

Teachers' Perspectives on Sexuality Education:

Final Report

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Teachers are expected to reach unattainable goals with inadequate tools. The miracle is that at times they accomplish this impossible task.

~ Haim G. Ginott

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Part I: Summary of Focus Group Findings

EXECUTIVE SUMMARY

Sexuality education has been a contentious issue in the United States since its introduction into the classroom over a half century ago. Parents, politicians, health care professionals, researchers and special interest groups have all weighed in on what, how and when it should be taught. Ironically, public discourse has largely ignored the perspectives of sexuality education teachers. Teachers perform a critical role in delivering sexuality education, and the lack of information on their perspectives is an important gap. Learning from teachers about how they are trained, how they handle a controversial and personal subject, what challenges they face and how they are supported is a crucial step towards addressing these challenges and enhancing supports to enable sexuality education teachers to do their work more effectively. The goal of this research, therefore, is to learn from teachers of 6th-12th grade students about their experiences on the “front line” of sexuality education in Minnesota.

We conducted seven focus groups with sexuality education teachers from the Twin Cities, surrounding suburbs, and other areas of Minnesota, in January and February 2009. The goal of these focus groups was to identify experiences, supports and challenges educators face in teaching sexuality education. Participants included a diverse sample of 42 sexuality education teachers, both those who are licensed classroom teachers, and non-licensed sexual health educators at community organizations. Over 900 unique, substantive comments were coded into themes and sub-themes in an iterative process, and a schema was developed to capture participants’ responses to all discussion questions.

Results are categorized in three sections regarding preparation for teaching sexuality education, teaching sexuality education, and areas for change. Key findings are highlighted below:

Getting Started: How are Minnesota’s teachers trained – or not – to teach sexuality education?

- Minnesota’s teachers came to teach sexuality education with a wide variety of training experiences. Although most participants were trained as classroom health teachers, many had no formal training specifically in sexuality education. Those with minimal training typically sought out supplementary training in sexuality education early in their careers. Some had excellent student teaching experiences during a sexuality education unit, which they found extremely valuable.
- It was commonly recognized that neither having knowledge of the content area, nor general teaching skills, were in themselves sufficient to teach high quality sexuality education – one had to have training and expertise in both.

- All classroom health teachers agreed sexuality education was a standard part of their health education program and they expected to teach it. Most teachers noted that their experience teaching sexuality education was as good or better than they initially expected it might be, but that they had many surprises in their first years of teaching. Teachers came to believe that sexuality education was among the most important topics they taught.

In the classroom: Trying to meet students' needs

- Minnesota's sexuality educators felt fortunate to have a wealth of sexuality education resources available including area clinics, agencies and organizations; the Minnesota Health Educators' Conference; district, city or county offices; public health agencies; state agencies; and other sources. Teachers also spoke of how they benefited from connecting with each other to exchange materials and ideas. Lack of time and money were cited as primary barriers to taking full advantage of existing resources.
- Teachers described many areas in which additional training, support or resources could improve their sexuality education pedagogy. In particular, they mentioned informational updates, contemporary materials, culturally specific trainings, and materials written in languages other than English.
- Teaching sexuality education involves many activities exceeding the usual classroom practice, including getting administrative approval, working with parents, dealing with students' issues, creating comfortable and respectful environments, using extra caution, debunking myths, and using a variety of experiential teaching methods. Teachers also devoted considerable energy to advocating on behalf of sexuality education.
- Many teachers developed their own curricula for teaching sexuality education. They evaluate their courses based largely on the latitude they have to teach what they feel students need and the amount of time available to cover the topic.
- The most common topic that teachers said they would add or expand on in their sexuality education programs was *healthy relationships*.
- Teachers overwhelmingly noted that they would like to continue teaching sexuality education, because they enjoyed teaching in this area and believed that sexuality education was extremely important for their students.

Where do we go from here? Supports and challenges in teaching sexuality education

- Teachers felt that policy changes could be very helpful in supporting sexuality education. Many teachers favored a state law mandating comprehensive sexuality education beginning at early ages, and inclusion of health education as a graduation requirement, and noted the importance of funding to support this subject.
- Teachers overwhelmingly believed their students were more engaged in sexuality education than in most other health topics, largely due to its relevance in their lives, and this engagement resulted in greater learning. They offered many ideas for integrating sexuality education content into other subject areas to increase interest, yet noted that this could not replace a dedicated sexuality education unit.
- Teachers' most commonly cited barrier to teaching sexuality education in a way they thought would be of most benefit to their students was school- or district-level policy that prevented them from including certain topics viewed as more controversial. Other common barriers included limited time and a lack of financial resources.
- Teachers expressed frustration with the undue influence of outspoken parents, usually representing a small minority, on sexuality education policy.
- Teachers described diversity in their student bodies as an additional challenge. Specifically, it is challenging to offer classroom programming that takes into account cultural differences, a broad range of students' personal experiences, and disparities in basic knowledge among students within a given class or school.

Minnesota's sexuality education teachers are passionate about this topic and dedicated to their work. They strongly desire to reach their students with current, accurate and useful information, and typically go beyond the call of duty to strengthen their courses. However, teachers face many challenges which could be addressed with changes in policy, training and programming. Teachers' collective experiences and challenges lead to recommendations to support teachers in providing the best possible sexuality education to Minnesota's young people.

INTRODUCTION

Sexuality education has been a contentious issue in the United States since its introduction into the classroom over a half century ago. Parents, politicians, health care professionals, researchers and special interest groups have all weighed in on what, how and when it should be taught, and policy battles have erupted over different approaches. As a result, a complicated patchwork of sexuality education programs covers the U.S., with substantial differences in educational offerings from state to state, school district to school district, and classroom to classroom.

In Minnesota, school districts are required to develop local standards in health education, but currently no statewide graduation standard for health exist. Minnesota statute requires education on reducing the risk of sexually transmitted infections, including HIV/AIDS (MDE, 2007), which is typically included in health classes. The state does not specify any requirement for sexuality education more broadly.

The content of sexuality education has shifted in recent years to include more “abstinence-only” education, due in large part to the 1998 Social Security Act (Section 510) that provided \$50 million in annual grants for these programs. For example, from 1995 to 2002, the proportion of youth who received formal abstinence-only education increased from approximately 9% to 23%; simultaneously the proportion receiving education about birth control fell from approximately 84% to 68% (Lindberg et al, 2006). However, mounting evidence indicates that comprehensive sexuality education programs can delay sexual activity and improve condom and contraceptive use among those who are sexually active (Kirby, 2001; Manlove et al, 2004), while abstinence-only programs have been largely ineffective at changing behavior (Trenholm, 2007). A growing body of research with adults – and parents in particular – speaks to overwhelming support for offering comprehensive sexuality education in public schools (Eisenberg et al, 2008; Constantine et al, 2007). In Minnesota, 89% of parents of school-age children favored teaching about both abstinence and contraception, and this support was high across all demographic categories of parents. Of note, over two-thirds of parents also supported including topics that are often seen as controversial, such as sexual orientation and abortion.

The research and public discourse around sexuality education has, ironically, largely ignored sexuality education teachers. Although some studies have described what is taught in their classes (MDE, 2007; Lindau et al, 2008), we were unable to find any qualitative research with teachers in the U.S. regarding their experiences teaching sexuality education. Teachers play a critical role in providing sexuality education, and the lack of information on their perspectives is an important gap. Learning from teachers – about how they are prepared to teach in this area, how they handle subject matter that can be controversial and personal, what challenges they face and how they are supported – is a crucial step towards supporting sexuality education teachers in doing effective work. The goal of this research, therefore, is to learn from teachers about their experiences on the “front line” of sexuality education in Minnesota.

METHODS

Design, recruitment and sample

We conducted focus groups with sexuality education teachers from the Twin Cities, surrounding suburbs, and other areas of Minnesota. The goal of the focus groups was to identify experiences, supports and challenges that teachers face in teaching sexuality education.

Study participants included 42 sexuality education teachers, both those who are full-time classroom teachers, and those based out of community organizations who teach in various settings (including schools, by invitation). Two primary methods were used to recruit teachers. First, the Minnesota Department of Education (MDE) provided a contact list of all health teachers in Minnesota (N~800). Study staff sent a letter of invitation to these teachers at their school addresses in early January, 2009, and interested teachers called the study to sign up for a scheduled focus group session. Follow-up e-mails were sent to teachers on the MDE list for whom we had e-mail addresses. In addition, we invited several teachers who requested information about the study at Pro-Choice Resources (PCR) meetings, conference tables, newsletters (PCR and other local agencies), and in response to our health teacher mailing. This procedure allowed us to include teachers in disciplines other than health.

Using these methods, we recruited a diverse sample of teachers, including populations that are under-represented in health education in Minnesota (male, African American & Latino teachers). Participants had a broad range of teaching experience (new teachers to those with 30+ years of teaching experience); health teachers and those from other disciplines (e.g., Family and Consumer Science teachers; community educators); middle- and high school teachers; teachers from urban, suburban and small town schools; those from large and small schools; and those teaching in traditional public schools, charter schools and alternative learning centers (ALCs).

Development of the focus group interview guide

The focus group interview guide was developed by the study team in consultation with PCR staff members, colleagues at the Minnesota Department of Education, and the Birds & Bees Project funder. Questions were designed to elicit information about the supports teachers receive and the challenges they face in teaching sexuality education. Questions were ordered with the intent of moving from less sensitive to more sensitive topics in order to build rapport within the group during the focus group session.

An initial series of eleven discussion questions was reviewed and revised for use with a pilot focus group of community-based sexuality educators. At the conclusion of the pilot focus group, participants were asked to comment on question ordering, clarity, language, sensitivity and other aspects of the focus group script; this feedback was used to further revise the focus group guide. As is common in qualitative research, the interview guide underwent additional revision in the course of data collection. The focus group team (two facilitators, two note-takers and one observer) met to review the script and protocols after two focus groups; additional minor revisions to question wording and ordering were made at that time. The final focus group interview guide contained nine questions plus related probes for more detailed information (Appendix A).

Focus group data collection

We conducted a total of seven focus groups in January and February, 2009. Groups were held in various settings (e.g. conference rooms, public libraries). Two groups were specifically scheduled around statewide conferences being held in the area (the Minnesota Health Educators Conference in Bloomington, MN, and the Minnesota Association of Alternative School Programs in Rochester, MN) to accommodate participants from greater Minnesota who gathered for these events. Between 2 and 12 participants attended each group. In addition, one teacher from Northern Minnesota was unable to attend scheduled focus groups, but provided written responses to the questions on the focus group interview guide.

Two study staff members conducted each focus group, including a facilitator and a note-taker who recorded participants' comments. Additional staff (Birds & Bees Project staff or student volunteers) were present as observers at select focus groups. All focus groups were digitally recorded and transcribed verbatim by an experienced transcriptionist. Focus group discussions ranged from 60 to 105 minutes. All participants received a \$25 gift card in appreciation for their time and insights.

Analysis

Primary data analysis was conducted by the study's principal investigator. Analysis began with a complete review of all digital recordings and transcripts. Minor transcription errors were corrected and certain jargon and abbreviations were clarified in consultation with the other focus group facilitator. All comments responding to each focus group question (or probe) were grouped in separate documents; additional comments about challenges and supports not directly related to a focus group question were also grouped, and these "leftover" comments were set aside (approximately 9% of total). Over 900 unique, substantive comments were counted, excluding interjections of agreement (e.g. "That's a good way to put it!") and clarifying questions or comments asked by participants (e.g. "So can you teach that?").

Within each document, all comments were organized by themes and sub-themes in an iterative process. A "first pass" through the data was used to characterize all comments with Level 1 headings (e.g. "caution in teaching"), which were then sorted and revised as needed. Within each Level 1 heading, comments were further characterized with Level 2 headings to describe or explain the Level 1 heading (e.g. "having a balanced/non-judgmental presentation," "fear of being misinterpreted"); these were also sorted and revised in an ongoing manner. Level 3 headings were used for some documents, as needed. Quotes were moved between levels and between documents throughout this process to reflect emerging themes and sub-themes. Representative comments within each Level 2 or Level 3 category were highlighted to maintain the integrity of participants' own words and provide specific examples of teachers' views and experiences. Coding documents are attached in Appendix B. Comments that did not fit within themes were grouped with "leftovers," and previously leftover comments were reviewed and incorporated into the coding documents, as appropriate. A schema was developed to organize all codes, incorporating headings at all three levels and representative quotes.

An additional member of the research team and two participating teachers individually reviewed the coding documents and schema, and provided feedback to

increase the validity of the analysis and findings. Their comments on the coding, organization, and representative quotations were used to revise the analysis and create a final coding schema which was representative of teachers' views across focus groups.

RESULTS

Teachers' views on sexuality education are described in detail below. Results are categorized in three sections regarding preparation and pre-teaching experiences, teaching sexuality education, and areas for change. Focus group questions are noted in italicized font, followed by general themes and representative quotes from teachers. Information about a participant's school location, age group(s) and/or primary content area taught, were provided by participants during the focus group discussions and follow individual quotes.

Getting Started: How are Minnesota's teachers trained – or not – to teach sexuality education?

Think about when you were in college. What kind of training did you have to prepare you to teach this subject matter? Did you receive any specific sex education training?

I remember learning a lot but I don't remember feeling prepared to teach when I left. Does that make sense? I can remember standing up there and going, 'Okay....' And bringing that all together and just preparing for it and thinking, I am not qualified to do this. Am I qualified? How do I know?
(ALC and high school health/PE teacher)

Minnesota's teachers came to teach sexuality education with a wide variety of training experiences. Although most participants were trained as health educators, many had no formal training in sexuality education, due in part to the culture and time of their education: "I had none. Absolutely none. It was a very Catholic college and it was a very long time ago" (Small town ALC health/FACS teacher). Many who had little training sought out courses early in their careers, either in specific curricula (e.g. Our Whole Lives, Worth the Wait), or from an agency (e.g. Planned Parenthood, Red Cross), to prepare them to teach this subject matter. "I had nothing really, I have to say, in college. Everything I learned I got afterward actually" (7-9th grade health teacher). Other teachers described sexuality education units as part of other content or methods courses, but not as an official part of their program. "When we did mini lessons I know there was a week we worked sex ed stuff. But that was kind of like us wanting to, so we shared lessons on that. But there was nothing mandated" (Small town Teen Age Parents teacher). Outside trainings were particularly important for those in non-health disciplines (e.g. special education), or community educators whose backgrounds were in non-education fields (e.g. gender studies).

Many of Minnesota's teachers did receive valuable education in sexuality and appropriate teaching methods, even if they had to go beyond their usual course offerings.

“I had a human sexuality class too, but it was not curriculum-based. And I had a health minor in college and they did not go over human sexuality at all - it was just a course I took” (Urban 7-8th grade PE/health teacher). While the information was worthwhile, teachers commented that it didn’t necessarily prepare them to teach: “I just felt that I wasn’t given tools to be able to use right in the classroom.” A few had methods courses which included sexuality education, and these were particularly useful: “I had a course in undergrad which we had a panel [of speakers] ... and also our professors brought in curriculums for us to look at ... and then we would actually do the activities like the kids would, and then I had a grad class about the same as that” (6-8th grade health/PE teacher). Excellent instructors were important models, perhaps moreso in a sensitive topic area than in others. “I feel really fortunate, my professor, she didn’t hold back anything” (Suburban teacher).

