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Tennessee Comptroller of the Treasury, Justin P. Wilson
Legislative Brief

Response to Public Chapter 585 (2012): HIV/AIDS Prevention Education in Tennessee Public Schools

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Key Points

It is difficult to determine the level of school districts' compliance with Tennessee law and with Tennessee State Board of Education policies regarding HIV/AIDS education. Tennessee state law places the responsibility for development, implementation, and evaluation of family life education programs on school districts. Districts do not have to submit their family life education curriculums to the Tennessee Department of Education (TDOE) for approval, and TDOE does not keep a record of family life education curriculums or policies used by districts. Most Tennessee school districts report that they are addressing some, if not all, state curriculum standards pertaining to HIV/AIDS awareness and prevention. Aside from self-reported responses from districts, there is not a state-level procedure in place to determine whether school districts are implementing HIV/AIDS curriculums in compliance with state law and TSBE policies. In addition, it is difficult to determine students' level of knowledge about HIV/AIDS because there are no state assessments related to these curriculum standards.

The rate of HIV diagnoses is increasing among youth in Tennessee. The number of youth ages 13 to 24 living with an HIV diagnosis in Tennessee has more than tripled in the last five years, with 779 reported cases in 2011 compared with 183 cases in 2007. Between 2006 and 2011, the number of persons aged 15 to 24 diagnosed with HIV in Tennessee increased approximately 35 percent. In 2007, youth ages 15 to 24 comprised 19.21 percent of HIV diagnoses in Tennessee. By 2011, this age group comprised 25.5 percent of HIV diagnoses in Tennessee.

There is a lack of consistency between Tennessee state laws and Tennessee State Board of Education policy regarding HIV/AIDS instruction. State law requires school districts located in counties with teen pregnancy rates above 19.5 per 1,000 females ages 15–17 to implement a family life education program, but no longer specifically requires districts to include HIV/AIDS prevention education. Tennessee State Board of Education policy, however, requires districts receiving Coordinated School Health funding to include an HIV/AIDS component within their family life education program.

Citing liability concerns, the Tennessee Department of Health is no longer providing HIV/AIDS prevention education in Tennessee public schools. Legal counsel for the Tennessee Department of Health indicates the current law is unclear whether or not their health educators are protected from liability should a parent or legal guardian file a complaint about the promotion of gateway sexual activity under TCA 49-6-1306. The legal counsel for TDOH has determined that some family life curriculum topics, including HIV/AIDS prevention, may violate TCA 49-6-1303 pertaining to sexual gateway activity. According to TDOH officials, Department of Health regional offices are no longer providing presentations related to these topics in schools.

Introduction

In 2012, the 107th Tennessee General Assembly passed Public Chapter 585 (PC 585), which required the Comptroller's Offices of Research and Education Accountability (OREA) to determine whether the state's school districts are implementing HIV/AIDS prevention curricula in compliance with state laws that require:

- sexual violence awareness and prevention as part of the family life curriculum, to include information about the nature and prevention of AIDS and other sexually transmitted diseases (*TCA* 49-1-220)
- primary emphasis on abstinence and avoidance of drug abuse in AIDS education programs (*TCA* 49-6-1008)
- the teaching of a family life curriculum (which includes a component concerning HIV/AIDS awareness and prevention) in all school districts in counties with a teen pregnancy rate that exceeds 19.5 pregnancies per 1,000 females 15–17 years of age (*TCA* 49-6-1301, et seq.)

Subsequent to the passage of PC 585, the General Assembly passed Public Chapter 973, which revised the law concerning the state's family life curriculum (*TCA* 49-6-1301, et seq.). Because the statutes concerning family life education reference HIV/AIDS, OREA analysts took the revisions into account in responding to PC 585.

PC 585 also required the Tennessee Department of Health to study HIV/AIDS prevention curricula adopted and implemented by school districts in other states and consider Centers for Disease Control and Prevention guidelines related to school curricula, among other directives. The Department of Health has submitted its findings in a separate report to the education committees of the Senate and the House of Representatives.

This legislative brief provides information on what the State of Tennessee requires public schools to teach students about HIV/AIDS prevention, analyzes the status of HIV/AIDS infection among the state's youth, and reviews alignment of statute, policies, and HIV/AIDS prevention instruction.

Tennessee Laws and Policies Pertaining to K–12 HIV/AIDS Prevention Education

In Tennessee public schools, students receive education about HIV/AIDS and other sexually transmitted diseases (STDs) within the framework of the family life curriculum outlined in *TCA* 49-6-1301, et seq., *TCA* 49-6-1008, and *TCA* 49-1-220.

Originally passed in 1989 at the height of the AIDS epidemic, ***TCA* 49-6-1301** required all LEAs in counties with a teen pregnancy rate exceeding 19.5 per 1,000 females ages 15–17 to create and implement a family life instruction program over the following four years. The 1989 law required family life curriculum programs to emphasize:

- abstinence from sexual relations outside of marriage,
- the right and responsibility of a person to refuse to engage in sexual relations,
- basic moral values,
- the obligations and consequences that arise from intimacy, and
- the nature and prevention of AIDS and other sexually transmitted diseases.

