California Education Code §§ 51930-51939:
An Exercise in Trailblazing and Incrementalism

Until fairly recently, California adolescents did not have access to age-appropriate social health education at a time in their lives when they face a variety of social and health challenges including constant access to technology and media, increasing rates of sexually-transmitted infections, limited access to affordable health care services, and pervasive gender-based harassment and violence. The California Healthy Youth Act (CHYA), adopted in 2016, sought to address these challenges by introducing a host of new and expanded requirements for sexual health education. While CHYA is the most comprehensive sexual health education requirement in the United States, it has not been without its challenges in achieving broad adoption at the district level.

A Brief History of Sexual Health Education in California

Sex education has had a long and storied history in the United States. According to Dr. Lisa Andersen in an interview on The Longest Shortest Time podcast (2017), sex education was initially introduced in public schools during the late 1800s in some Common Schools. Sex education went through a variety of iterations through the early 20th century and, by the 1940s and 1950s, sex education was largely seen as an integral strategy to strengthen the family and combat increasing divorce rates. Sexual health topics were addressed quite frankly in the classroom in the interest of ensuring that students were not surprised by sexual experiences when they got married – a good sex life meant a good marriage. In the 1960s, however, there was considerable vocal resistance to sex education being taught in public schools, perhaps driven by the increasing openness of young people to sexuality. In response, sexuality educators shifted their focus from advocating for sex education to support family life to advocating for the importance of addressing growing public health challenges such as teen pregnancy and sexually-transmitted infections. By the 1990s, sex education was almost entirely focused on preventing these negative health outcomes.

In 2003, California adopted the Comprehensive Sexual Health and HIV/AIDS Prevention Education Act, which covered sections 51930-51939 of the California Education Code (Combellick & Brindis, 2011). Prior to the adoption of this law, there was a confusing and fragmented set of requirements that fell across a variety of topic-specific section of the Education Code and content standards (Combellick & Brindis, 2011). This new law required that HIV prevention education be provided at least once in grade 7 or 8 and at least once in grades 9-12. Beyond HIV prevention education, sex education was not required to be taught, however, if a school district did choose to teach sex education, it had to meet a list of content requirements and instructional criteria (Combellick & Brindis, 2011). While there are some obvious flaws in the Comprehensive Sexual Health and HIV/AIDS Prevention Education Act – namely, how one teaches about prevention of HIV without teaching one of the primary sources of transmission, sexual activity – this requirement was an important step in empowering students to make informed decisions about their health.

In 2011, a statewide survey of a sample of California schools districts was conducted by Combellick & Brindis to determine the extent to which these districts were in compliance with the requirements of the Comprehensive Sexual Health and HIV/AIDS Prevention Education Act. While the study found that most school districts in the study were providing HIV prevention education, a significant minority were not in compliance with all of the requirements of this law in a variety of ways – teacher training, parent notification, conceptual approach, and coverage of all required topics, to name just a few (Combellick & Brindis, 2011).

In response to this study and anecdotal reports from school districts and non-profit organizations

© Abigail Karlin-Resnick 2018

across the date, in 2015, the Sex Ed Roundtable, a collaborative of youth-focused and sexual health organizations in California, spearheaded an effort to update sections 51930-51939 to provide more clear guidance to districts on what should be taught in sex education, to update the Education Code language to reflect current medical advances in preventing pregnancy and sexually-transmitted infections, to make instruction more inclusive of diverse student identities, and to incorporate more robust content requirements about healthy relationships. In October 2015, AB 329, the California Healthy Youth Act, was signed into law and went into effect in January 2016.

Notable Health and Social Trends

Teen pregnancy hit an all-time high in 1990 at 118 births/1,000 15-19 year olds (Child Trends Databank, 2016) – four to fifteen times higher than most other industrialized countries at that time (The World Bank, 2018). It has since declined by 81% in the United States (Centers for Disease Control and Prevention, 2017) and 75% in California (California Department of Public Health, 2017). There are several hypotheses offered for this precipitous decline, sexual health education being chief among them (Klein, 2013). Sexually-transmitted infections (STIs), however, have shown a very different trend from teen pregnancy. While some STIs rates declined in the late 1990s and early 2000s, over the last ten years, they have shown alarming increases (California Department of Public Health, 2017). It is not clear, yet, what is driving these increases.