In some instances, teachers happened to complete their student teaching during a host teacher’s sexuality education unit. Teachers with this experience felt it was invaluable on-the-job training that would be useful for all health educators. One commented “My first day and my last day of student teaching ending up being the exact same thing, when I walked in on the first day she had a table about this long with everything laid out: IUDs, everything. And I was like, ‘oh my God’ ... and I was like, okay I can do it now after 12 weeks of student teaching” (10th grade health/PE teacher). The support of peers and instructors at this stage of training allowed for reflection on this experience, for example, “I took a required sex ed class for college and I too, the same thing, did student teaching through sex ed, I was nervous and it was probably my best week. ... you have the support back at college with your student teachers, you know ‘How do I say this? What do I do here?’” (Urban 10th grade health teacher).

What additional training or support would have been helpful to you in college or prior to teaching sexuality education?

Well I think one of the tricky things about teaching sex ed, or teaching anything, is that you have to have content knowledge and you also have to know how to teach, and they are really two separate skills.

(4th-12th grade sexuality educator)

Teachers had numerous suggestions for ways their training could have better prepared them to teach sexuality education. There was general recognition that neither having knowledge of the content area, nor general teaching skills were sufficient to teach high quality sexuality education – one had to have training and expertise in both. This was relevant for both classroom teachers, who may have been less comfortable with the content area, and for community-based sexuality educators, who may not have training in pedagogy.

With regards to teaching methods, participants thought that more exposure to various sexuality education curricula would have been valuable: “I think what would be nice ... is to have exposure to different curriculums. ... If you can have curriculums,

look at them and gather ideas, ... before you actually get to a school and they look at you and say 'here's some money, buy some curriculum.' And to be able to have those conversations with soon-to-be professionals, at least or your colleagues or classmates, that would be, I think, helpful. You know, statistically what's been most successful, instead of having someone coming in and trying to sell you their curriculum. You have time, it's kind of neutral ground to look at the curriculum." In addition, teachers acknowledged the importance of student teaching to gain comfort and experience with sexuality education. One said, "Don't you think everyone should have to teach a sex ed topic? It's not a big deal to teach about disease or first aid. That's not the uncomfortable part for the kids or you. So it would've been nice to have to teach that unit or a lesson from that unit" (6-10th grade health teacher).

Other areas where courses could have better prepared participants for teaching sexuality education included approaches for managing controversy, the political and advocacy aspects of sexuality education, and working within school and school district guidelines. Teachers agreed that sexuality education units engendered more controversy than any other topic, among parents, administrators, and individual students themselves: "That's the thing about methods classes, is you do a lot of practice among other students that all want to do the same thing as you. ... You don't ever get practice in dealing with parents who don't agree with what you are teaching, or students that are challenging what you are teaching, or administrators that are" (Community sexuality educator). Controversy also arises within the classroom, and teachers are often called upon to manage these conflicts while teaching. For example, "The students I have in my [Teen Age Parent] class are very opinionated. That gets frustrating because I feel like they just shut down anybody that's considering anything besides raising their kids. I feel like they really don't have a free choice because of the other students in the classroom. So learning how to manage that... I feel like I could do better" (Small town Teen Age Parents teacher). Exploring the politics of sexuality education and learning how to advocate were perceived as important assets that were missing from most teachers' methods training: "I would say also the politics of it is really valuable. An assignment of advocacy in front of the school board or colleagues or a parent group - you know, that's part of the job" (6-10th grade health teacher). Relatedly, many teachers worked with significant restrictions on what they were permitted to teach, and felt that training on how to work effectively within these limits would have been beneficial. "You know another thing that might have been helpful is how to teach this when you are not supposed to teach this. ... The information they really do need to know for their health, without the morality..." (6-10th grade health teacher).

In addition to teaching methods, teachers recognized the need for more content. In particular, learning about sexuality education resources available in the community would have been beneficial, including both agencies and curricula: "Having Family Tree come in and having them do an anatomy lesson. To see them actually perform it. Because then when they were cut I was able to just replicate what she did" (Urban 10th grade health teacher). Another teacher commented, "I wasn't given resources at that time like Reducing The Risk or Safer Choices. Those are things I picked up after the fact, so even had I been exposed to those, I think, in college I would have known where to go to help myself better" (7-9th grade health teacher). Another need that came up repeatedly was for culturally sensitive and culturally specific sexuality education resources. Many

teachers commented that they felt ill-prepared to teach to Somali, Asian or Native American youth, who typically grow up with social mores that differ from their own. For example, “We have a strong Asian community and their belief in marriage and children and labor is a lot different than my background” (Urban 10th grade health teacher).

How did you get assigned to teach sex education?

What was your reaction when you were first assigned to teach sex ed? What did you think it would be like to teach sex ed? How has your experience compared to what you first expected?

I think if you are applying for a health job, you pretty much assume you are going to be teaching sex ed. (Urban 10th grade health teacher)

When asked about being assigned to teach sexuality education, all health educators agreed sexuality education was a standard part of their program and they were expected to teach it. For some, it was the most exciting part of the job: “This is the reason I went in to teaching” (Suburban 6-8th grade health teacher). Other teachers found that they were assigned the sexuality unit – or volunteered for it – because they were the only ones with a relevant background or training in a particular curriculum. One teacher commented, “I was the only health major that had been hired, everybody else was either just a broad major, which is PE and Health put together back then, or you were just PE You’re the expert, you get to teach it” (9th grade health teacher).

While several teachers reported that their initial experiences teaching sexuality education were as good as expected or better, others reported being nervous or embarrassed, often due to characteristics of the students (e.g. family members of the teacher) or teacher (e.g. young age): “I think a lot of it has to do with being so close in age with the kids. Especially when I was student teaching” (Health/PE teacher). Many teachers described being surprised in their first years of teaching, both by the students and the parents. For students, the combination of their apparent sophistication and their lack of knowledge caught teachers’ attention. The range of maturity levels within a class of students initially surprised some teachers. “I think the thing I was most amazed at is their lack of knowledge, when they think they know it but they really don’t” (Suburban 10-12th grade health teacher). Another recalled, “The ones sitting in back that know everything, but then, ‘the baby comes from where?!’” Teachers were also surprised by parents, in terms of both the support and the opposition they encountered. “I think sometimes parents are both more and less worried than I thought they would be. We either get parents that are, ‘thank you, you’re so amazing, we really appreciate you,’ or parents are livid that you are even talking about it at all. ... So I think that is more than I expected. More extremes than I expected” (Community sexuality educator). Of the two types of parent responses, opposition was more common and many teachers felt unprepared for it. For example, “when I first started teaching I was kind of naïve and not really thinking that parents might have such a ‘no way, Jose, you’re not teaching that to

my children, you're not going to say the word sex.' That parents would put up that wall and put it up so strongly." That teacher went on to say, "I have come to a better understanding about it but initially I didn't expect it and I wasn't really trained on how to advocate and get through that conversation. You learn as you go."

Teachers also discussed how important they came to appreciate that sexuality education was for their students. One stated, "I think it has got to be at least as important as drivers ed" (City charter school teacher, high school level). They felt it was very important to give students complete and accurate information to help them stay healthy: "I personally was at that point where I think kids needed to know. They didn't need to know the watered down version. They needed to know what's really going on" (Urban community educator). Other teachers stressed the importance of normalizing sexuality as part of the human experience, and wanting to promote that message with their students: "The more it can be demystified and just made human and normal, the better. I guess that's my agenda" (City charter school teacher, high school level). Other areas in which teachers reported being surprised included students' enjoyment of the unit and the extent of society's influence on sexuality.

In the classroom: Trying to meet students' needs

Now think about since you've been teaching sex education. What kind of continuing training or other support or assistance do you get?

We do have good resources, if you have the time and the resources to access them. (4-12th grade sexuality educator)

Minnesota's sexuality educators felt fortunate to have a wealth of resources available in the area, and took advantage of them both for general professional development as well as for keeping up-to-date with the evolving field of sexual health. Teachers named numerous resources they draw upon for their programs, including area clinics, agencies, and organizations (e.g. MOAPPP, Family Tree Clinic); the Minnesota Health Educators' Conference; district, city or county offices; state agencies (e.g. MN Department of Education); and other sources (noted in Table 1). Teachers also spoke of the benefits of connecting with each other to exchange materials and ideas, "I think that's a good thing about sexuality education is that the people that teach it I think are so passionate that they are always looking to the best resources. They are always willing to go to someone else and say 'try this, try this' and back and forth. I don't think it always happens in other areas" (Community based FACS/social studies teacher).

Various agencies provided different types of support, including conferences, trainings and workshops; speakers; curricula, lessons and materials. While many teachers reported attending specialized trainings related to sexuality, teen pregnancy prevention or HIV prevention, many also preferred broader offerings: "As a generalist, because we have to teach more than just sex ed, I would prefer to go to a conference where I can get a lot of information on a lot of different units that we have to teach.

Although sex ed is one of my favorites, I still have to make sure that I am keeping up to date with the other ones too” (9th grade health teacher). Speakers were another resource that teachers found particularly useful: “It was huge to have Family Tree come in. I had it first trimester, so for me it was nice because they can’t come in every trimester. So I would, I would basically re-teach, they would literally give me their lessons and I would do it how they did it ... it was fun for [the kids], but they also learned the material. So for me that was a big plus” (Urban 7-8th grade PE/health teacher).

Teachers also reported substantial barriers to taking full advantage of existing resources, primarily the costs associated with purchasing new materials, attending conferences and supporting substitute teachers: “The problem with the conferences is that our school districts are so tight on budget” (Urban 10th grade health teacher). Some reported they did not want to take more time away from their students, conferences falling during a busy time of year, or not knowing about opportunities until too late to plan for an absence.

What additional training or support would be helpful to you now?

I would like to be updated on the STIs. The kids are always asking questions on that. And I am like, there are so many, and there is always a new one. I always just feel like I am never fully prepared for that, for all their questions. And even with the birth control stuff, there is always something new.

(Small town ALC health teacher)

While acknowledging the many opportunities available in Minnesota, teachers also cited many areas in which additional training, support or resources could improve their sexuality education programs. The need for updated information and materials was discussed repeatedly, as statistics, policies, best practices and medical information change over time. In addition to the need for updates on sexually transmitted infections and contraceptives, “Well you know I think the laws, the state laws, are always nice to be refreshed on, in terms of your abortion laws, your parent notification laws, your consent, the consent laws are huge and I am always having to refresh myself on that” (Suburban 10-12th grade health teacher). Another teacher felt that, “That’s one of the most frustrating things for our students, if they see statistics that are three years old they are like, ‘that doesn’t apply to us.’ I mean they really want updated things. Even though there is not a whole lot of change in three years, they think they are different from the last group” (Small town Teen Age Parents teacher). Other teachers commented that having realistic, contemporary materials was important for engaging students: “I have found there is a lack of videos – especially puberty and early sixth/seventh – they are all just either super cheesy or cartoon sex, and there really is a lack of that kind of resource.... You can’t have kids with 80s haircuts - you have to be able to relate to them” (6-10th grade health teacher).

Many teachers noted that trainings on teaching sexuality education to specific groups of students would be useful. For example, “The other population we need to talk

about supporting is the students with special needs. There really isn't a lot of training and things.... In every class that comes up, you have the girl whose body is ready to go but her mind is like eight, and so vulnerable, and that's huge. You really don't have a lot" (Urban 10th grade health teacher). Teachers also desired trainings and information on sexuality in non-Western cultures: "The Muslim populations are growing a lot more in our schools and we're finding it's a whole different ball game as far as teaching sex ed, and I am learning, but I have much more to learn. And the Asians, I think each of our cultural groups have specific needs" (Suburban 6-8th grade health teacher). Likewise, curricular materials in other languages were needed. While some teachers had been able to obtain (or develop) materials in Spanish, these were not widely accessible, and other languages were not available at all. Teachers also expressed the need for new materials in general, including curricula that were brief, active and engaging for students, as well as for materials and resources for parents, to support them in talking about sexuality with their teens. Finally, some felt that guest speakers from non-controversial agencies would be helpful, particularly in districts that had considerable restrictions on sexuality education programs.

Teachers described several mechanisms to provide these types of support, in addition to the existing resources described above. Several teachers appreciated their informal network of colleagues and hoped to see it expanded: "I would like to see just more people networking so like I know what you are doing, you know what I am doing" (Urban community educator). In addition, other teachers recalled a more formal group, now defunct, which had been useful for sharing materials, collaborating, and arranging for team teaching or teacher observations: "There was something called MCHET, Minnesota Coalition of Health Education Teachers ... we could all sit and share, and we all brought 20 copies so we weren't reinventing the wheel. We were saying, 'this works, kids enjoy this.' ... It was fantastic because you could walk out of there excited ... and you walk out with 20 lesson plans in your hands that you can use the next day, and ideas, new curriculums, speakers" (Urban 10th grade health teacher). Teachers also expressed a need for a centralized agency that was able to provide consistent information to sexuality educators around Minnesota, for content updates, as well as training opportunities. For example, one teacher commented, "I just don't think that there is any kind of resource that tells educators in a very sort of central way, there's new pap guidelines now. You know stuff like that. ... I certainly see how youth in different areas are going to hear a lot of different things" (6-12th grade sexuality educator). Another stated, "I am sure there are lots of workshops that we could go to but I just don't feel like I am made aware of them in enough time. So some sort of messaging system that would cover all things that would apply, would be great" (Small town Teen Age Parents teacher). Teachers commented on the challenges they faced with changes in programs and resources ("Kind of on a broader note, to know that there is going to be funding for the programs. Because you can refer somebody somewhere to receive services and then next month it might not be there" (Sexuality educator)), but also recognized the challenges inherent in maintaining consistency over time: "It's hard to be a resource when the institution is in limbo all the time. Or it is changing all the time just based on money or personnel" (9th grade health teacher).

Now I want to think about teaching sex education compared to teaching your other units. Are there additional responsibilities associated with teaching sexuality education, that are not associated with teaching other topics?

Sex ed is unique in that if you're teaching English or you're teaching math, you're not necessarily teaching to potentially influence behavior, that's not necessarily the goal. So that changes how you have to teach and what you have to talk about as well.

(4-12th grade sexuality educator)

Teachers described many ways in which teaching sexuality was different from teaching their other topic areas. Sexuality education typically involved additional activities including a) dealing with parents, b) using more caution, c) addressing students' personal questions and concerns, d) debunking myths with accurate and current information, e) getting administrative approval, f) creating a comfortable and respectful environment, and g) using a range of experiential teaching methods. They also expressed concerns that the stakes were higher, due to the real-life application of the subject matter.