***TCA* 49-6-1301, et seq.**, also required the Tennessee State Board of Education (TSBE) to develop a family life instruction program to be made available to those school districts that were required to develop their own program but had failed to do so. The program included an AIDS and sexually transmitted diseases (STD) component, as well as policies and procedures for implementing, administering, and evaluating family life education, and utilizing the services of outside parties, such as health care professionals and social workers, to assist in instruction. The statute provided that school

> Family life education means an abstinence-centered sex education program that builds a foundation of knowledge and skills relating to character development, human development, decision-making, abstinence, contraception, and disease prevention.
>
> *T.C.A. 49-6-1301(6)*
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> HIV/AIDS awareness and prevention is typically taught in K–8 health classes and in lifetime wellness classes in grades 9–12.

districts that do not implement either their own family life education programs or the state board's program could lose state funding.[1] Although the pregnancy rate for females ages 15–17 has declined 33.5 percent statewide since 2001, as of 2010, the latest year of statistics collected by the Tennessee Department of Health, 61 counties, and the 89 school districts within them, had teen pregnancy rates high enough to require implementation of a family life instruction program.[2] See Exhibit 6 for the statewide teen pregnancy rate from 2001 through 2010. See Appendix A for adolescent pregnancy rates by county for females ages 15–17. See "Recent Revisions to Family Life Curriculum Laws" for legislative changes made to *TCA* 49-6-1301, et seq., in 2012.

***TCA* 49-6-1008** requires that all instructional material that addresses AIDS must place "primary emphasis on abstinence from premarital intimacy and on the avoidance of drug abuse in controlling the spread of AIDS." This part of the statute makes any program of AIDS education permissive and subject to approval by the local board of education before its implementation.[3]

***TCA* 49-1-220** addresses sexual violence awareness and prevention as part of the family life curriculum, including information about the nature and prevention of AIDS and other sexually transmitted diseases.[4]

***TCA* 49-1-205** requires the TDOE to develop and maintain a program of technical support and assistance for districts that provide family life education. Districts may request this assistance as needed. **PC 973 (2012)** removed the provision that required districts in counties with pregnancy rates exceeding 19.5 per 1,000 females ages 15–17 to use TDOE's technical support.[5]

Updated in 2005, **TSBE Policy 5.300** "HIV/AIDS Policy for Employees and Students of Tennessee Public Schools" addresses the educational, legal, and social issues raised by HIV infection. The policy requires all districts to "provide age-appropriate, ongoing HIV prevention education instruction" in accordance with TDOE's health and lifetime wellness curriculum standards. Current policy reflects compliance with the Family Life Education Law of 1989, no longer in effect. (See "Recent Revisions to Family Life Curriculum Laws.") The policy states it is the responsibility of each district to develop a comprehensive HIV/AIDS policy. Districts may develop their own HIV/AIDS policy, using the TSBE's HIV/AIDS policy as a model, or they may adopt the TSBE's HIV/AIDS policy as their own.

Adopted in 2000, **TSBE Policy 4.204** "Standards and Guidelines for Tennessee's Coordinated School Health Program" requires all districts that participate in the

HIV/AIDS: A brief history and definitions

The AIDS epidemic began in the early 1980s. Before physicians and scientists were able to link HIV and AIDS infection through blood transmission, at least 50 percent of the 16,000 persons with hemophilia in the United States and an additional 12,000 recipients of blood transfusions had been infected with HIV.

Human Immunodeficiency Virus (HIV) destroys specific blood cells that help the body fight off diseases. HIV is spread through the sharing of bodily fluids (blood, semen, or vaginal secretions), usually through unprotected sexual intercourse, by sharing a needle or syringe to inject drugs, or from mother to child during pregnancy, birth, or breastfeeding. HIV can lead to AIDS (Acquired Immune Deficiency Syndrome), a disease characterized by a weakening of the immune system that causes the body to lose its natural protection against infection. A person with AIDS is more likely to become ill from infections and unusual types of pneumonia and cancer that healthy persons normally can fight off. Currently, there is no vaccine or cure for AIDS.

Public health researchers estimate that 1.7 million people in the US have been infected with HIV since 1981, and approximately 619,000 people in America have died from HIV or AIDS related illnesses since that time. By the end of 2008, approximately 1.2 million adults and adolescents in the US were living with HIV infection.

Sources:
Kent A. Sepkowitz, "AIDS – The First 20 Years," The New England Journal of Medicine (2001) Vol. 334, pp. 1764–1772, http://www.nejm.org/.
Centers for Disease Control and Prevention, "HIV/AIDS Basics," November 6 2006, http://www.cdc.gov/.
Centers for Disease Control and Prevention, "HIV and AIDS: Are you at Risk?" August 1, 2007, http://www.cdc.gov/.
Tennessee Department of Health, HIV/STD Program, "HIV/AIDS," not dated, http://health.state.tn.us/.
AIDS.gov, "HIV/AIDS 101: U.S. Statistics," June 6, 2012, http://aids.gov/.

coordinated school health program to develop and maintain local school system policies pertaining to a number of topics, including HIV/AIDS and family life curriculum. Districts are required to develop and maintain comprehensive pre-K–12 health education and physical education programs, which include HIV/AIDS prevention education.

Due to the 2012 changes made to the family life curriculum statutes, TSBE is considering a review of current policies including those that address HIV/AIDS education.[6]

Recent Revisions to Family Life Curriculum Laws

In 2012, the Tennessee General Assembly revised the family life curriculum statutes.[7] **PC 973 (2012)** deleted the requirement that family life curriculum programs address HIV/AIDS. School districts in counties with adolescent pregnancy rates above 19.5 per 1,000 females ages 15–17 must still adopt a family life instruction program but are no longer required to continue the program over the following four years.[8] Because state law no longer explicitly requires HIV/AIDS prevention instruction, it is unclear whether all students will receive instruction in this area. (See pullout box titled "Language deleted from Tennessee laws regarding AIDS-related instruction in K–12 schools.") TCA 49-6-1304, newly created with the adoption of Public Chapter 973, requires a family life curriculum to address, among other items, sexually transmitted diseases, but does not specifically reference HIV/AIDS.