While much of the focus of sex education for the last 30-40 years has been on public health outcomes, there are two other important social trends that relate to sexual health education and outcomes. First, the increase in student access to and active use of technology has likely had a dramatic effect on how young people engage with sexual health education, both in school and out. Access to sexual health information at one's fingertips is both a significant benefit and a new challenge. On the one hand, teens are now able to search for information about sexual health topics through internet and apps without depending on an adult – an important opportunity for teen empowerment. On the other hand, this access to technology provides access to vast amounts of sexually explicit material, also at young people's fingertips and free. Never before have teens had so much access to free pornography. Research suggests that teen engagement with sexually explicit media may have profound effects on how they perceive and engage in sexual activity, both as teens and throughout their lives.

Lastly, over the last five years, gender-based harassment has become a notable barrier to educational outcomes. A study by the Associated Press in 2017 found nearly 17,000 reports of student-on-student sexual assaults between 2011 and 2015, which included students in every grade, K-12 (McDowell, et al, 2017). Sexual harassment and sexual assault has been shown to impact students' self-esteem and mental and physical health (Gruber & Fineran, 2008) as well as students' school performance and long-term educational goals (GLSEN, 2015).

The California Healthy Youth Act sought to address each of these trends and more. In addition to requirements for teacher training, use of outside consultants, and parental notification, CHYA includes two primary sets of instructional guidance in how sexual health education must be delivered. According to the California Department of Education (2016), Section 51933 of the California Education Code lays out a set of baseline criteria that all sexual health education provided in grades K-12 must adhere to including: being appropriate for individuals of all genders, ethnicities, and religions; being accessible to English Language Learners and students with disabilities; affirmatively recognizing that people have different sexual orientations; teaching about gender identity, gender expression, and the harm of negative gender stereotypes, and teaching about healthy relationships, among much else. Section 51934 lays out an extensive set of content requirements that must be covered at least once in grades 7 or 8 and at least once in grades 9-12 including, among other things: all ways a pregnancy or STI can occur and the effectiveness and safety of all FDA-approved methods to prevent a pregnancy or STI; students' legal rights to access health care services; all legally available options for a person who becomes pregnant; and information on sexual harassment and assault, healthy and unhealthy relationships, including

intimate partner violence, human trafficking, and relationship abuse.

Challenges with CHYA Implementation: Observations from the Field

While the California Healthy Youth Act is trailblazing in concept, the implementation has been gradual at best. The following analysis of CHYA is based on my personal observation of the implementation since its adoption in 2016 from my perspective as the Executive Director of one of the primary non-profit organizations partnering with California school districts to implement the requirements of CHYA.

The California Healthy Youth Act sought to provide additional guidance and structure to school districts in providing sexual health education, based on anecdotal feedback from districts and the results of the Combellick & Brindis study in 2011. However, it also significantly increased the content requirements on school districts without putting a specific curriculum in place for the instruction. While it was important to give local communities leeway in adopting materials that are consistent with their district and community values and priorities, it also put school districts in a tough spot to try to develop their own curriculum covering a vast array of highlight sensitive topics. How could they identify accurate, up-to-date information about birth control methods and medical treatments, best practices in behavior change strategies, and other applicable laws, such as students' right to health care, for example? How could they determine if the materials are in full compliance with CHYA? Are there service providers who could support implementation and if so, how could a district assess the quality of the provider and their materials?

Another significant challenge was how to ensure that teachers who are providing the instruction are sufficiently trained to deliver the instruction in a value-neutral, medically accurate manner. A health teaching credential is not required for teachers who provided sexual health education, which afforded districts some flexibility in which subjects sexual health education is integrated, since many districts do not have a required health class, but it also created challenges in that the teachers who were often asked to provide the instruction had little or no background in sexual health education. To make the situation more challenging, when CHYA was adopted, there were essentially only two organizations in the state able to provide training on specific curricula that covered most or all of the required content to be covered. There were also an assortment of training providers who offered training on specific aspects of teaching sexuality education – answering student questions, core competencies, sexually transmitted infections, contraceptive technology – but this required districts to piece together a patchwork of training topics and sessions for entire grades of teachers.