The predominant way teachers felt sexuality education differed from their other topic areas was the direct interaction with parents, either to obtain consent for their child's participation or to respond to their concerns. This issue came up with almost every group of teachers, and they expressed frustration with a process which was time-consuming and often challenging. "The initial informational letter going out to parents, you have to outline close to every topic or word you are going to say and basically ask for permission that they be in class. You never ask for permission for anything else. That's something specific for this unit" (Classroom teacher). Another commented, "Trying to get permission from parents who are not involved is a hard thing" (Urban community educator). While several teachers said they had little negative response from parents ("You might get a phone call now and then, but you know what, I haven't had a phone call in years" (9th grade health teacher)), some had to contend with feedback that was intensely negative. "The rest of the units are pretty stress-free in general.... But then knowing the sexuality unit is coming up, my heart starts racing a little bit, I am nervous about what the responses are going to be on the sheet, you know I think there is an emotional cost there, but that's just me.... I had a really difficult situation with a parent that said very mean things to me, and he'd never met me ... 'Who do I think I am to be teaching this' and 'how do I know everything about sexuality' and saying 'you don't have children, I heard,' and I was just like, wow. So that's why my heart rate goes up, I get nervous with that kind of confrontation" (Classroom teacher).

Many teachers also described using extra caution when teaching their sexuality education unit: "You really have to think, in the way you phrase things, the way you say things. I always feel a little more exhausted after the [sexuality unit]." Teachers were very conscious of the need to give a balanced and non-judgmental presentation, both in terms of presenting multiple views of a controversial issue, as well as listening to students' comments respectfully. One teacher commented, "There are very few topics where personal opinion is sort of so *allowed* into the curriculum But it is such a politicized topic that it really requires extraordinary sensitivity in a way that only a few

others, the only other thing I can think of that might come close is global warming, you know everybody has an opinion about whether it is real or not” (4-12th grade sexuality educator). Another stated, “Even more than in some of my other classes, I think it is important that I am absolutely neutral. It’s not my job to judge what their question is or to judge where they are or what their decisions are” (City charter high school teacher). Teachers’ caution often stemmed from their fear of repercussions if they were to misstep: “I think you also have to be worried about not saying the wrong thing. Because you don’t want administration to jump on your back or you don’t want a parent. So you always feel guarded or unsure ... are you doing too much or not enough?” (10th grade health teacher). Another teacher expressed her concern that her program might be jeopardized, stating, “I am very cautious in that unit. I am all about comprehension, but I am also very respectful of my parents that are in that district. Because I feel my program is so important, the 20 day stint I have for sexuality, I don’t want to risk my program because I decided to go against what the parents want, then my whole program is gone” (Suburban 10-12th grade health teacher). Likewise, teachers expressed concerns about being misinterpreted by students, especially where language or cultural differences existed: “If they do go home and talk about it, and it gets twisted a little bit, and it’s like, ‘No. I didn’t say that.’ Or you play the devil’s advocate trying to get both sides of an issue out, and they go home and say ‘that’s what she thinks’” (10th grade health/PE teacher).

A third way in which teachers identified differences between sexuality education and other topic areas was in addressing students’ additional questions, concerns and personal issues, often outside of class time. Several teachers reported that they had good relationships with their students, which tended to engender additional conversations. For example, “I have a pretty close relationship with the kids so it is usually me they come to if they have a question. And I don’t know if that is personality or because I teach those subjects, probably a little of each” (Small town ALC health/FACS teacher). Similarly, “Just from the time I put the condoms in my room I have had so many students who I have never even had in my class ... who, just because I have that basket of condoms, they come up and ask me, ‘I think my girlfriend is pregnant. What should I do?’ So that has just been a door opener. They see that as I am open to that topic and I am not going to judge them. So that has brought on a lot of conversation too” (Small town Teen Age Parents teacher). Although teachers seemed, in general, happy to help students with a listening ear, the topics were often very significant and personal concerns. One teacher commented, “[It is] very difficult for me to deal with all their problems. I felt like I needed a counselor to talk to” (ALC and high school health/PE teacher).

Teachers felt that misinformation was more common and more firmly entrenched in the area of sexuality than in other areas, and were often challenged to communicate accurate information to their students: “When you tell them the facts they don’t believe you because they have heard it differently from somebody else.... Whereas for some odd reason, the other topics they are like, ‘okay.’ In another topic they believe you” (Urban 7-8th grade PE/health teacher). Similarly, another teacher shared that, “I just had a birth control class this week with probably 7 girls and one girl, you know we were talking about side effects of the patch and one girls says ‘oh yeah, and death. I heard a news report about that.’ So I can say whatever I want at that point, but all those girls in the

classroom just heard ‘you’re gonna die if you use the patch.’ And that’s really challenging, you know?” (4-12th grade sexuality educator).

Another area requiring extra effort for teachers is in obtaining administrative approval for the contents of their sexuality education unit, to a greater or lesser degree depending on the school’s or district’s policies. In a more conservative area, “I cannot bring in a new speaker without getting permission from administration first. And I think it’s just cause they want to be informed because they get the phone calls first” (Suburban 10-12th grade health teacher). Even in areas with more comprehensive sexuality education programs, teachers reported district-level involvement. For example, “[Our curriculum director for the district] is working really closely with us and our health education curriculum and the 2 areas we are spending all the time on is sex ed and drug ed ... I was just thinking, we’re not talking about what to teach in nutrition, he’s just assuming that we know what to teach” (Suburban 6-8th grade health teacher).

Teachers also go out of their way to create respectful and comfortable classroom environments before teaching a sexuality education unit, typically leaving it until late in the term. Many commented that they strive to build respect among students so they can talk openly about personal and potentially embarrassing topics, as well as share differing viewpoints. For example, “I wait to teach these topics until we have established classroom boundaries and an atmosphere where asking questions is comfortable” (Small town high school health teacher). Another stated, “I think a lot of times too you want to make sure that kids don’t feel self-conscious or get made fun of” (Urban 9-12th grade health teacher). Several teachers also described the need to use a range of hands-on teaching methods for sexuality education, such as active learning and games rather than more traditional book-work, in order to make sure students learned real-life skills. For example, one commented, “I think what’s really important as far as advocating for our students’ needs is providing an activity or something ... giving them an opportunity to call a hotline or having something like that built in like, here’s your assignment, we’ll give you some time during class to look on this comprehensive sexuality education web site or call a hotline and ask a question. But giving them kind of real ... opportunities to learn more so that they are not reliant on the one time a year I am there as an educator” (6-12th grade sexuality educator).

Several teachers also commented that sexuality education was unique because the stakes were high if students didn’t learn the information, and they took pains to see that their materials were accurate and current. “You have to make sure that you’re always on top of the current information because it can definitely affect their behavior or the choices that they do make in a negative or positive way. You know if you teach a math problem the wrong way, okay you get it wrong on the test and you can correct it. But if you teach the wrong information about birth control and somebody gets pregnant - there’s a bigger choice. Or they get an STD and that’s something that they have to deal with” (Sexuality educator).

When teaching sex education, do you have additional conversations with administrators, parents, or other people about how and why to teach sex education? Are there other ways in which you advocate for sex education or for the students in these classes?

I didn't realize how much I would be advocating. I have to bring the rights and lefts together.... We have to understand why sex ed is important, and they are all looking at me, and why should I talk about birth control, abstinence, abortion? So you have to have everyone be happy with what you are doing.

(Urban 10th grade health teacher)

Focus group participants felt the precariousness of their positions as teachers in non-mandated subject areas and often found themselves defending health education, and sexuality education in particular. Typically their advocacy was targeted towards their school- or district-level administrators: "We've been having a lot of conversations with representatives of the school board trying to get why it's important, why it needs to be taught, why it needs to be required" (Urban 10th grade health teacher). In addition, many teachers found themselves talking with parents about the importance of sexuality education, and often cited religious or cultural differences as a barrier. For example, "I deal with girls who... come from a Christian-based home ... so it's one of those just trying to teach the mom, 'we're not trying to tell her to do it, we're just giving her the tools in case things happen, we want her to be safe' and all that, but the mom feels that if we give her information, then that's telling her to do it. So I do a lot of that because I do work with a lot of troubled teens" (Urban 10th grade health teacher). Several teachers remarked that they also became advocates for sexuality education in other settings, with people not directly connected to their programs: "You know I find myself [talking about sexuality education] at family gatherings or whatever, cause we're all passionate about it and believe it is the most important thing that we teach. I become an advocate for it anytime, anywhere" (6-10th grade health teacher).

Several teachers advocated for sexuality education more formally, and included their students in the process. Some reported having letters to the editor published, speaking with legislators, and participating in rallies ("I brought students to the capitol to a rally for sex ed" (6-10th grade health teacher)). Connecting students with resources, organizations and others in their community was also viewed as a form of advocacy for some teachers, in that it gave young people the skills and connections to help themselves. One community-based educator commented, "So I think it's really valuable when I am in a classroom and I can say something like ask the question out loud, "Do you guys have a gay-straight alliance in your school? Who is the person that leads that?" and then have somebody say 'oh it's Mr. So-and-so.' So kind of bringing awareness, like you may not be aware of all the resources within your school or within your community but now we've just said it that you can talk to somebody else when I leave. There is somebody else who would support you when I am gone. And so I think that makes it really real having somebody in their community or within their school. That they know there are other resources and support systems I think, for me, is an important way to advocate" (6-12th grade sexuality educator).

Compared to other units that you teach, how comfortable is it for you to teach sex education? What makes it easier or more difficult than other subjects?

I think if you were to ask me that same question before I started teaching it I think I would've been completely uncomfortable with it. But after teaching it and [seeing] how open they are and how it is not a big deal to them, I think that has put all that at ease.

(Small town Teen Age Parents teacher)

Several teachers said that they felt less comfortable teaching their sexuality unit than other topics, at least early in their teaching careers. This was often due to personal circumstances, for example, "I was teaching health when I was pregnant and I am like, God, they know how this happened!" (ALC and high school health/PE teacher). Some young teachers also reported feeling inexperienced in comparison to their students, which felt awkward: "They are already doing it. My first year, I hadn't had a baby yet, but I had a 16 year old girl who had just given birth to a baby and I said, 'anything you want to add?' Because I had no clue" (10th grade health/PE teacher). Teachers also reported feeling less comfortable if they knew the content was likely to be controversial for students within the classroom. One stated, "The places where I might feel uncomfortable with it are the areas of curriculum where I know people have real significant differences of opinion, but if I know those are coming I can just tackle it head on" (City charter school teacher, high school level).

By and large, however, teachers said they felt very comfortable with sexuality education. For many, this comfort grew out of experience, and increasing their own knowledge level: "It was hard the first couple of years I was teaching it. I felt like I was half a step ahead of them - maybe. But that's again another reason why I started getting more information and teaching myself more. I didn't like that feeling of not really expanding upon what they needed to know or challenging them to learn more about it. But now I feel comfortable with it" (7-9th grade health teacher). The students' interest in the subject matter also contributed to teacher comfort and enjoyment. For example, "I think it is my favorite thing to teach. I don't find it hard at all because the kids are eager" (Urban 6-12th grade health teacher). Other teachers simply attributed their comfort level to their own interest and personality: "I am very comfortable teaching it.... I don't know why I am but I was from the beginning" (High school special education teacher).

Thinking about the sex education curricula or content you use, what grade would you give it in terms of how well it prepares students to be sexually healthy adults and why?

I would give my curriculum a D. But my class discussions and the things I can talk about ... with my kids in the classroom is like A++.

(ALC and high school health/PE teacher)

Many sexuality education teachers developed their own programs, bringing together curricula and materials from a variety of sources: “I would say that most of us use a combination and a little bit of our own, and there is a lot of improvising that goes on depending on the questions that are being asked. So I am not really convinced that a lot of people use a standard curriculum. I feel that most of us use a combination of many different ones” (6-12th grade sexuality educator). For this reason, teachers often had a hard time giving a letter grade to their programs. However, they cited many factors contributing to their evaluation of their sexuality education offerings.

A primary consideration was the amount of restriction or latitude teachers had to develop a program they felt would meet their students’ needs. In districts with a strict focus on abstinence-only education, teachers faced greater challenges and were generally less satisfied with their programs: “We could probably do better if we had more control over what we could present” (4-12th grade sexuality educator). In some areas, teachers were very limited in what they could present, but were permitted to respond to questions raised by students. For example, “I would give it a C. Just because it is general. And we can’t say, or we are not supposed to talk about gay, lesbian, unless of course somebody asks you can answer, or oral sex” (10th grade health teacher). This teacher went on to say, “I don’t think we should have to rely on the kids to have to ask to get a comprehensive education.” At the other end of the spectrum, teachers with more freedom to teach a comprehensive curriculum were typically happier with their work: “I have never had a problem with school board or administration. Because the principal we have right now used to be a health teacher... We could talk about whatever we want” (Small town 9th grade health teacher). This teacher also commented, “I would say A- not because of our book, but because of the things that we are allowed to say and do and show the kids. Knock on wood! I’ll probably get a phone call tomorrow.”

A second major contributor to teachers’ evaluations of their programs was the amount of time available to them for teaching sexuality education. Many commented they felt a pinch, having only a single term in which to teach a full health curriculum. For example, “In some schools I have taught, we have had like a whole semester of 84 minute [classes], so depending on how much time you have to cover it the way you really want to. Whereas when I was in the junior high we had a little trimester or a little quarter, and you’ve got this whole health curriculum and you are trying to get to everything. So depending on where I have been, I would say anywhere from like an A to a D. Because you almost feel like you just rushed through it” (Urban 6-12th grade health teacher). Timing was also an issue for community-based sexuality educators, who were typically invited into classrooms for only a brief period: “Well if you are only doing one day ... I don’t know if I would give my one day shot an A. But it has the potential to be an A if I

was given more time. It is part of something that would be an A” (High school sexuality educator).

Teachers also expressed dissatisfaction with the timing of their programs, typically that sexuality education came too late for many students: “We have some students who need this information earlier than we provide” (Small town high school health teacher). More generally, several teachers felt that their sexuality education program simply was not able to meet the needs of the students in their classroom, especially where students had troubled histories. One commented, “I would [give my curriculum] an F. It is not a good curriculum. It sucks. I say it all the time, it sucks, it’s terrible, it is not for the kids we work with” (Urban community educator). Another teacher echoed that viewpoint: “Three-quarters of the students in my class were sexually active by the time they were 13, and 4 of them, I think there were 11 students there that day, 4 of them it was non-consensual. ... Why, why with that group would you have a wall? ... I am looking for better curriculum to help these kids and their needs” (ALC and high school health/PE teacher). Other teachers recognized the shortcomings of sexuality education more globally, and the challenges of teaching in the midst of adolescent development and prominent media messages about sex and sexuality. For example, “We follow everything that education tells you that you need to do in terms of teaching kids skills, practicing it, focusing - you know just not sitting there and telling them to read and write notes. But because we are still seeing such a huge jump in sexual activity from their freshmen year to their senior year, that’s telling me something is not working. And I don’t know if any curriculum can trump being an adolescent” (Suburban 10-12th grade health teacher).

Teachers also provided numerous examples of teaching strategies they felt strengthened their sexuality education unit, such as bringing in speakers and using other outside resources. In particular, they offered various techniques for talking about relationships and love, which they often found lacking in existing curricula. For example, “I ask them, in my class of 35, how many of your parents married their high school sweetheart? And there’s usually about 2 or 3. And that answers it right there. I go, the person you are in love with right now is not going to be your final mate.... So that’s kind of a visual, and then of those three who raised their hand, how many are still married? And usually 2 are divorced. Aha! But it proves my point. This is not the woman of your dreams. This is not the man of your dreams. You are not going to marry this guy or this girl” (9-10th grade health teacher).