Although TDOE must provide technical support and assistance by request, 2012 revisions deleted the requirement that districts required to implement a family life program must use TDOE's services. Districts are thus solely responsible for the implementation, evaluation, and review of a family life program within their schools.

State law defines gateway sexual activity as sexual contact encouraging an individual to engage in a non-abstinent behavior. A person promotes a gateway sexual activity by encouraging, advocating, urging or condoning gateway sexual activities.

Source: *TCA* 49-6-1301

Language deleted from Tennessee laws regarding AIDS-related instruction in K–12 schools

PC 973 (2012) removed a provision from the 1989 version of the family life curriculum law regarding the coverage of AIDS and other sexually transmitted diseases within the content of family life education. The deleted language is shown below.

49-6-1301(b): ***The [locally devised and implemented family life education] program shall also include a component that specifically addresses the nature and prevention of AIDS and other sexually transmitted diseases.***

The law also restricts districts from utilizing the services of any individual or organization to assist in teaching family life if that

> individual or organization endorses student nonabstinence as an appropriate or acceptable behavior, or if that individual or organization promotes gateway sexual activity.[9]

PC 973 (2012) allows a parent or legal guardian of a student enrolled in family life to file a complaint with the director of schools if they believe that a teacher, instructor, or representative of an organization has not complied with the requirements set forth in *TCA* 49-6-1301, et seq., regarding the promotion of gateway sexual activity. Parents and guardians have up to one year after the alleged violation occurred to bring forth a complaint. Those persons or organizations in violation of the law may be subject to a cause of action against them for actual damages, attorney's fees, and a civil fine of up to $500. Teachers are excluded from some portions of the law. Teachers, instructors, and organizations may be protected from recourse if they are answering in good faith any pertinent questions or series of questions initiated by a student or students enrolled in the course.[10]

Relationship between Coordinated School Health and HIV/AIDS education

Established in 2000, the Tennessee Department of Education's Office of Coordinated School Health is responsible for improving student health outcomes and supporting the connection between good health practices, academic achievement, and lifetime wellness.[11] TSBE Policy 4.204 regarding Coordinated School Health (CSH) requires all school districts that

accept funding for CSH to develop and maintain local school system policies pertaining to, but not limited to, family life curriculum and HIV/AIDS education.[12] Since 2007–08, all public school systems in Tennessee have received funding and implemented a CSH program.[13]

The Office of Coordinated School Health contains an HIV Education Consultant position, which is funded by the CDC's Division of Adolescent and School Health. This position is responsible for providing technical assistance and professional development to school districts regarding the teaching of HIV/AIDS awareness and prevention. This staff member is also responsible for overseeing the administration of the Youth Risk Behavior Survey (YRBS).[14] For more information on the YRBS, see the pullout box titled "Youth Risk Behavior Survey" and Appendix B for survey results for both Tennessee and Memphis.

Youth Risk Behavior Survey

The Youth Risk Behavior Surveillance System (YRBSS) monitors six types of health-risk behaviors that contribute to the leading causes of death and disability among youth and adults, including sexual behaviors that contribute to unintended pregnancy and sexually transmitted diseases, including HIV infection. The latest survey conducted in 2011 provides both statewide and Memphis responses. Partly because Memphis has one of the nation's highest rates of new HIV infections, Memphis City Schools is the only school district in Tennessee that receives separate funding from the CDC's Division of Adolescent and School Health to conduct its own YRBS, as well as to implement policies and programs to avoid, prevent, and reduce sexual risk behaviors among students that contribute to HIV infection, STDs, and pregnancy. These surveys help states and districts identify the percentage of high school students who engage in sexual risk behaviors and describe state and local characteristics of health education and the school environment among middle and high schools that may help address the problem and protect HIV-infected students and staff. For more information about the YRBS, visit the CDC website at http://www.cdc.gov/healthyyouth/yrbs/index.htm. See Appendix B for select responses for Tennessee and Memphis regarding sexual behaviors.

Source: Centers for Disease Control and Prevention, "Adolescent and School Health: Memphis, TN," June 7, 2012, http://www.cdc.gov/(accessed Feb. 2013).

Health Education and Lifetime Wellness Standards

HIV/AIDS topics, and the sexual violence awareness and prevention curriculum outlined in *TCA* 49-1-220, are generally discussed in Tennessee public schools within the framework of TDOE's Health Education curriculum standards for grades PreK–8, and within the Lifetime Wellness curriculum in high school. Although the family life education law (*TCA* 49-6-1301, et. seq.) no longer requires districts to address HIV in family life education programs, a separate section of state law (*TCA* 49-6-1008(a)), requires K–12 instructional material related to the prevention of AIDS or other STDs to place primary emphasis on abstinence from premarital intimacy and on the avoidance of drug abuse in controlling the spread of AIDS. *TCA* 49-6-1008(b) maintains that adoption of any program of AIDS education shall be permissive and is not required in any district until the local school board has adopted a program of instruction. Tennessee State Board of Education Policy 5.300, however, requires districts receiving Coordinated School Health funding to include an age-appropriate, ongoing HIV/AIDS component within their family life education program.[15]

This program shall:

- Be taught at every level, kindergarten through grade 12;
- Follow content guidelines prepared by the Centers for Disease Control and Prevention (CDC);
- Build knowledge and skills from year to year;
- Be appropriate to students' developmental levels, behaviors, and cultural backgrounds;
- Include accurate information on reducing the risk of HIV infection;
- Stress the benefits of abstinence from sexual activity, alcohol, and other drug use;
- Address students' own concerns about HIV transmission;
- Be taught by well-prepared instructors with adequate resources and support;
- Be consistent with community standards; and
- Involve parents and families as partners in communication.