Many of these challenges are also closely related to the fact that there was no funding attached to the adoption of CHYA. In fact, the teacher training requirement in the law was softened through the appropriations process because it was determined that, in its initial form, which required teachers to be trained on sexual health topics broadly, it would put too heavy a financial burden on school districts. The language was adjusted to maintain the previous requirement for teachers to only be trained in HIV prevention education. There are ways that school districts can allocate funds towards sexual health education training and support, but with a trend towards less categorical funding in state funding structures (under which there were funds allocated to AIDS instruction), much of the earmarked funds for sexual health education are incorporated into large block grants that get subsumed into school districts' general funds.

Lastly, a major challenge with CHYA has been the lack of mechanisms to either monitor for district compliance or institute consequences for school districts out of compliance. The California Department of Education has 1.5 full-time equivalent staff members dedicated to overseeing sexual health education implementation in the 1,000 plus school districts in California. A significant portion of their time was initially dedicated to servicing a large federal grant for sexual health education in just fifteen school districts in the state, which means that there was the equivalent of less than one person in the state to monitor implementation of CHYA. This leaves

© Abigail Karlin-Resnick 2018

most of the monitoring to nonprofit organizations, which primarily operate in the major metropolitan areas, without any systematic way to monitor implementation beyond the onerous process of requesting curricular materials and documentation from districts under the Public Records Act. There is no definitive tracking of district compliance (also a critical problem), but the best estimates from key nonprofit organizations working with school districts is that perhaps 30% of the 1,000 school districts in the state are in compliance or close to it. The remaining 70% are either unknown in their level of implementation or are out of compliance.

This was particularly problematic when CHYA went into effect because there were no consequences from the California Department of Education, should a school district be found out of compliance. The only available threat was the possibility of a long, expensive lawsuit filed by the American Civil Liberties Union (ACLU) on behalf of families in each district found out of compliance. The ACLU presumably doesn't have the resources or the desire to bring lawsuits against every school district that is out of compliance.

While the California Healthy Youth Act was implemented with relatively little fanfare in 2016, significant community pushback began bubbling up in communities in mid-2017. The community resistance was largely in affluent suburban communities with either highly educated immigrant populations or high concentrations of religiously conservative populations. The resistance was largely focused on specific curricula that are being adopted for use in $5^{th} – 7^{th}$ grades. One common thread in several of the communities has been the presence, sometimes overt, of right-wing nonprofit organizations, which have been documented as strongly anti-LGBTQ. While most of the arguments from oppositional parents focus on age-appropriateness of content and parents' rights to access materials, there is a clear undertone of anti-LGBTQ sentiment.

Strategies for Addressing Implementation Challenges

First and foremost, it is critical for the state departments of education and public health to allocate earmarked categorical funds for sexual health instruction. One option is for an integrated strategy across both departments to allocate funds towards assessing and monitoring compliance on a county-wide level as well as issuing grant funds to districts to implement and sustain implementation. This could be in the form of training and technical support for implementation or subcontracting instruction to vetted nonprofit organizations. While categorical funds have been criticized for being too restrictive in allowing districts to meet requirements, it provides an incentive for districts to prioritize sex education to receive the funding and engages county-level governments in supporting implementation to address concerns of over-reach by the state department of education. This option would require disaggregating AIDS instruction funds from California's Mandate Block Grant, however, which could be politically untenable.

Alternatively, the California Department of Education could conduct a competitive grant process targeted at areas of the state with less-known implementation status (particularly rural communities). This could be conducted in conjunction with the state Department of Public Health also conducting a statewide competitive grant process targeted to areas with high rates of negative health outcomes (e.g., early unintended pregnancy, STI rates, sexual harassment claims). This funding approach could be linked to existing funding infrastructure of California's primary education funding infrastructure, the Local Control Funding Formula, for which districts are required to provide accountability plans annually.

Either of the options above could be implemented through the state departments or could be implemented through a quasi-governmental organization. One such candidate would be the Adolescent Sexual Health Work Group (ASHWG), an existing collaboration between governmental organizations, research institutions, and nonprofit organizations (ASHWG, 2018). Using ASHWG as a granting partner could provide the

© Abigail Karlin-Resnick 2018

added benefit of incorporating evaluation of the impact of CHYA and an assessment of effective implementation strategies via the collaborating research institutions. This research effort could not only serve to assess effectiveness and impact, it could also provide the justification for continued investment in sexual health education (perhaps into younger grades) and could inform practices in other states.