If it were totally up to you, what would you teach your students?

At the beginning of school this year I asked them, “If you could have your choice of any unit that I taught, what would you want?” And they said more on relationships.

(Urban 9-12th grade health teacher)

While some teachers said they would keep the contents of their sexuality education unit the same (perhaps teaching it earlier), most teachers noted areas in which they would

expand their courses. The most common topic that teachers said they would expand in their programs was healthy relationships. Teachers commented that many of their students had never experienced – or even witnessed – a healthy romantic relationship, and therefore had no model to look to ask they experimented with their own relationships: “One thing I have always wished I could figure out a way to teach, is a way to teach them and show them that a long term, committed relationship ... that that’s worth working for and it’s worth fighting for, and it’s beautiful, and wonderful and great. A way to show them that, because so many of them have never had that in their life” (Small town ALC health/FACS teacher). Another ALC teacher added, “Especially with our kids. It’s like half of them have never seen a healthy relationship in their lives. They don’t even know what it looks like. And then the cycle keeps going.” They particularly noted the need for teaching about the emotional component of sexual relationships, commenting “That is what they see on TV and when you go into Abercrombie. I mean everything is just physical. And there is nothing in between. It’s like you kiss and have sex. Nothing in between, you don’t hold hands, no relationship” (Urban 10th grade health teacher). Teachers also described the non-traditional family structures that many of their students came from, and how these different norms contributed to their understanding of relationships. For example, “They ask me my age and I tell them how old I am and they say, ‘How come you don’t have kids?’ And I say, ‘Well, I am not married,’ and they’re like, ‘So?’ And I am just floored. I shouldn’t be, by now. But I am, I am still amazed how they don’t think it is a big deal if you are married or not” (Urban 7-8th grade PE/health teacher).

In addition to focusing on relationships, teachers expressed a need for more skill-building activities in their courses: “The skills. I mean we do already, we do tons of it, but I don’t know that you can ever get too much of that. The refusal skills, the negotiation skills, the communication skills that they need” (9th grade health teacher). Other teachers talked about the need to include more information regarding sexual orientation and sexual identity, as well as STD and pregnancy prevention methods: “At least have the option of telling them that if you are going to do it, here’s what you can do so that you’re not up at three in the morning with a baby in nine months” (10th grade health/PE teacher). Another commented, “I would like to be able to have what you have, like a box of condoms or something in the room. Because that is a huge open door for the kids. I would love to be able to do that” (Small town ALC health teacher). Other suggestions included adding material on the media, long-term consequences and costs of parenting, a companion course for parents of adolescents, or even offering a whole course just on sexuality.

If it were totally up to you would you continue teaching it? Why or why not?

Yes, I would definitely still teach it. I feel it’s very important, and where would they get their information from if it’s not from teachers? They are not talking to their parents about it.

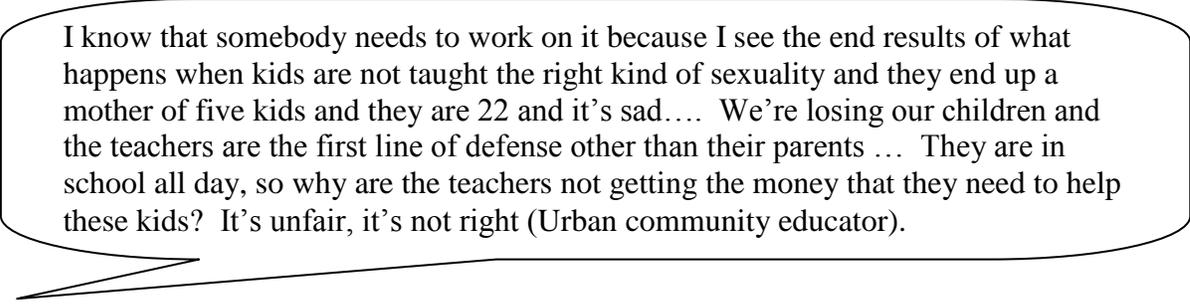
(Health teacher)

Overwhelmingly, teachers in all focus groups said they would continue teaching sexuality education, and they cited two main reasons: they enjoyed it, and they felt it was extremely important. The enjoyment of teaching sexuality education came largely from their students, whose energy and interest fueled their own: “Absolutely I would teach it. It’s fun, kids like it, it’s one of their favorite things. You get that energy up and it’s always changing. And there is some great curriculum out there, I think every one of us could probably teach it for a year and nothing else” (Urban 10th grade health teacher).

Teachers reiterated in many ways how important they felt it was to provide students with accurate information, especially when they had so few other sources of reliable information. One teacher stated, “I would definitely teach it because it is amazing how much they don’t know and how nobody else is talking to them about it” (Suburban teacher). Another echoed this observation, “We do have so many students, 6th, 7th, & 8th grade that aren’t hearing credible information, and ... they are not hearing it at home and you want to teach them the right information” (Classroom teacher). Teachers also described their role as “normalizing” sexuality as part of the human experience, and the importance of that message for young people: “It is the most important thing I teach. I feel like if I could chose it would be the one that I choose to keep. It is being a human being” (6-10th grade health teacher).

Where do we go from here? Challenges and supports in teaching sexuality education

What kinds of policies or standards do you think would be beneficial in supporting teachers to teach sexuality education?



I know that somebody needs to work on it because I see the end results of what happens when kids are not taught the right kind of sexuality and they end up a mother of five kids and they are 22 and it’s sad.... We’re losing our children and the teachers are the first line of defense other than their parents ... They are in school all day, so why are the teachers not getting the money that they need to help these kids? It’s unfair, it’s not right (Urban community educator).

Participants overwhelmingly felt that policy changes could be very beneficial to sexuality education in Minnesota, and believed that this type of support could come from all levels. At the federal level, for example, teachers noted the importance of presidential leadership (“You have to think about the president’s support. Abstinence only or comprehensive. I mean it goes all the way to the top” (Urban 7-8th grade PE/health teacher)), and the potential for national policy to set the stage for a cultural shift regarding healthy sexuality. Participants also noted several federal policies and programs that were not specifically related to sexuality education, but had an impact on it nonetheless, including welfare, health care and education policy: “No Child Left Behind is not helping our cause. Because their focus is so on those reading, writing and

arithmetic that everything else is getting lost quickly and that is part of the problem.... That is in some regard very crippling for a lot of the physical education, health education, fine arts, music all those kind of things which are just so, I mean if you can't be in touch with those components of who you are how can you be a good math student?" (ALC and high school health/PE teacher).

Much of the discussion focused on state-level policies for sexuality education. In all seven focus groups, teachers discussed state standards for health education and mandatory comprehensive sexuality education. For example, "I think a state law, getting a really good comprehensive sex ed law passed, that everybody had to teach it and some educational state standards that were very clear on what comprehensive sex ed includes. And of course there's room for interpretation based on the community that somebody is teaching in, but expanding what you have to teach" (Community sexuality educator). Some even favored doing away with the common "opt out" provision which allows parents to remove their students from sexuality education classes: "Everyone has to take it. You can't opt out. And a note out to parents: It will be taught. It's part of health. And if you don't want the teacher to be the first one to tell your child about it, you have up until that point to teach them" (9th grade health teacher). Participants felt this type of policy would take pressure off teachers and administrators, giving them "something really important to fall back on. 'This is the law,' you know" (6-12th grade sexuality educator). Several also mentioned the need to mandate this type of comprehensive education earlier than it is generally offered, "starting before 8th grade, preferably" (4-12th grade sexuality educator). Many teachers commented that health education would not get appropriate attention unless it was a graduation requirement with a standardized test, as in other subjects, "We need a health exam to validate us. If we had a standardized test it would help our cause" (ALC and high school health/PE teacher). However, teachers also noted that the current educational emphasis on testing is not good for students, and were reluctant to add to it: "You think of the other health effects of the testing, the stress and the depression, it just tears at my heart with some of these kids" (9th grade health teacher).

Teachers felt that comprehensive sexuality education policy would be beneficial in several ways. First, dedicated funding to support health education that should come with such policy would ensure the continuity of this subject matter, and validate its importance. Many teachers commented that health education was threatened when funding for education was tight: "Just having the legislature make it mandatory. Because we are the first to go, and money is an issue" (Urban 6-12th grade health teacher). Cuts on a smaller scale were frequent and also compromised teaching. One teacher commented, "I mean my classes are up to almost 45. I have no room in my room. I can't even imagine - they want me to add like 3 more students. I have 2 already not in desks because I can't fit them.... They don't worry about having 45 health kids in one room. It is not where the funding goes" (Urban 10th grade health teacher). Teachers also felt that state-level policies or standards would underscore the importance of health education, and its contribution to overall learning: "If there's lots of funding cuts, it's the phy ed and health. No. This is important. Our kids are important. If they are not healthy, no matter what area it is, they are not going to be able to do great on tests. They are not going to be able to get these scores that we need them to have" (Suburban teacher). Training and certification for sexuality educators was also viewed as an important

component of sexuality education policy. One community educator commented, “Something that says we’re here. We’re important. The information that we have is important. We should be respected and valued for that. Everybody gets a certificate for something, yet we have nothing” (6-12th grade sexuality educator).

It is important to note that not all teachers supported legislation mandating sexuality education and its contents. Several felt that this type of oversight would *not* be beneficial, particularly in cases where they had the latitude to teach what they felt their students needed, and preferred to keep policy-makers out of their classrooms. One said, “I can’t imagine anything worse than the Minnesota Legislature deciding what content there ought to be in a sex ed class. ‘Good heavens!’ ‘Oh, dear!’ Even when it is locally determined that there are things that you can’t talk about, it’s probably better that it is local than there is some kind of statewide mission” (City charter school teacher, high school level). Another agreed, “I don’t want the legislature deciding this. That’s where I have the advantage, which is nobody is meddling with what I do” (Small town ALC health/FACS teacher).

Compared to other units that you teach, do you think students are more or less engaged in learning about sex education?

When people say, “I don’t know how you do it,” I say, “It’s wonderful!” It’s easy because they are so engaged, it’s like a light bulb goes off every two minutes. ... They want to know.

(Community based FACS/social studies teacher)

Teachers overwhelmingly felt that their students were engaged in sexuality education – often to a greater extent than in other topics they taught. Teachers remarked that students felt sexuality education was highly relevant to their lives: “It’s important to them. It’s more real than a math problem” (High school special education teacher). Another commented, “It’s incredibly related to their life. Whether they are having sex or not. The hormones, the talking about how do you know if somebody likes you. I think it’s so relevant” (Community sexuality educator). This engagement also resulted in greater student learning: “I feel like it’s the one unit I really reach them on. Every day they leave, [and] I feel like they learned a lot” (8-9th grade health teacher). Several teachers said they felt students were more engaged in the sexuality unit, as evidenced by more questions and better attendance: “I tend to get more thoughtful questions from a greater percentage of the students” (9th grade health teacher). Another commented, “That is the quietest week in the whole nine weeks. They are so focused. I have no one come in tardy and no one leave” (Small town 9th grade health teacher).

If more engaged, do you think there are ways to incorporate these topics into the general curriculum that would encourage overall learning?

Students learn better when it is integrated, we all know that.

(9th grade health teacher)

Teachers offered a wide variety of ideas for integrating sexuality education content into other subject areas, and noted how rarely they had such integration in their own education: “I look at my background and think, why was this topic always isolated and not integrated?” (Sexuality educator). In addition to Family and Consumer Science, where sexuality was often taught, teachers described several other classes where some aspect of sexuality education could be included. For example, “They do it in biology. They study the human anatomy and I know they talk about HIV. Those are the only two areas that they actually pull from our curriculum into theirs (Suburban 10-12th grade health teacher). Another said, “I think social studies is another obvious option. You know, how do different cultures handle sexuality? How do they view relationships? How do they view marriage? You know all those kind of things” (4-12th grade sexuality educator). Relationships and sexual decision-making were viewed as topics that could most easily be integrated into other subject areas, and would be of great interest to students: “When you are talking about kids in middle school and high school there are just so many topics that come up that are related to sexuality in reading, and I think that schools kind of gloss over those because they don’t want to talk about them. But I think that is such an opportunity. Like how did these characters deal with their relationship? How did they make decisions to have sex or not have sex?” (4-12th grade sexuality educator). Teachers felt that integrating these topics would enhance student learning, as it increases the relevance and interest in these other subject areas. One said, “any time you can talk about relationships in any way, it makes kids interested. Because relationships, either romantic, friendship, family, those are all things that kids want to learn about, want to know how to deal with issues surrounding them. So anything like that. And that is a piece of sexuality education, it’s not just contraception and STIs. Relationships is a big piece and you can incorporate that in other subjects I think. It makes it more interesting for the kids” (Community sexuality educator).

However, teachers also commented that other teachers often shied away from any sexuality education content and were, in many cases, glad they didn’t have to teach it: “They get scared of it. They are glad that we do it and they don’t have to. We’re the sex people” (Small town 9th grade health teacher). Many perceived that teachers in other subjects were simply uncomfortable with the topic. One said, “I hear my colleagues say “I don’t know how you can teach that. I don’t know how you can sit there and say penis or vagina in front of all those twelve year olds” (Classroom teacher). Participants were also adamant that sexuality education could not be replaced by including portions of the content in other required classes. Many commented on their training as being critical to providing this specialized education: “We are specialized in this. I would be afraid of what type of information would be put out. There would have to be a lot of training” (Suburban teacher). Similarly, another stated, “I think I could teach some basic math

concepts but I couldn't teach algebra. So you know it's kind of that same type of thing. They could teach some basic health or sex ed topics but to really do it justice....” Teachers also felt that building relationships and trust with students was especially important for effective sexuality education, and that others did not emphasize this: “Health education, sexuality education can not be replaced. It needs to be taught by health teachers for it to be effective. Developing the relationships. Knowing the topic. Being comfortable. I think it would be even difficult for it to be, or wouldn't be as effective, if say for instance the school just had the school nurse come in and teach it for maybe three days” (Suburban 6-8th grade health teacher).

What prevents you from teaching the way you'd like to? Challenges for sexuality education teachers.