Because TSBE policy references the 1989 version of the Family Life Education Law, the board is considering revisions to better reflect the current statutes, including those that no longer require HIV/AIDS education.[16]

No state assessments address the Health Education curriculum standards for grades PreK–8, and there is no end-of-course assessment for the required Lifetime Wellness high school course.

Background: Status of HIV/AIDS Infection Among Tennessee Youth

HIV/AIDS diagnoses are increasing in Tennessee among youth ages 15–24.

Between 2006 and 2011, the number of persons aged 15 to 24 diagnosed with HIV in Tennessee increased approximately 35 percent. This age group accounted for approximately 25 percent of new HIV diagnoses in 2011. (See Exhibit 1.) The number of persons aged 15 to 24 living with an HIV diagnosis in Tennessee rose 350 percent between 2007 and 2011, increasing from 170 to 766 cases.[17] (See Exhibit 2.)

Although awareness and treatment of HIV and AIDS have improved since the epidemic was recognized in 1981,[18] approximately 50,000 people are newly infected with HIV each year in the United States. In 2010, approximately 12,000 of those newly infected were youth.[19] Both nationally and in Tennessee, approximately 26 percent of new HIV infections occur among youth ages 13 to 24.[20] According to the CDC, young people are less likely than other age groups to seek out testing for the virus and may be unaware they have it, putting themselves and others at greater risk of infection.[21] Thus, the 766 cases among persons aged 15 to 24 living with an HIV diagnosis in Tennessee may represent an undercount. (See Exhibit 2.)

African Americans have the highest rate of HIV infection among both 13–24 year olds and adults in Tennessee.

African Americans are disproportionately infected with HIV, a trend that is found both nationally and in Tennessee. Approximately 60 percent of new infections in youth occur in African Americans.[22] In Tennessee, African American youth accounted for 151 of the 222 cases (68 percent) reported among 13–24 year olds in 2011.[23] (See Exhibit 3.) Between 2007 and 2011, the number of African Americans living with an HIV diagnosis in Tennessee increased approximately 26 percent. This group accounted for 61 percent of

Exhibit 1: Number of persons diagnosed with HIV in Tennessee by year of diagnosis and age at diagnosis

Age (years)	Cumulative Cases through 2006	2007	2008	2009	2010	2011	Cumulative cases through 2011 (total)	% increase between 2006 and 2011
<13	158	2	3	6	6	4	179	13.29
13 to 14	22	1	2	1	0	0	26	18.18
15 to 24	2,968	186	218	203	206	224	4,005	34.93
25 to 34	7,649	271	290	239	221	218	8,888	16.19
35 to 44	6,131	270	248	234	206	209	7,298	19.03
45 to 54	2,306	170	172	161	156	164	3,129	35.69
55 to 64	667	59	55	74	60	48	963	44.38
>=65	196	9	12	14	13	10	254	29.59
Total	20,097	968	1,000	932	868	877	24,742	23.11

Source: Tennessee Department of Health, "HIV Disease Epi Profile for State of Tennessee, 2011," p. 9.

Exhibit 2: Number of persons living with diagnosis of HIV in Tennessee by year, ages <13 to 24

Current Age (years)	2007	2008	2009	2010	2011	% increase between 2006 and 2011
<13	38	41	47	53	57	50
13 to 14	13	13	13	13	13	-
15 to 24	170	282	398	560	766	350

Source: Tennessee Department of Health, "HIV Disease Epi Profile for State of Tennessee, 2011," p. 13.

diagnosed HIV cases in the state in 2011. By comparison, the next highest group of diagnoses is White/Non-Hispanics, accounting for 33 percent of HIV cases.[24] (See Exhibit 4.)

Males who have sex with other males are disproportionately affected by HIV infection. Nationally, approximately 72 percent of the 12,200 new HIV infections among youth in 2010 were attributable to male-to-male sexual contact. The CDC finds that young males who have sex with males are more likely to contract HIV due to several factors: less condom use, more alcohol and drug use, and greater likelihood of having sexual intercourse with older partners. In 2010, approximately half (54.4 percent) of the 8,800 new infections among youths attributed to male-to-male sexual contact were among African Americans.[25] In Tennessee, 60 percent of new HIV infections among 13–24 year olds in 2011 were attributable to male-to-male sexual contact. (See Exhibit 5.)

Exhibit 3: New HIV Infections among 13 to 24 year olds in Tennessee by race, 2007–2011

	2007	2008	2009	2010	2011
Black, Not Hispanic	148	180	150	159	151
White, Not Hispanic	32	35	44	30	63
Hispanic, All Races	9	9	6	12	5
Other	1	0	5	3	3
Total	190	224	205	204	222

Source: Thomas J. Shavor, Epidemiology Director, Surveillance and Data Management HIV/STD Section Tennessee Department of Health, e-mail attachment, Jan. 15, 2013.

Exhibit 4: Number and percent of diagnosed HIV cases in Tennessee by sex and race/ethnicity, 2011

	Male		Female		Total	
Race/Ethnicity	#	%	#	%	#	%
Hispanic, All Races	31	4.7	8	3.7	39	4.4
American Indian/Alaska Native	3	.5	0	0	3	.3
Asian	5	.8	2	.9	7	.8
Black	383	58	152	70	535	61
White, Not Hispanic	234	36	54	25	288	33
Multiple Race, Not Hispanic	3	.5	2	.9	5	.6
Total	659	100	218	100	877	100

Source: Tennessee Department of Health, "HIV Disease Epi Profile for State of Tennessee, 2011," p. 1.