The second category of strategies is monitoring and consequences. There must be a robust team of monitors in the California Department of Education to both assess implementation and provide technical assistance to districts seeking to get in compliance with the requirements of CHYA. This is a function that would need to be housed in the Department of Education, not the Department of Public Health or in an outside organization because it needs to have both the credibility to monitor compliance and the organizational weight to impose consequences. Given the size of California, there would ideally be monitors assigned to particular regions of the state, who would monitor 100-200 school districts within their region through regular site visits and account management. School accreditation processes could serve as a template for this monitoring approach.

Last, but not least, effective implementation requires appropriate consequences for non-compliance. These consequences could include frequent audits of progress and additional requirements for health risk behavior assessment through the national Youth Risk Behavior Survey and/or the California Healthy Kids Survey. Additionally, the California Department of Education could post the compliance status of each school district on its website as a form of public accountability. As a last resort, the Department of Education could levy financial sanctions against a school district until compliance is achieved.

Conclusion

Going forward, effective implementation requires an integrated effort that calls on each of these strategies in order to first achieve broad adoption of compliant comprehensive sex education under the California Healthy Youth Act and then work with school districts to achieve excellence in sex education. While this would likely require a notable increase in annual funding requirements, this investment would position California as a leader in the U.S., making student health a priority. If California can effectively implement and demonstrate impact from the most comprehensive sexual health education requirements, at least some states will take notice and follow suit. California has the ability not only to impact the sexual health decisions and long-term health and wellness of its six million students (California Department of Education, 2017), but also several million more in other states and perhaps even nationally one day.

© Abigail Karlin-Resnick 2018

References

ASHWG. (n.d.). *About ASHWG*. Retrieved from http://ashwg.org/about/

California Department of Education. (2017). *Fingertip facts on education in California - CalEdFacts (CA Dept of Education)*. Retrieved from https://www.cde.ca.gov/ds/sd/cb/ceffingertipfacts.asp

California Department of Public Health. (2017). *Sexually transmitted diseases in California: 2017 snapshot*. Retrieved from https://www.cdph.ca.gov/Programs/CID/DCDC/CDPH%20Document%20Library/STDs-CA-2017Snapshot.pdf

California Department of Public Health. (2017). *Adolescent births in California 2000-2015*. Retrieved from https://www.cdph.ca.gov/Programs/CFH/DMCAH/CDPH%20Document%20Library/Data/Adolescent/Adolescent-Birth-Rates-2015.pdf

Centers for Disease Control and Prevention. (2017). *Teen pregnancy in the United States*. Retrieved from https://www.cdc.gov/teenpregnancy/about/index.htm

Child Trends Databank. (2016). *Teen Pregnancy*. Retrieved from https://www.childtrends.org/?indicators=teen-pregnancy

Combellick, S. and Brindis, C. (2011). *Uneven progress: Sex education in California public schools*. Healthpolicy.ucsf.edu. Retrieved from https://healthpolicy.ucsf.edu/sites/healthpolicy.ucsf.edu/files//wysiwyg/Documents/Uneven_Progress_Full%20Report_Nov2011.pdf

Frank, H. (Executive Producer). (2017, August 23). *How to make a fella feel relaxed* [Audio podcast].

GLSEN. (2015). *The 2015 national school climate survey*. pp. 1-146.

Gruber, J. & Fineran, S. (2008). *Comparing the impact of bullying and sexual harassment victimization on the mental and physical health of adolescents*. Sex Roles. 59. 1-13. 10.1007/s11199-008-9431-5.

Klein, R. (2013). *California teen birth rate sees HUGE drop, report says*. HuffPost UK. Retrieved from https://www.huffingtonpost.com/2013/07/19/california-teen-pregnancy-rates-drop_n_3625090.html

McDowell, R., Dunklin, R., Schmall, E., & Pritchard, J. (2017). *Hidden horror of school sex assaults revealed by AP*. Associated Press. Retrieved from https://www.ap.org/explore/schoolhouse-sex-assault/hidden-horror-of-school-sex-assaults-revealed-by-ap.html

The World Bank. (2018). *Adolescent fertility rate (births per 1,000 women ages 15-19)*. Retrieved from https://data.worldbank.org/indicator/SP.ADO.TFRT

© Abigail Karlin-Resnick 2018