Were you part of the study at the U? And wasn't it 78% of parents want sex ed in the schools? So why do we keep listening to this smaller percentage?
(10th grade health teacher)

Teachers' most commonly cited barrier to teaching sexuality education the way they would like to was policy at the school or district level. School districts often had policies that were too restrictive: “It is so frustrating because you want to really teach more but you can't” (Small town ALC health teacher). Teachers recognized that their students received sexuality information from many other sources (peers, media), but as teachers, they were not able to provide accurate information in an educational context: “They can say it on the news but you can't talk about it in your classroom. I mean it's ridiculous” (6-8th grade health teacher). In many cases there was an egregious mismatch with the needs of students in that setting: “A classroom of 17, a lot of them are parents, three of them are pregnant, okay. Let's change the curriculum here because we have a problem” (ALC and high school health/PE teacher). Other schools permitted more comprehensive instruction, but were also bound by a requirement to provide “fair and balanced” presentations – even when scientific evidence did not necessarily support both sides of an issue: “When I go in and talk about pregnancy options it would be like if the day after I talked about the Holocaust they have someone come in and say ‘well the holocaust never happened and here's why.’ It's just the science doesn't get supported in our topic, and so we have to deal with people coming in and ... completely dissuading everything I just said” (High school sexuality educator). Teachers attributed many of these restrictions to a lack of respect for research on educational best practices, as well as fear of controversy. For example, “My experience in working with the [city] school district is there is also a big fear of litigation. So very quickly, a parent calls in upset about something that happened in sex ed class, that will get sent to the lawyers like that [snap]. And so then the lawyers always take the most conservative ... ‘then you can't talk about that at all then,’ rather than talking about what's reasonable or what's likely ... I don't think it is based in reality. But there is such a fear about that” (4-12th grade sexuality educator).

Participants reported additional challenges from administrators and teachers. Many commented that administrators were afraid to adopt sexuality education practices that might make waves in their community: “You know some of the organizations you mentioned, the PFLAG and Planned Parenthood, I have tried to have them come in as speakers and [administrators] are absolutely like, ‘no.’ They don’t want to go there, our administrators don’t want to talk about it. And he said, ‘You know personally I would be okay with it, but we are going to have to pass on that because I have a feeling that it would cause an uproar.’ And it seems like a lot of administrators, they don’t want to deal with that battle” (10th grade health teacher). On the other hand, supportive school administrators had the power to set a positive tone for sexuality education and make health a priority, which was greatly appreciated by teachers who had this type of support. Community-based sexuality educators also noted that classroom teachers could present barriers to their work: “I think it is hard when there are teachers that you feel like are having you in to the room because they have to not because they want to. That doesn’t happen very often but when it does they’re just sort of like a pall over the room and you just wish you weren’t there” (Community sexuality educator). This group also expressed the need to have very clear guidance from teachers (and school administrators) regarding what they could and could not discuss in their presentations. One stated, “Coming in as an outside person, we often times, especially if it’s a new district, say ‘What can we talk about?’ And teachers often are like, ‘I don’t know.’ ... They have to go through 28 levels before they can let us know.... And sometimes they say it’s fine and then we find out after that they didn’t ask anybody and we get angry phone calls from the superintendents saying ‘why are you talking about this?’ So we end up being the scapegoats because nobody checked.”

Parents’ influence on administration and restrictive policies was very evident to teachers, and they commented on the undue sway of small, outspoken groups, “because they make more noise. The other people just assume that the school district is going to let teachers teach. And a small portion is making all the racket” (6-8th grade health teacher). One commented that the reverse was never true: “There’s no parent calling school saying ‘how dare you NOT teach my kid sex ed!’ And that would be nice” (4-12th grade sexuality educator). Teachers expressed frustration more generally with parents speaking out against comprehensive sexuality education in schools. One commented, “That’s my favorite thing, when parents come in and say this abstinence thing is working, and there are five girls walking around pregnant, and I am like, ‘yeah, works great’” (10th grade health/PE teacher); another said, “As a teacher, I am 100% supportive of what those parents want to do.... I am very respectful of what parents believe is right for their child because they ultimately are their parents. But it is difficult” (Suburban 10-12th grade health teacher). Teachers perceived that many of these same parents also failed to talk with their own kids about sex: “It’s hard for us when parents are so adamant that they should be the ones teaching their kids about this stuff and it shouldn’t be us, but then they don’t.... So if you don’t want me teaching it and you don’t teach it, they are going to learn it from someone, and wouldn’t you rather have it be me than that kid in the 3rd floor bathroom?” (Community sexuality educator). Some teachers also felt a general sense of distrust from parents. One educator commented, “another thing that is really hard is no matter how outlandish the claim is, when parents automatically believe what their kid says as opposed to what the teacher or what I say. Couldn’t you take it with a grain of

salt? ... No, we don't lock people in the rooms and no, I didn't force the kids to call me 'the sex lady' or I wouldn't answer their questions. So that's a hard thing" (Community sexuality educator). Importantly, other teachers felt the support of parents and the community, which was a significant asset in teaching sexuality education: "I don't feel like we have parents in our district that we have to advocate it for, they want us to do it. I feel really like they're supportive of it, [so] administration kind of lets us go" (7-9th grade health teacher). Other teachers also mentioned community agencies, such as churches, which were able to support sexuality education by sharing similar messages with young people. For example, "A lot of the churches that I work with are getting more involved with sexuality and how to teach it or how to preach it to the youth, that's been kind of a big support for me with working with students and having that reinforced through the churches" (6-12th grade sexuality educator).

Other significant barriers to teaching their best sexuality education were time and financial resources. One teacher commented, "There is so much that I would want to teach if I had time. I mean if time was not an issue we would be covering everything from media to gender stereotypes, I mean it would just be so much more than birth control and STIs. And there's just not time" (High school sexuality educator). Other teachers noted they didn't have resources to purchase current materials for their students, or even to enhance their own learning. For example, "Probably five years ago, we had this book that we were using, and in it, it said you could get HIV from open mouth kissing. And I would tell the kids, 'if you read this, please, this is not true, we need to get rid of these books, but we don't have money yet'" (10th grade health teacher). Another teacher commented, "Sometimes that would be more helpful too to have more money to be able to purchase some things, even if they were just to teach myself so I could teach them better, not necessarily classroom sets or anything" (7-9th grade health teacher).

In some cases, differences among the students in a classroom also presented challenges for sexuality education teachers. In urban settings in particular, diverse cultural values and practices made it difficult to present messages that were salient to all students. For example, one teacher shared, "I had some Somali girls in my classroom ... She said, 'Ms. C, why do you say, why do tell these kids about premarital sex? You don't do that. You don't do that in our culture. It just doesn't happen.' And she was saying, seriously, people get stoned back in Somalia where she was from and she said it just doesn't happen. I didn't realize I had kind of blown her away with some of the things we were talking about" (7-9th grade health teacher). Likewise, another added, "and then the other end where you have [Hmong] students who are culturally married and we are supposed to be teaching them abstinence only?" (9th grade health teacher). In addition to ethnic diversity, students came to class with a broad range of experience levels, as well as physical and emotional maturity: "You have kids who don't want you mentioning any sexual term and then you have kids who have already been there, done that" (6-10th grade health teacher). Another teacher articulated this challenge, "So it's finding that part where you are answering all the questions from the students that don't know and also keeping the other students interested" (Urban 9-12th grade health teacher). Teachers also described some students who had not learned basic information, and were therefore unprepared to learn age-appropriate material. For example, "One of the 9th grade boys leaned over to me very seriously in the presentation and said, 'yeah, um, do we have a uterus?' and I went no, oh my word, we need to back up here a little bit.

Where is our 6th, 7th, 8th, and now we are in 9th and we are having these kinds of conversations, wow” (ALC and high school health/PE teacher). Another commented, “You can’t even imagine the questions that they throw out there. You’re like, did your mama ever talk to you kids? I mean just simple questions like where does a baby come from ... And I was like, ‘Oh my God!’ I could not believe that, and she was pregnant. So this baby was fittin’ to have a baby and she didn’t know where it came from.... She’s going to get a rude awakening when she goes to the hospital cause no one has ever told her” (Urban community educator).

Finally, participants described many challenges to sexuality education in the culture itself, citing media influences, and societal attitudes about sexuality. Teachers noted the messages young people received from television and other media sources: “So what kids are viewing now is, it is pretty much okay to be sexually active. So you are almost talking to them about something that is pretty alien to them because no matter what you watch, even the commercials you watch, what you see in magazines, everything is geared towards sex. Because sex sells. So it makes it even harder for them to contemplate that you can say no. So they have the feeling that if somebody is coming on to them they did something so therefore they have to continue doing this. And it is not necessarily so. They *do* have a brain. They *do* have options and one of them is ‘no’” (6-8th grade health teacher). Participants were also very cognizant of sociocultural messages that made it difficult to promote norms of healthy sexuality. One commented, “We really need a cultural shift around sexuality. I mean that’s ultimately what we need, is that it needs to be okay to talk about. It needs to be okay to ask questions.... We have that weird dynamic where it’s everywhere and yet it’s taboo” (4-12th grade sexuality educator).

CONCLUSIONS

Key messages for stakeholders in sexuality education

Several broad themes emerged across all focus groups and all questions. First, Minnesota’s sexuality education teachers are passionate about this topic and enjoy teaching it. They thrived on the energy of the students, and deeply felt the importance of sexuality education in their lives. Teachers strongly desire to reach their students with current, accurate, useful information which will help them make healthy choices. They typically go “above and beyond” the normal requirements of classroom teachers by creating curricula, being a resource for students, and advocating on behalf of their programs. However, teachers face many challenges as they seek to provide their best sexuality education, including restrictions on what, how and when they can teach; a lack of funding paired with a lack of respect for health education; and the need to continuously update their material.

Although participants in this focus group study were volunteers and may not represent the opinions of all Minnesota sexuality educators, their words give teachers a voice in the ongoing public discourse regarding sexuality education. The viewpoints expressed here speak clearly about a number of ways to support sexuality educators in their work. Based on these findings, we make the following recommendations:

Policy

- Mandate comprehensive sexuality education, including medically accurate information about pregnancy and STI prevention methods, as a component of K-12 health education programs in Minnesota

Training

- Require sexuality education – both content and methods – as part of all health education training programs in Minnesota
- To address unique challenges in teaching sexuality education, pre-licensure and continuing education training for teachers should address topics such as understanding and teaching to diverse learners; answering difficult questions; dealing with divergent moral perspectives on sexuality education; and dealing with community reactions to sexuality education (Hedgepeth & Helmich, 1996)
- Consider expanding practicum experiences that allow teachers hands-on practice and feedback with teaching classroom sexuality education. Consider mechanisms for offering classroom coaching/mentoring of teachers involved in teaching sexuality education.
- Require school administrators (i.e. principals and superintendents) to participate in a for-credit course on sexuality education for licensure, including effective sexuality education programs; dealing with divergent moral perspectives on sexuality education; and dealing with community reactions to sexuality education.

Programming

- Require successful completion of a health education course for graduation from Minnesota schools, with sufficient time allotted to include a variety of topics including sexuality education
- Create and support local networks of school-based health educators to facilitate sharing of ideas, materials, methods and resources related to teaching sexuality education; and support existing networks such as the Minnesota Sexuality Education Resource Review Panel (MSERRP) and Sexuality and Family Life Educators
- Provide resources for updated sexual health information and current curricular materials that are easily accessible to Minnesota teachers, such as MSERRP, the state's CDC-supported sexual health curriculum resource, and disseminate materials widely
- Support programs that teach parents to be their children's first sexual health educators, so that students are prepared to learn age-appropriate sexual health information

- Work towards sociocultural change to reduce taboos around discussing sexuality and promote representation of healthy sexuality in the media

Table: Specific resources named by focus group participants

Resource	# mentions (total)	Mentioned in # groups
MOAPPP	11	7
MN Dept of Health/Ed/ Coordinated Health	7	4
MN Health Educators Conference	8	3
New Life Family Services/ Molly Barnhardt (speaker)	6	3
Bird & Bees	5	3
Family Tree Clinic	5	3
City/County/District	4	3
Planned Parenthood	3	2
HYD-PRC/U of M	2	2
MCHET	2	2
Red Cross	2	2
West Suburban Teen Clinic	4	1
Baby Think-It-Over	2	1
PFLAG	2	1
Adam and Eve (CD-ROM)	1	1
Advocates for Youth	1	1
Association for Physical Education	1	1
Breaking the Silence	1	1
CDC	1	1
Cornerstone	1	1
Current Health (magazine)	1	1
Deb Tackman (speaker)	1	1
I am Worth Waiting For (curriculum)	1	1
MN AIDS line	1	1
Out for Good	1	1
Search Institute	1	1
SFLE	1	1

Part II: Summary of Survey Findings

EXECUTIVE SUMMARY

Following the focus group phase of this study, survey data were collected from sexuality education teachers in Minnesota to determine how common the beliefs, attitudes and experiences expressed by focus group participants were in a more representative sample of sexuality educators. We partnered with the Minnesota Department of Education by adding a one-page sexuality education survey to their School Health Profiles project. A total of 368 usable surveys were returned from the Profiles sample of lead health teachers, plus a supplemental sample of teachers in other subject areas and alternative school teachers who attended the Minnesota Association for Alternative Programs conference in February, 2010.

Key findings:

- Most teachers received pre-service training in basic information regarding human sexuality, and for most it was a required part of their training. Teachers were much less likely to have received training on effective communication with parents, advocacy, and cultural sensitivity in sexuality education. Teachers in alternative schools were less likely than those in mainstream schools to have received relevant pre-service training.
- Over half of teachers had received professional development regarding sexuality education in the two years preceding the survey. However, many more teachers indicated that they *would like to receive* professional development in these same topics. Teachers in the Twin Cities metropolitan area were more likely than others to report they had received and would like to receive professional development on these topics.
- Specifically in the area of HIV, many teachers reported recent professional development. HIV-related training was more common among health teachers than those in other disciplines.
- Teachers overwhelmingly felt that sexuality education was at least as important as other units they taught. Over 60% considered this the most important topic, or felt it was more important than many of their other units.
- Teachers reported spending more time on various tasks for their sexuality education units than for their other subjects, including responding to students' personal concerns and correcting inaccurate information. Teachers of middle

school grades were significantly more likely than teachers of high school grades to report spending additional time talking to parents and obtaining parental permissions.

- Over half of teachers reported having guest speakers present some of the content during their sexuality education units, and this was more common among high school teachers.
- Teachers were nearly unanimous in their views that certain subjects (e.g. healthy relationships, abstinence, and STDs) should be included as part of sexuality education. A majority of teachers also thought other, more controversial topics should be taught (e.g. abortion, sexual orientation). For all fourteen sexuality topics on which they were queried, the proportion of teachers who reported that they *currently teach* the topic was lower than the proportion who thought it should be taught.
- Lack of time, financial resources, and curriculum were among the most frequently cited reasons why teachers taught sexuality education differently than they would like to. Twin Cities metropolitan area teachers were more likely than other teachers to report teaching differently due to their school district's policy.
- Teachers endorsed many policies to support sexuality education, including a graduation requirement, district-wide standards, school board policy, and a statewide comprehensive sexuality education policy.

Based on these findings, we conclude that Minnesota's sexuality education teachers face many challenges in their work, and many opportunities exist to strengthen the support they receive. Implications for administrators, policy makers and other stakeholders are discussed.

INTRODUCTION

Over the past two decades, research with sexuality educators has largely sought to determine what content teachers deliver in the classroom, emphasizing a comparison between comprehensive sexuality education and abstinence-only programs (Darroch et al, 2000; Lindau et al, 2008). Studies have identified a shift towards abstinence-only content and a reduction in topics such as condom and contraceptive use, but have rarely looked beyond this subject matter to investigate teachers' experiences in teaching this content (Landry et al, 2000). What kind of pre-service training and continuing education do they receive? What kind do they want? What challenges do they face in this work? What support do they receive? What kind of policies would teachers support regarding sexuality education? Teachers' views on these issues will provide needed insights to inform the ongoing debate about school-based sexuality education.