Exhibit 5: New HIV infection by transmission category, ages 13–24, Tennessee, 2007 through 2011

Transmission Category	2007	2008	2009	2010	2011
Male-to-male sex	100	137	118	114	135
Injection drug use (IDU)	2	1	3	2	2
Male-to-male sex and IDU	0	0	2	1	1
Heterosexual contact	42	32	35	19	24
No Risk Reported	46	54	47	68	60
Total	190	224	205	204	222

Source: Thomas J. Shavor, Epidemiology Director, Surveillance and Data Management, HIV/STD Section, Tennessee Department of Health, e-mail, January 15, 2013.

Analysis of HIV/AIDS Prevention Curricula in Tennessee Public Schools

In December 2012, the Comptroller's Offices of Research and Education Accountability (OREA) requested information from all Tennessee superintendents regarding their district's level of HIV/AIDS education. District officials from 102 districts in 78 counties (74 percent response rate) provided information. (See Appendix C.) Analysis in the following section is taken from district responses, as well as information provided by the Tennessee Department of Education (TDOE), the Tennessee Department of Health (TDOH), and the Centers for Disease Control and Prevention (CDC).

Several factors make it difficult to determine the level of school districts' compliance with both Tennessee law and TSBE policies regarding HIV/AIDS education.

Tennessee state law places the responsibility for development, implementation, and evaluation of family life education programs on school districts. It is difficult, however, to determine the level of school districts' compliance with both Tennessee law and Tennessee State Board of Education policies

regarding HIV/AIDS education. Districts do not have to submit their family life education curriculums to the Tennessee Department of Education (TDOE) for approval, and TDOE does not keep a record of family life education curriculums or policies used by districts.[26] Most Tennessee school districts report that they are addressing some, if not all, of the state curriculum standards pertaining to HIV/AIDS awareness and prevention.[27] In addition, it is difficult to determine students' level of knowledge about HIV/AIDS because there are no state assessments related to these curriculum standards.

School districts may use the curriculum endorsed by TDOE or implement a curriculum they determine best fits an abstinence-only or abstinence-centered approach. Districts must submit their chosen program of family life education to their local board of education for approval as well as make it available annually for community review.[28]

CDC School Health Profile Survey Categories

Survey data from the CDC's School Health Profile Survey helps the Tennessee Department of Education develop programs, allocate resources, and provide staff development opportunities for teachers. The CDC survey monitors the current status of:

- School health education requirements and content
- Physical education requirements
- Asthma management activities
- Food service
- Competitive foods practices and policies
- Family and community involvement in school health programs
- School health policies related to HIV/AIDS, tobacco use prevention, violence prevention and physical activity

Source: Tennessee Department of Education, "School Health Profiles," http://state.tn.us/.

Prevention Challenges Among Tennessee's Youth

Sexual Risk Factors. The 2011 Youth Risk Behavior Survey found that approximately 68 percent of high school seniors had engaged in sexual intercourse, but 45.4 percent of those currently sexually active did not use a condom during their last sexual intercourse. According to the CDC, young people are less likely than other age groups to seek out testing for the virus and may be unaware they have it, putting themselves at risk for sickness and early death and placing others at risk for contracting the disease. Approximately 19 percent of high school students reported never being taught in school about AIDS or HIV infection.

Substance Use. Youth who abuse alcohol or other drugs are more likely to engage in high-risk behaviors, such as unprotected sex, when they are under the influence of drugs or alcohol. In 2011, 65 percent of Tennessee high school students reported having had at least one drink of alcohol in their life, approximately 33 percent reported having had at least one drink in the 30 days prior to answering the survey, and approximately 20 percent reported having used marijuana at least once in the 30 days prior to answering the survey. According to the CDC, "runaways, homeless young people, and young persons who have become dependent on drugs are at high risk for HIV infection if they exchange sex for drugs, money, or shelter."

Lack of Awareness. Many people may not be aware of their HIV status or do not know that they need to get tested. Estimates show that "approximately 1 in 5 adults and adolescents in the US living with HIV are unaware of their HIV status…. Late diagnosis of HIV infection is common, which creates missed opportunities to obtain early medical care and prevent transmission to others." The CDC found that although approximately 45 percent of males and females in 9th to 12th grade reported having had sexual intercourse, only 22.2 percent had ever been tested for HIV. Early diagnosis and treatment can help reduce HIV progression and prevent transmission; however, youths are less likely to be tested, access care, remain in care, and achieve viral suppression, putting themselves and others at risk.

Sources:
Centers for Disease Control and Prevention, "CDC Vital Signs: HIV Among Youth in the US," November 2012, http://www.cdc.gov/, (accessed December 2012).
Centers for Disease Control and Prevention, "HIV Among African Americans," February 2013, http://www.cdc.gov/, (accessed March 2013).
Centers for Disease Control and Prevention, "Vital Signs: HIV Infection, Testing, and Risk Behaviors Among Youth – United States," Morbidity and Mortality Weekly Report, 61, no. 47, November 30, 2012, pp. 971–976, http://www.cdc.gov/ (accessed March 2013).
Tennessee Department of Education, "2011 Youth Risk Behavior Survey Results: Tennessee High School Survey," not dated, http://www.tn.gov/ (accessed March 2013).

Under *TCA* 49-1-205, TDOE is required to develop and maintain a program of technical support and assistance for districts that provide family life education. Districts may request this assistance as needed, but state law no longer requires districts in counties that exceed the pregnancy rate trigger established by *TCA* 49-6-1302 to use TDOE's technical support.

