication			Shown to improve academics and decrease risky behavior
Goal-setting		Healthy relationships			
Decision Making and personal reflection		influence			
Values clarification to explore their own values		goal-setting			
Health, wellness and self-understanding		Decision making			
Community service learning		Community service learning			