Findings from the focus group phase of this study were used to guide the survey phase, in order to determine how common the beliefs, attitudes and experiences expressed by focus group participants were in a more representative sample of sexuality educators. In addition, we explore differences in these beliefs and experiences across different groups of teachers, to identify characteristics which may be relevant to future work aimed at improving teachers' experiences providing sexuality education in Minnesota.

METHODS

To conduct this survey of health education teachers, the Healthy Youth Development Prevention Research Center and The Birds & Bees Project partnered with the Minnesota Department of Education on their School Health Profiles ("Profiles") project, which surveys a random sample of health teachers biannually as part of a cooperative agreement with the Centers for Disease Control and Prevention (<http://www.cdc.gov/HealthyYouth/profiles/index.htm>). The Profiles project, conducted in all 50 states, large urban school districts and territories, helps state and district education and health agencies monitor the current status of school health education; physical education; school health policies related to HIV infection/AIDS, tobacco use prevention, and food service; asthma management activities; and family and community involvement in school health programs. The Minnesota Department of Education allowed us to insert a one-page, double-sided survey specific to sexual health into the more general Profiles survey that went out to Minnesota's teachers.

Recruitment, population and sampling

Teachers in the present study were recruited as part of three sub-samples: 1) the Profiles sample, 2) other subject teachers sample, and 3) MAAP sample. For the Profiles sample, all regular secondary public schools in Minnesota having at least one of grades 6 through 12 were included in the sampling frame. Schools were sorted by estimated enrollment in the target grades within school level (senior high schools, middle schools, and combined junior/senior high schools) before sampling. Systematic equal probability sampling with a random start was used to select schools for the survey. The initial

sample was drawn by Westat Corporation (contracted to provide research services to the CDC partners for the Profiles project) and reviewed by staff at the Minnesota Department of Education for updates (school closures, etc). 420 schools were selected for the survey out of 992 in the school data file. 295 health education teachers returned complete and usable questionnaires (70.2%).

One item on the supplemental sexuality education survey (described below) asked lead health teachers in the Profiles sample to identify other classes in which material on human sexuality was taught. If respondents indicated other classes (up to three), an abbreviated version of the Profiles survey and the sexuality education survey were sent to the teacher of that class. This respondent driven sampling resulted in an additional 110 surveys sent, and 82 complete and usable questionnaires (74.5%).

In addition, the Birds & Bees Project staff members attended the Minnesota Association of Alternative Programs conference in February 2010 and recruited 14 additional study participants. Teachers attending the conference that visited their display table or attended their session were asked if they had received the Profiles survey. If they had not, they were invited to sit at a table behind the display booth and complete the supplemental sexuality education survey. This sample did not receive any items from the main Profiles survey.

The total study sample, therefore consisted of 391 teachers from all areas of Minnesota, including those in middle and high schools, mainstream and alternative schools, and teaching health and a variety of other subjects. All participants received a \$25 Target gift card in appreciation of their time and insights.

Survey development and measures

The Profiles survey was developed by the CDC in collaboration with state, territory, and local departments of health and education; existing items were not modified for the present study. This survey included many items relevant to the present study, such as recent professional development related to human sexuality, HIV prevention, pregnancy prevention, training needs in these areas, and years of teaching experience. The Profiles survey is attached in Appendix C.

In addition the PRC-HYD team and the Birds & the Bees project staff, developed a new supplemental sexuality education survey which was mailed with the main Profiles survey (as described below). We developed 10 new items (consisting of 77 sub-parts) to address the barriers, benefits, challenges and supports identified by teachers offering sexuality education in Minnesota schools. New items were based on a review of existing literature and findings from the focus groups conducted during the formative phase of this research, and were revised based on input from adolescent health researchers, HYD-PRC community partners with expertise in sexuality education (e.g. MOAPPP, SFLE), and the Minnesota Department of Education. The penultimate version of new survey items was sent to several classroom health teachers in neighboring states and others involved with health education in Minnesota (retired teacher, teacher trainer). Eight respondents pilot tested the instrument and provided feedback on wording, flow and face validity; final changes were made to the new survey items in response to this feedback.

Measures on the supplemental sexuality education survey included pre-service training to teach sexuality education, the importance of teaching sexuality education, additional activities associated with teaching this subject matter, use of guest speakers,

what content is currently taught and what teachers' believe should be taught, barriers to teaching sexuality education, preferences for policies and standards regarding sexuality education, and demographic items. The final supplemental sexuality education survey is included in Appendix D. Items regarding what teachers believe should be taught and what they teach were used to derive count variables summing the total number of topics teachers thought should be taught (range=0-14) and currently teach (range=0-14). The difference between these was also calculated for use in analysis.

Additional geographic items were derived from the ZIP code of each participating teacher's school. Participants were categorized as being in the 7-county Twin Cities Metropolitan Area (Metropolitan Council, 2010), one of eight congressional districts, and by population size of the city (Department of Administration, 2010).

Data collection

Data collection ran from January-May, 2010. For the Profiles sample, survey packets (including cover letters, Profiles survey booklets, the supplemental sexuality education survey, return post cards, and postage-paid return envelopes) were compiled and mailed to the principal of each selected school by Minnesota Department of Education staff with instructions to have the lead health teacher in the school complete the teacher survey and return it directly to the Department of Education. After the requested survey return date passed, non-respondents were contacted by Department of Education staff by phone to remind them to return the survey. If the teacher needed a replacement survey, a full survey packet was sent by mail. When surveys were returned, data from relevant Profiles items (#16-23) were entered into an Excel spreadsheet by Department of Education staff. Data from supplemental sexuality education surveys were entered by Northwest Key punch, a Minneapolis-based data entry service.

For the other subject teachers sample, relevant items from the Profiles survey (#16-23) were mailed, along with the supplemental sexuality education survey and other data collection materials, to teachers identified by Profiles participants. Mailings were addressed to the subject teacher (e.g. "Family and Consumer Science teacher") at the school address. No follow-up contacts were made to encourage participation in this subsample. All data from this subsample were entered by Northwest Key punch.

For the MAAP sample, surveys were distributed and collected in person by the Birds & Bees project staff. All data from this subsample were entered by Northwest Key punch.

Data from the Profiles survey and supplemental sexuality education survey were merged into a single de-identified dataset for analysis.

Data analysis

Because this study's research questions pertained to sexuality education teachers, data were reviewed to identify respondents who did not appear to teach sex education. Where respondents indicated they taught 0 hours of sexuality education or were missing data on this item, and responded "no" or were missing on all specific content areas they "currently teach," they were assumed not to teach this subject matter and were excluded from analysis (n=23, ~6%; see Appendix E for detailed information). The final analytic sample included 368 sexuality educators.

We reviewed frequency distributions on all key variables and demographic/personal

variables from the Profiles and supplemental sexuality education survey, and central tendency, range and shape for continuous variables. Chi-square tests of association, t-tests and ANOVA models were used, as appropriate, to detect differences in all categorical variables across a) grade level taught, and b) sub-samples, and significant associations are reported. These same tests were also used to detect differences between selected sexuality education variables and geographic area. For these analyses, congressional districts were collapsed into Districts 4 and 5 (representing Minneapolis and St. Paul) vs. all other districts, and population size was grouped into small (<2500 residents), medium (2500-49,999) and large ($\geq 50,000$) areas in order to conduct more meaningful and robust tests.

RESULTS

Characteristics of the sample

Approximately $\frac{3}{4}$ of the study sample were from the main Profiles sample, with an additional 20.9% who taught other subjects, and 3.8% from MAAP. A majority (61.5%) of teachers were female and white (98.4%), which is comparable to the overall full-time teacher population in Minnesota (72% female, 94% white; Kathy Brothen, personal communication). A majority reported that their pre-service training was in health and physical education (60.2%) and were certified, licensed or endorsed by the state of Minnesota to teach health (78.5%). Participants reported many years of experience teaching in this field, with 41.9% reporting 15 years or more, and an additional 17.9% with at least 10 years. Additional details of the sample are shown in Table 1.

Table 1: Characteristics of the sample (n=391)

	N	%
Subsample		
Profiles	277	75.3
Other subject teachers	77	20.9
MAAP	14	3.8
Gender		
Female	225	61.5
Male	141	38.5
Race		
White	361	98.4
Other	6	1.6
Grade level		
Middle school (6-8)	138	38.1
High school (9-12)*	224	61.9
Emphasis of professional preparation		
Health and phys ed	210	60.2
Health education	37	10.6
Physical education	23	6.6
Other education	17	4.9
Home economics/FACS^	33	9.5
Other	29	8.3
Certified to teach health	274	78.5
Years of experience teaching health		
1 year	19	5.5
2-5 years	71	20.5
6-9 years	49	14.2
10-14 years	62	17.9
15 years or more	145	41.9

*includes 36 who marked both middle school and high school as most frequently taught

^Family and consumer science

One-third of respondents were from schools located in the seven-county Twin Cities Metropolitan Area (Table 2). Teachers came from all eight congressional districts and from cities of all different sizes, with almost one-quarter from cities with 100,000 or more residents.

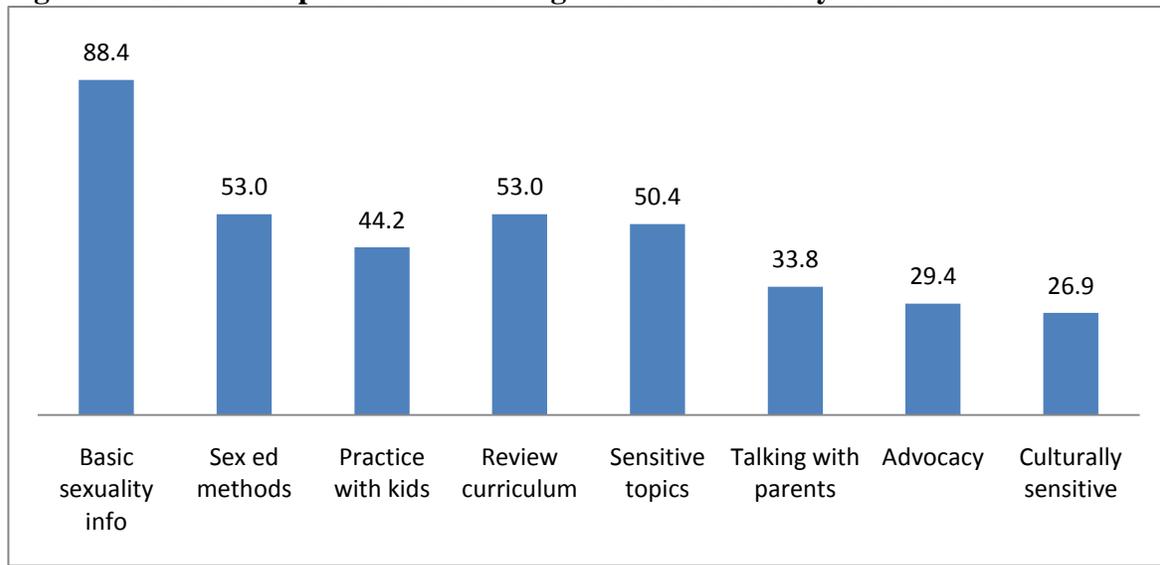
Table 2: Geographic distribution of participants

	N	%
Twin Cities metropolitan area		
Yes	120	32.6
No	248	68.4
Congressional District		
1 (non-metro)	54	14.8
2 (non-metro)	40	11.0
3 (non-metro)	32	8.8
4 (metro)	34	9.3
5 (metro)	20	5.5
6 (non-metro)	46	12.6
7 (non-metro)	81	22.2
8 (non-metro)	58	15.9
City Population Size		
100,000+ (large)	79	21.6
50,000-99,999 (large)	20	5.5
25,000-49,999 (medium)	13	3.6
10,000 - 24,999 (medium)	58	15.9
5,000 - 9,999 (medium)	34	9.3
2,500 - 4,999 (medium)	44	12.1
1,000 - 2,499 (small)	51	14.0
500 - 999 (small)	38	10.4
0-499 (small)	28	7.7

Pre-service training and ongoing professional development

Most teachers received pre-service training in basic information regarding human sexuality (88.4%), and this was the most commonly endorsed topic (Figure 1); furthermore, 79.0% of teachers who received this training reported that this was a required part of their educational program. Approximately half also indicated they had been trained in methods for teaching sexuality education (53.0%), had the opportunity to review curricula (53.0%), and learned strategies for dealing with sensitive material in the classroom (50.4%). Most did not receive any training in how to communicate effectively with parents, how to advocate for sexuality education, or how to deliver this information in culturally sensitive ways.

Figure 1: Content of pre-service training related to sexuality education



The proportion of teachers reporting training in sexuality education topics differed significantly by sub-sample (Table 3). Teachers in the MAAP sub-sample were significantly less likely to report having received training in basic sexuality information, sexuality education methods, practicing with youth, and teaching this material in culturally sensitive ways compared to teachers in the Profiles sub-sample or the sub-sample who taught other subjects. In addition, MAAP teachers were marginally less likely to report receiving training about communicating with parents and advocating for sexuality education compared to those in the other samples.

Table 3: Differences in pre-service training for sexuality education

	Profiles	Other subject teachers	MAAP	
Basic sexuality info	90.1	88.3	57.1	$\chi^2=14.1, p<.001$
Required?*	81.6	75.7	41.7	$\chi^2=11.6, p=.003$
Sex ed methods	57.5	41.6	28.6	$\chi^2=9.6, p=.008$
Practice with kids	46.9	41.6	7.1	$\chi^2=8.8, p=.012$
Talking with parents	36.3	29.9	7.1	$\chi^2=5.7, p=.057$
Advocacy	31.9	24.7	7.1	$\chi^2=5.0, p=.083$
Culturally sensitive	30.6	18.4	0.0	$\chi^2=9.8, p=.007$

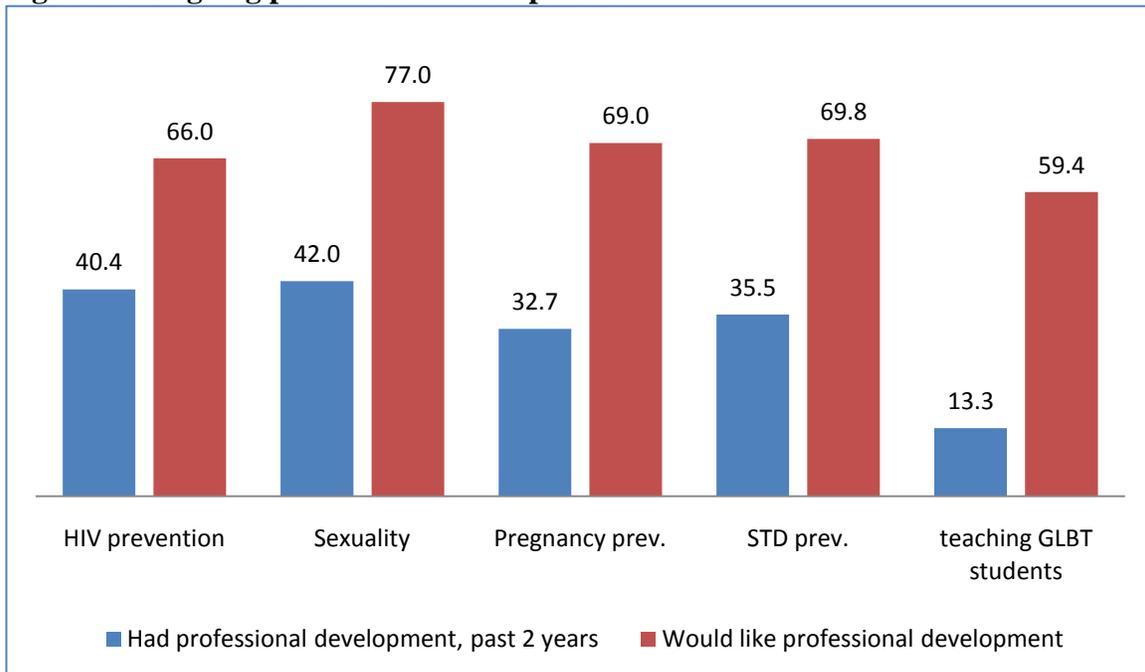
*among those reporting they had received training in basic sexuality information

A majority of teachers (53.6%) received additional training beyond pre-service training to prepare them to teach human sexuality. Many teachers had received professional development on topics in this area in the two years preceding the survey (Figure 2), including HIV prevention (40.4%), human sexuality (42.0%), pregnancy prevention (32.7%), STD prevention (35.5%), and teaching students of different sexual

orientations or gender identities (13.3%). Importantly, many more teachers indicated that they *would like to receive* professional development on these same topics, with the largest gap between having received professional development training and desiring additional training for teaching students of different sexual orientations and gender identities (Figure 2).