> "Abstinence-based" or "abstinence-centered" means an approach that promotes sexual risk avoidance, or primary prevention, and teaches vital life skills that empower youth to identify healthy and unhealthy relationships, accurately understand sexually transmitted diseases and contraception, set goals, make healthy life decisions, and build character.
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> Source: *TCA* 49-6-1301(2)(A)

According to a CDC survey, most Tennessee districts report that they are addressing curriculum standards related to HIV/AIDS. Limited information regarding HIV/AIDS instruction in Tennessee classrooms is collected through the CDC's School Health Profile, a system of surveys conducted every two years that provides information regarding school health policies, including those specifically related to HIV/AIDS. The survey provides state-level data based on responses from teachers and other education officials throughout the state.[29] See Exhibit 6 for a list of responses from lead health education teachers regarding questions pertaining to HIV, STDs, and pregnancy education in Tennessee.

The majority of Tennessee school districts reported using the Michigan Model, a family health and wellness curriculum, for some or all of their family health and wellness education. The Tennessee Department of Education recommends districts use the Michigan Model, which aligns closely with Tennessee's health and wellness standards. TDOE staff indicate the model can be taught with an abstinence-based or abstinence-centered focus to comply with *TCA* 49-6-1008, which requires that HIV/AIDS instructional material maintain a primary emphasis on abstinence and avoidance of drug abuse as methods of prevention.[30, 31] The Michigan Model also contains lessons that meet the requirements of *TCA* 49-1-220 regarding sexual violence prevention education. Seventy-seven districts indicated they use the Michigan Model curriculum for some or all of their family life education and/or HIV/AIDS instruction. (See Appendix D for a list of select curriculum standards addressing HIV/AIDS.)

In addition, as a part of the annual application to maintain CSH funding, school officials must submit documentation to their district CSH coordinator certifying that they are meeting the requirements of Tennessee laws regarding family life curriculum and any aspect of family planning in schools. Beginning in the 2012–13 school year, TDOE will also require CSH coordinators to provide information on the number of schools that provided HIV/AIDS prevention education in their districts.

Aside from self-reported responses from districts, there is not a state-level procedure in place to determine whether school districts are implementing HIV/AIDS curricula in compliance with state law and TSBE policies.[32]

Districts report that they begin HIV/AIDS education programs at varying grade levels.
Tennessee's Health Education and Lifetime Wellness standards address HIV/AIDS in an age-appropriate manner. Standards are applicable to instruction beginning in grades PreK–2 and address HIV/AIDS as a common communicable disease. The standards require that school districts teach HIV/AIDS education from both viral and behavioral standpoints.[33] Although it is difficult to determine how HIV/AIDS is taught at any grade level, the curriculum standards provide guidance for how districts may approach the topic. See Appendix D for Tennessee's Health Education Curriculum Standards for grades PreK–8 and Lifetime Wellness Curriculum Standards for grades 9–12 pertaining to HIV/AIDS education. HIV/AIDS education in Tennessee districts begins as early as grade 3 or as late as grade 10, based on district responses to OREA's December 2012 survey. Most districts reported they begin to address HIV/AIDS in grades 6 or 9.

The CDC encourages HIV, STD, and pregnancy prevention education in grades 6–8 because many students are not yet sexually active at that age. Prevention education that includes the benefits of abstinence and the delaying or limiting of sexual activity can prevent behaviors that could lead to HIV infection,

STDs, and pregnancy.[34] The 2010 profiles indicate Tennessee health education teachers begin covering most HIV, STD, and pregnancy prevention topics in grades 9–12. In middle school, 63.2 percent of teachers report having taught students how to prevent HIV, other STDs, and pregnancy,[35] compared with 94.3 percent of teachers in grades 9–12.[36]

Students typically receive HIV/AIDS education from their classroom teachers in grades Pre-K–8 and from a certified lifetime wellness teacher in grades 9–12.

Responses to the OREA questionnaire indicate that elementary and middle school students typically receive health education, including HIV/AIDS education, from classroom teachers. School counselors, physical education teachers, and school nurses often provide supplemental instruction.

High school students must complete 1.5 credits of Physical Education and Wellness for graduation.[37] These credits are typically comprised of one year of physical education and one semester of a health or

Exhibit 6: Percentage of schools in which teachers taught HIV, STD, or pregnancy prevention topics in a required course, 2010 (based on the CDC 2010 School Health Profiles Report for Tennessee)

HIV, STD, or Pregnancy Prevention Topic	Grades 6, 7, or 8*	Grades, 9, 10, 11, or 12**
	Percent of schools	
The differences between HIV and AIDS	63.6	95.2
How HIV and other STDs are transmitted	65.8	95.2
How HIV and other STDs are diagnosed and treated	58.5	93.3
Health consequences of HIV, other STDs, and pregnancy	63.0	94.1
The relationship among HIV, other STDs, and pregnancy	57.5	94.2
The relationship between alcohol and other drug use and risk for HIV, other STDs, and pregnancy	61.2	93.4
The benefits of being sexually abstinent	64.5	96.2
How to prevent HIV, other STDs, and pregnancy	63.2	94.3
How to access valid and reliable health information, products, and services related to HIV, other STDs, and pregnancy	53.6	92.4
The influences of media, family, and social and cultural norms on sexual behavior	58.0	90.5
Communication and negotiation skills related to eliminating or reducing risk for HIV, other STDs, and pregnancy	55.9	89.4
Goal-setting and decision-making skills related to eliminating or reducing risk for HIV, other STDs, and pregnancy	57.8	89.3
Compassion for persons living with HIV or AIDS	45.7	82.1
Efficacy of condoms: how well condoms work and do not work	39.1	73.3
The importance of using condoms consistently and correctly	28.1	62.1
How to obtain condoms	21.8	57.1
How to correctly use a condom	19.6	43.3