No significant differences were found by grade level taught, or between the Profiles and other subject teachers sub-samples (MAAP teachers did not complete these items). Teachers in the Twin Cities metropolitan area were significantly more likely than non-metro teachers to report that they would like to receive professional development on human sexuality (84.8% vs. 73.3%, $\chi^2=5.7$, $p=.017$). Twin Cities area teachers were also more likely to report that they had received additional training on teaching GLBT students (22.5% vs. 8.9%, $\chi^2=12.1$, $p<.001$), as were teachers from larger cities (26.4% vs. 7.0% in medium and 10.6% in small cities; $\chi^2=19.0$, $p<.001$). Twin Cities area teachers were also more likely to say they would like to receive this type of training (70.5% vs. 54.0%, $\chi^2=8.6$, $p=.003$).

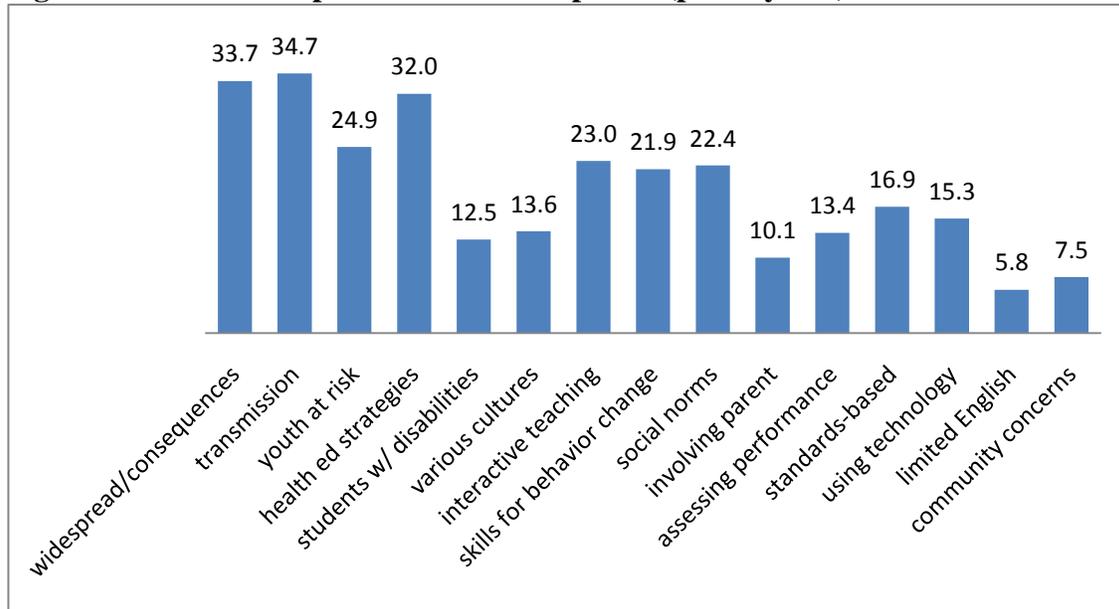
Figure 2: Ongoing professional development



Minnesota statute requires that schools educate students about HIV and other sexually transmitted infections, and the Profiles survey includes several questions specific to this type of programming. Teachers reported receiving recent professional development on a variety of topics specifically related HIV (Figure 3). The most common topics were modes of transmission (34.7%), the prevalence of HIV and consequences of infection (33.7%), and using health education strategies for prevention (32.0%). The least common topics, endorsed by 10% or fewer of teachers, were teaching HIV prevention to students with limited English language skills (5.8%), addressing community concerns about HIV education (7.5%), and involving parents in HIV

education (10.1%). Teachers in the Profiles sample were significantly more likely to report receiving recent professional development in assessing students' performance in HIV education compared to the other subject teachers (15.8% vs. 5.2%; $\chi^2=5.8$, $p=.016$), and in using technology in HIV education (18.2% vs. 5.2%, $\chi^2=7.8$, $p=.005$).

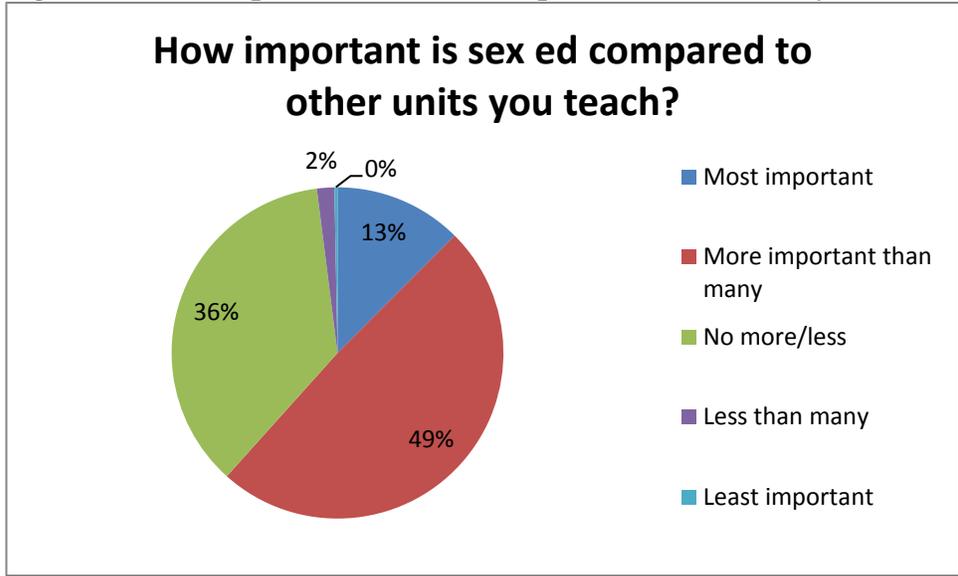
Figure 3: HIV-related professional development (past 2 years)



Importance of sexuality education

Teachers overwhelmingly felt that sexuality education was at least as important as other units they taught. Almost half (49.2%) believed it was more important than many of their other units, and an additional 12.5% considered this the most important topic. There were no significant differences in perceived importance by grade level taught or sub-sample.

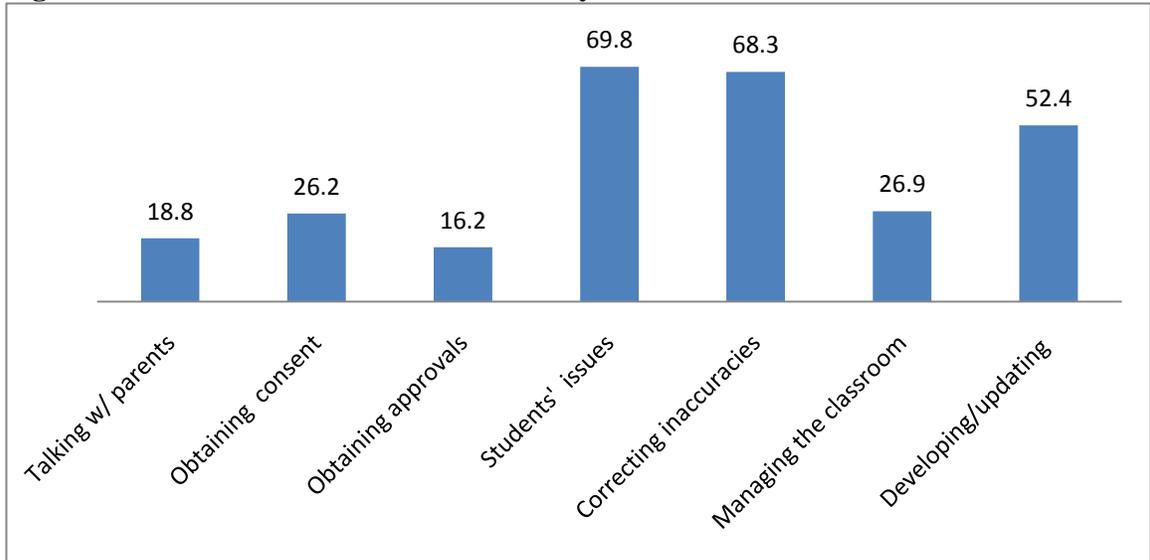
Figure 4: How important is sex ed compared to other units you teach?



Additional tasks for sexuality education

Teachers reported spending more time on numerous tasks for their sexuality education units than for their other subjects (Figure 5). Over two-thirds of teachers spent additional time responding to students’ personal concerns and questions (69.8%) and correcting inaccurate information (68.3%). Among teachers who reported spending extra time on any of these activities, the number of hours ranged from 1-75 additional hours per term, with a median of 4.0 hours.

Figure 5: Additional activities for sexuality education



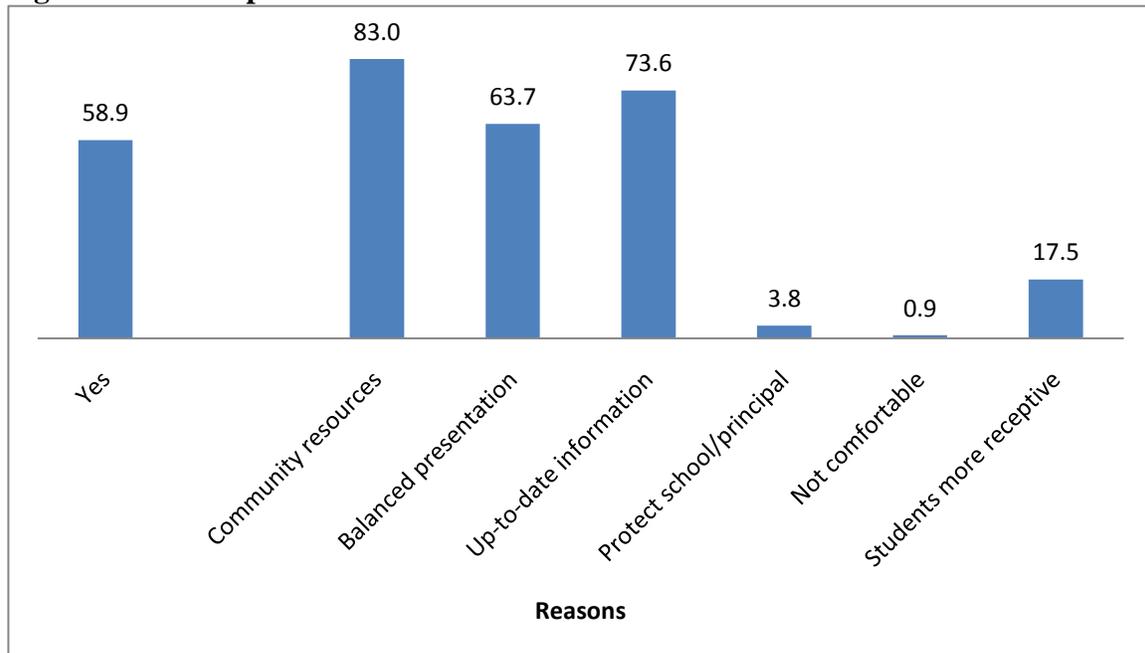
Teachers of middle school grades were significantly more likely than teachers of high school grades to report spending additional time talking to parents (25.4% vs. 14.4%; $\chi^2=6.6$, $p=.011$) and obtaining parental permissions (33.1% vs. 21.8%; $\chi^2=5.4$, $p=.020$). Likewise, teachers in medium (23.4%) or large (24.0%) cities were more likely than those in small cities (9.0%) to report spending additional time talking to parents ($\chi^2=10.5$, $p=.005$). Teachers in the MAAP sub-sample (100%) were significantly more likely than Profiles (67.7%) or other subject teachers (71.6%) to report spending additional time addressing students' personal concerns ($\chi^2=6.7$, $p=.034$).

Use of guest speakers

Over half of teachers (58.9%) reported having guest speakers present some of the content during their sexuality education units (Figure 6). Among these teachers, most indicated that they did so in order to introduce their students to resources in the community (83.0%), present the most up-to-date information (73.6%) or to provide a balanced presentation on a controversial issue (63.7%). Less than one percent invited guest speakers because they themselves were uncomfortable teaching this material.

High school teachers (66.4%) were more likely than middle school teachers (48.9%) to have guest speakers teach some sexuality content ($\chi^2=10.8$, $p=.001$). Use of guest speakers did not differ by subsample, Metropolitan area or city size.

Figure 6: Guest speakers for sex ed



What teachers teach, what they think should be taught, and reasons for the difference

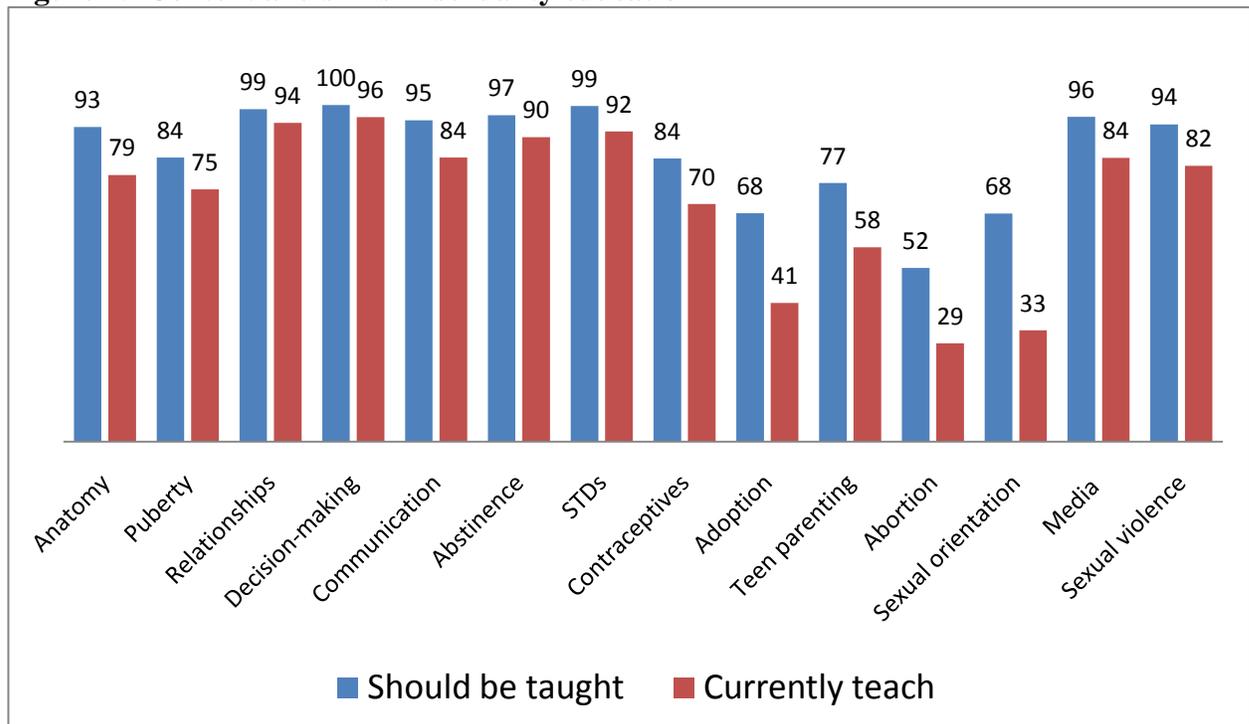
Teachers were nearly unanimous in their views that certain subjects should be included as part of sexuality education for the grade level they teach most often (Figure 7). For example, healthy relationships, decision making, interpersonal communication,

abstinence, sexually transmitted diseases (STDs) and media influence on sex were all endorsed by over 95% of teachers. A majority of teachers also thought that certain topics which are typically considered more sensitive and controversial should be taught, such as abortion (52%) and sexual orientation (68%). For all fourteen topics about which they were queried, the proportion of teachers reporting that they *currently teach* the topic was lower than the proportion who thought it should be taught. For example, while 94% thought issues of sexual violence should be addressed, only 82% reported teaching this topic. The largest gaps between what teachers thought should be taught and what they actually taught were for topics of sexual orientation, adoption and abortion.

Out of the fourteen topics on the survey, the mean number that teachers thought should be taught at the grade level they teach most often was 11.7. Almost one-third (31.0%) of teachers thought they should teach all fourteen topics. The mean number of topics teachers actually reported teaching was 9.8. Only 5.6% of teachers reported teaching more topics than they thought should be taught; 28.4% taught the same number of topics they thought should be taught, and the remaining 66.1% taught fewer topics than they thought they should.

Several significant differences were found across grade level taught. As expected, high school teachers thought that more topics should be taught (12.0 topics vs. 11.2, topics for middle school teachers; $t=2.87$, $p=.004$) and actually taught a higher number of topics (9.9 vs. 8.6, $t=3.56$, $p<.001$) than middle-school teachers. The subsamples also differed in their teaching, with the MAAP sample having the largest discrepancy between the number of topics they thought should be covered and the number they actually taught (discrepancy of 4.1 topics, vs. 2.0 among the “other” teachers and 1.8 among the Profiles teachers; $F=4.13$, $p=.017$).

Figure 7: Content and skills in sexuality education



Not surprisingly, there were significant differences in what topics teachers thought should be taught and what they actually taught, by grade level (Table 3). For topics more relevant to young adolescents (e.g. pubertal development), middle school teachers were significantly more likely than high school teachers to believe they should be taught and to actually teach them. For topics more relevant to older adolescents (who are more likely to be sexually active), high school teachers were more likely to believe they should be taught and to teach them. For example, 82.9% of high school teachers reported teaching about contraceptives, compared to 50.4% of middle school teachers ($\chi^2=41.2$, $p<.001$).

Table 3: Proportion of teachers who think topic should be taught and currently teach it, by grade level

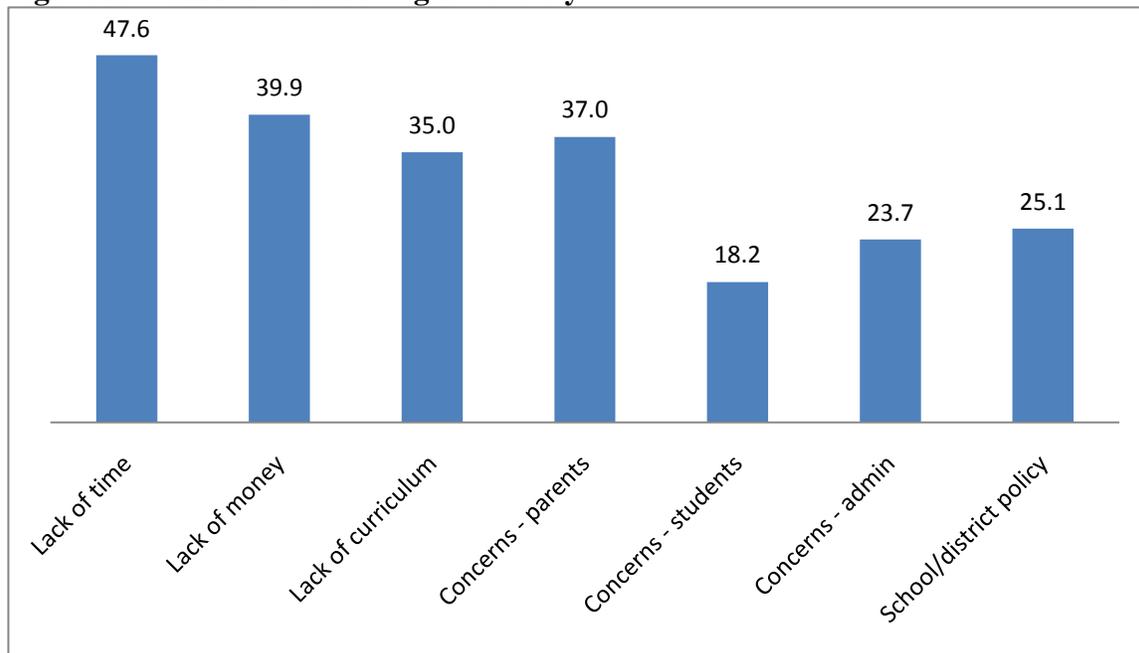
	Should be taught			Currently teach		
	Middle school	High school		Middle school	High school	
Anatomy	95.3	91.7	NS	86.2	76.0	$\chi^2=5.2$, $p=.023$
Puberty	95.2	77.0	$\chi^2=19.3$, $p<.001$	90.7	64.6	$\chi^2=28.7$, $p<.001$
STDs	98.4	100.0	$\chi^2=3.29$, $p=.070$	85.0	95.9	$\chi^2=122.9$, $p<.001$
Contraceptives	70.4	92.2	$\chi^2=27.6$, $p<.001$	50.4	82.9	$\chi^2=41.2$, $p<.001$
Adoption	57.5	73.8	$\chi^2=9.2$, $p=.002$	26.2	51.0	$\chi^2=19.5$, $p<.001$
Teen parenting	68.3	81.7	$\chi^2=7.7$, $p=.006$	46.2	65.9	$\chi^2=12.9$, $p<.001$
Abortion	38.7	58.8	$\chi^2=12.2$, $p<.001$	14.3	38.3	$\chi^2=21.9$, $p<.001$
Sexual orientation	65.0	69.3	NS	27.7	37.0	$\chi^2=3.1$, $p=.078$
Sexual violence	90.2	96.6	$\chi^2=5.9$, $p=.015$	74.2	86.7	$\chi^2=8.6$, $p=.003$

Some differences by sub-sample were also evident. Teachers in the MAAP sub-sample were significantly more likely to think they should teach about sexual violence (100%, vs. 95.6% of Profiles and 87.7% of other subject teachers, $\chi^2=7.2$, $p=.028$), but were less likely to report actually teaching this topic (64.3% vs. 84.3% of Profiles and 75.3% of other subject teachers, $\chi^2=6.0$, $p=.049$). There were also significant differences in the proportion of teachers who reported teaching decision-making (98.2% of Profiles, 90.8% of other subject teachers, and 85.7% of MAAP; $\chi^2=12.8$, $p=.002$) and abstinence (93.0% of Profiles, 85.3% of other subject teachers, and 61.5% of MAAP; $\chi^2=16.5$, $p<.001$).

Lack of time was the most frequently cited reason for teaching sexuality education differently than teachers would like to (47.6%), followed by lack of financial resources (39.9%), concerns about parents' responses (37.0%) and lack of curriculum (35.0%).

Additional barriers to teaching are shown in Figure 8. No significant differences in barriers were found across grade levels or sub-samples. However, teachers in small cities (46.5%) were significantly more likely than those in medium (31.0%) or large (34.7%) cities to report teaching differently because they were concerned about parental response ($\chi^2=6.8, p=.033$). Twin Cities metropolitan area teachers were more likely than non-Metro teachers to report teaching differently due to their school district's policy (36.0 vs. 19.8; $\chi^2=10.7, p=.001$).

Figure 8: Reasons for teaching differently



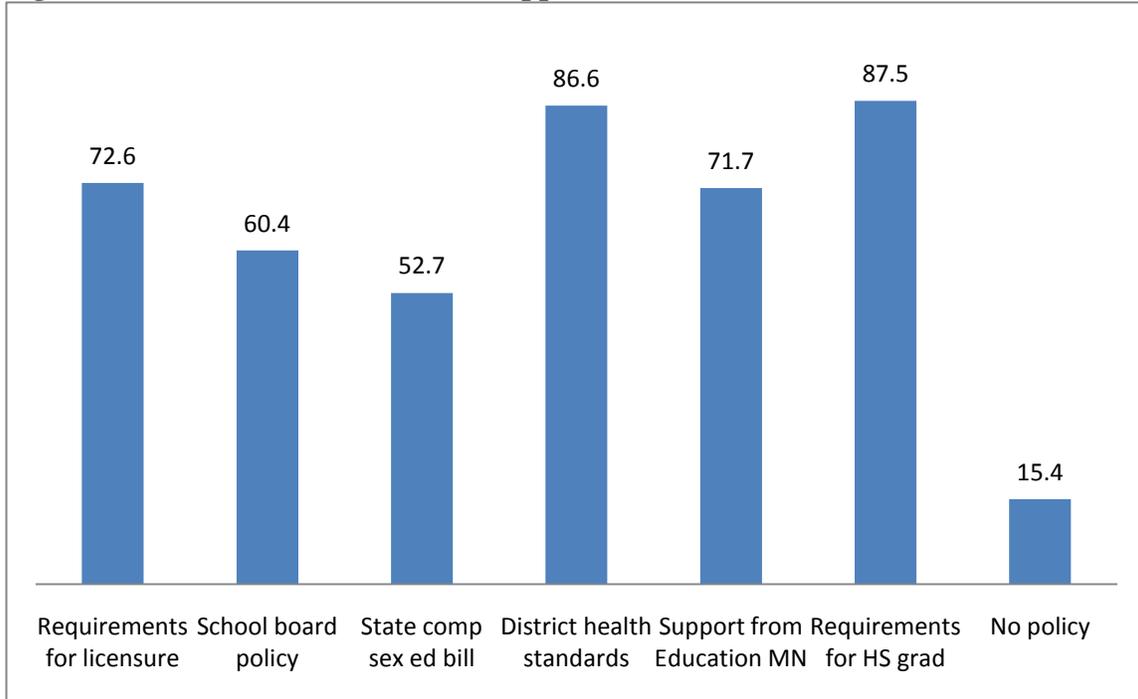
Policies and standards to support sex education

Teachers endorsed a variety of policies and standards to support sexuality education (Figure 9). A health requirement for high school graduation (87.5%) and regularly updated, age-appropriate district-wide health education standards (86.6%) received the strongest support, and a majority supported having a school board policy (60.4%) and a statewide policy of comprehensive sex education (52.7%). 15.4% checked that having no specific policy would be helpful; 3% of respondents indicated that they did not endorse any of the policy options listed on the survey.

Several significant differences by sub-sample were found in support for different policies and standards. MAAP (78.6%) and Profiles teachers (74.6%) were more likely than other subject teachers (60.0%) to endorse support from Education Minnesota as helpful ($\chi^2=6.5, p=.039$). The Profiles sample (91.1%) was more likely to endorse a health requirement for graduation, compared to other subject teachers (77.0%) and MAAP teachers (71.4%; $\chi^2=14.0, p<.001$). Other subject teachers were marginally more likely to endorse having no specific policy related to sexuality education (25.0%), compared to Profiles (12.7%) and MAAP teachers (11.1%, $\chi^2=5.9, p=.053$). Teachers in metropolitan congressional districts 4 and 5 (73.1%) were more likely than teachers from other districts (49.2%) to support a statewide comprehensive sexuality education bill

($\chi^2=10.2$, $p=.001$), and were less likely to indicate that “no policy” would be the most helpful (2.6% vs. 17.6%; $\chi^2=5.8$, $p=.016$).

Figure 9: Policies and standards to support sex ed



CONCLUSIONS

Key messages for stakeholders in sexuality education

This diverse sample of teachers included representation from all areas of the state, many different types of schools and primary disciplines, and is comparable to Minnesota teachers in terms of gender and race. Their survey responses therefore provide insight into a variety of challenges that sexuality education teachers face in doing this work, and suggest numerous avenues for increasing institutional and public support in Minnesota. Based on these findings, we make the following recommendations:

- Teacher training programs should mandate pre-service training in a wider variety of content areas related to sexuality, for health teachers and those in related disciplines. Ongoing in-service training should include expanded content to meet teachers’ needs, particularly in controversial areas where teachers indicated the need for additional training, such as reaching gay, lesbian and bisexual students. Ongoing in-service offerings should also be expanded particularly in non-metropolitan areas of Minnesota.

- Schools should provide additional support to sexuality education teachers for the extra work they do in this unit. This could include administrative assistance (to manage the parental consent process, for example) or other school personnel (such as school counselors) to work with students on personal issues that may be brought to teachers' attention.
- Teachers should have the latitude to develop and deliver sexuality education programs that meet their students' learning needs, as is standard practice in other subject areas. School administrators and policy at school, district and state levels can provide institutional support for these efforts.
- Policies at school, district and state levels should support sexuality education and health education more broadly. Mandates for medically accurate, evidence-based comprehensive sexuality education would protect teachers in doing this work, allowing them to focus on providing the best and most effective education possible to Minnesota students.

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APPENDICES

A: Focus Group Interview Guide

B: Coding Documents

C: Profiles Survey

D: Sexuality Education Survey

E: Exclusion Table