Note: Two questionnaires are used to collect data – one for school principals and one for lead health education teachers. The two questionnaires were mailed to 367 regular secondary public schools containing any of grades 6 through 12 in Tennessee during spring 2010. Usable questionnaires were received from 78% of principals and from 78% of teachers. Because the response rates for these surveys were greater than or equal to 70%, the results are weighted and are representative of all regular public secondary schools in Tennessee having at least one of grades 6 through 12.
*Source: Tennessee Department of Education, "Tennessee 2010 School Health Profiles Report Weighted Lead Health Education Teacher Survey Results: Grades 6, 7, or 8," http://www.tennessee.gov/ (accessed March 1, 2013), pp. 12-14.
** Source: Tennessee Department of Education, "Tennessee 2010 School Health Profiles Report, Weighted Lead Health Education Teacher Survey Results: Grades 9, 10, 11, or 12," http://www.tennessee.gov/ (accessed March 1, 2013), pp. 15-17.

lifetime wellness course. Responses indicated that information regarding HIV/AIDS and other sexually transmitted diseases (STDs) is typically taught in a lifetime wellness course by a certified wellness or physical education teacher.

Districts are responsible for requesting professional development for HIV/AIDS instruction from TDOE. According to the 2010 School Health Profiles, 24.8 percent of lead health education teachers in Tennessee had received professional development in the past two years on HIV-related topics including modes of transmission, effective prevention methods, identification of at-risk populations, and implementation of health education strategies for prevention.[38] According to TDOE, 96 percent of districts provided annual staff training on HIV and other blood-borne pathogens during the 2010–2011 school year.[39] This training is staff-specific, however, and is not related to professional development for classroom instruction on HIV/AIDS related subjects.

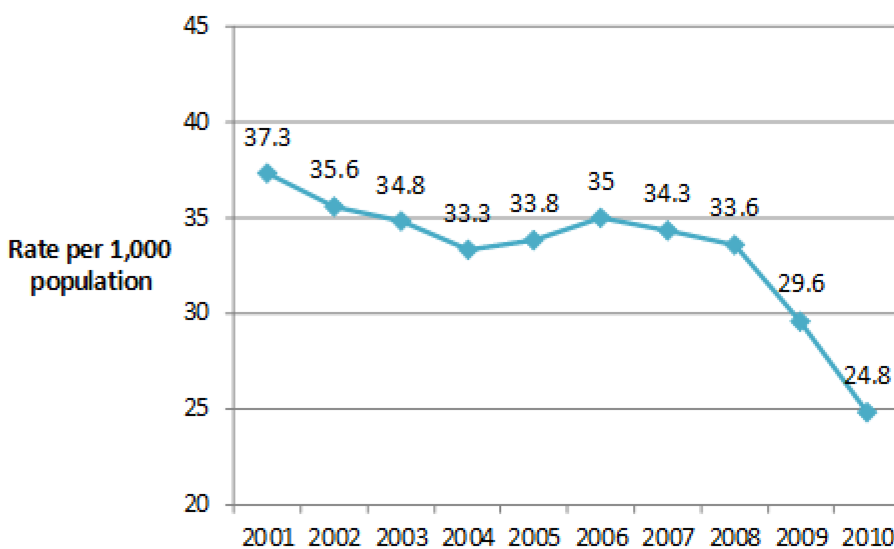
Professional development is currently provided statewide at the request of districts by Tennessee T.A.L.K.S. (Teaching Activities that Lead to Knowledge and Safety), a partnership between the CDC Division of Adolescent School Health (DASH), located at Middle Tennessee State University, and TDOE's Office of Coordinated School Health. Since 2010, this group has provided training sessions to teachers and other school administrators on a variety of topics including information on the Michigan Model curriculum.[40]

Tennessee state laws and Tennessee State Board of Education Policies are not consistent regarding HIV/AIDS instruction.

Tennessee state law at *TCA* 49-6-1301, et seq., no longer requires districts to include HIV/AIDS prevention education in their family life education programs; however, TSBE Policy 4.204 requires districts receiving CSH funding to include an HIV/AIDS education component within their family life education curriculum. Because state law no longer explicitly requires HIV/AIDS prevention instruction, it is unclear whether all students will receive instruction in this area.

Under state law, 102 districts currently must implement a family life curriculum based on their county's adolescent pregnancy rate.
Although the adolescent pregnancy rate among 15–17 year old females in Tennessee declined 33.5 percent between 2001 and 2010, according to the most recent data available, 61 counties exceed the 19.5 pregnancy rate trigger established by *TCA* 49-6-1302.[41] All school districts within those counties are required to implement a family life curriculum. (See Exhibit 7 and Appendix A.)

Exhibit 7: Tennessee statewide pregnancy rate per 1,000 females age 15–17, 2001 through 2010



Source: Tennessee Department of Health, "General Health Data: Pregnancy," http://health.state.tn.us/ (accessed Dec. 15, 2012).

All districts in Tennessee currently accept CSH funding and therefore are required under TSBE Policy 4.204 to implement a family life curriculum, including an HIV/AIDS prevention education component. According to TDOE, one goal of CSH is to increase the classroom teacher's capacity to provide effective, science-based HIV prevention education.[42] See pullout box titled "State laws and policies regarding HIV/AIDS education."

Citing liability concerns, the Tennessee Department of Health is no longer providing HIV/AIDS prevention education in Tennessee public schools.[43]

Legal counsel for the Tennessee Department of Health indicates the current law is unclear whether or not their health educators are protected from liability should a parent or legal guardian file a complaint about the promotion of gateway sexual activity under *TCA* 49-6-1306.[44] State law defines gateway sexual activity as sexual contact encouraging an individual to engage in a non-abstinent behavior. A person promotes a gateway sexual activity by encouraging, advocating, urging, or condoning gateway sexual activities.[45] According to *TCA* 49-6-1303, districts may utilize a qualified healthcare professional or social worker to assist in teaching family life education. However, districts must not use any outside individuals or agencies that promote student non-abstinence or gateway sexual activity.

The legal counsel for TDOH has determined that some family life curriculum topics, including HIV/AIDS prevention, may violate *TCA* 49-6-1303 pertaining to sexual gateway activity. According to TDOH officials, Department of Health regional offices are no longer providing presentations related to these topics in schools. In the 2011–12 school year, TDOH regional offices provided 942 such presentations in schools; in the 2012–13 school year, they have provided no such presentations. See Appendix E for the official response from TDOH.

Coordinated School Health staff have expressed concern about TDOH no longer providing HIV/AIDS instructional assistance in schools. Some schools previously used TDOH to supplement instruction of sensitive topics, including HIV, STD, and pregnancy prevention and awareness.[46]

Endnotes

[1] 96th Tennessee General Assembly, Public Acts, 1989, Chapter No. 565, An act relative to family life instruction.

[2] Tennessee Department of Health, "Tennessee Adolescent Pregnancy Summary Data 2010," Feb. 2012, http://health.state.tn.us/ (accessed December 2012).

[3] 96th Tennessee General Assembly, Public Acts, 1989, Chapter No. 215, An act relative to educational courses concerning the prevention of AIDS and other sexually transmitted diseases.

[4] 104th Tennessee General Assembly, Public Acts, 2006, Chapter No. 824, An act relative to sexual violence awareness and prevention curriculum, http://www.tn.gov/ (accessed March 2013).

[5] 95th Tennessee General Assembly, Public Acts, 1987, Chapter No. 442, An act relative to teenage pregnancy prevention.

[6] Dannelle F. Walker, General Counsel, Tennessee State Board of Education, e-mail, February 15, 2013.

[7] 107th General Assembly, Public Acts, 2012, Chapter No. 973, An act relative to family life instruction, http://www.tn.gov/ (accessed March 12, 2013).

[8] *Tennessee Code Annotated* 49-6-1302.

[9] *Tennessee Code Annotated* 49-6-1303.

[10] *Tennessee Code Annotated* 49-6-1306.

[11] *Tennessee Code Annotated* 49-1-1001, et seq.

[12] Policy of the Tennessee State Board of Education, Chapter 4.204, Standards and Guidelines for Tennessee's Coordinated School Health Program, effective Jan. 31, 2000.

[13] Tennessee Department of Education, "About Coordinated School Health," not dated, http://state.tn.us/ (accessed March 1, 2013). For more information on Coordinated School Health, see OREA's legislative brief on Coordinated School Health, http://www.comptroller.tn.gov/.

[14] Mark Bloodworth, HIV Education Consultant, and Rebecca Johns-Wommack, Executive Director, Tennessee Department of Education, Office of Coordinated School Health, interview, Oct. 8, 2012.

[15] Tennessee State Board of Education, Chapter 5.300, HIV/AIDS Policy for Employees and Students of Tennessee Public Schools, revised August 18, 2005.

[16] Dannelle F. Walker, General Counsel, Tennessee State Board of Education, e-mail, Feb. 15, 2013.

[17] Tennessee Department of Health, "HIV Disease Epi Profile for State of Tennessee, 2011," pp. 9 and 13, http://health.state.tn.us/ (accessed Dec. 2012).

[18] Kent. A Sepkowitz, "AIDS – The First 20 Years," *The New England Journal of Medicine,* Vol. 344, No. 23, June 2001, pp. 1764-1772, http://www.nejm.org/ (accessed Dec. 2012).

[19] Centers for Disease Control and Prevention, "CDC Vital Signs: HIV Among Youth in the US," Nov. 2012, http://www.cdc.gov/ (accessed Dec. 2012); CDC, "Vital Signs: HIV Infection, Testing, and Risk Behaviors Among Youth – United States," *Morbidity and Mortality Weekly Report,* Vol. 61, no. 47, Nov. 30, 2012, pp. 971-976, http://www.cdc.gov/ (accessed December 2012).

[20] Centers for Disease Control and Prevention, "CDC Vital Signs: HIV Among Youth in the US," Nov. 2012; Tennessee Department of Health, "HIV Disease Epi Profile for State of Tennessee, 2011," p. 2.

[21] Centers for Disease Control and Prevention, "CDC Vital Signs: HIV Among Youth in the US," Nov. 2012.

[22] *Ibid.*

[23] Thomas J. Shavor, Epidemiology Director, Surveillance and Data Management, HIV/STD Section, Tennessee Department of Health, e-mail attachment, Jan. 15, 2013.

[24] Tennessee Department of Health, "HIV Disease Epi Profile for State of Tennessee, 2011," pp. 1 and 12.

[25] Centers for Disease Control and Prevention, "Vital Signs: HIV Infection, Testing, and Risk Behaviors Among Youth – United States," *Morbidity and Mortality Weekly Report,* Nov. 30, 2012.

[26] Mark Bloodworth, HIV Education Consultant, and Rebecca Johns-Wommack, Executive Director, Tennessee Department of Education, Office of Coordinated School Health, interview, Dec. 19, 2012.

[27] The state's K-8 Health Education and 9-12 Lifetime Wellness curriculum standards both address HIV/AIDS awareness and prevention. Tennessee Department of Education, "Health, P.E., and Wellness Curriculum Standards," not dated, http://www.tn.gov/ (accessed March 2013).

[28] Mark Bloodworth and Rebecca Johns-Wommack, interview, Oct. 8, 2012.

[29] *Ibid.*

[30] According to the publisher's website, the Michigan Model is "an abstinence-based curriculum; however, it provides three options

for implementation, including an abstinence-only option." Educational Materials Center, "Michigan Model for Health," not dated, http://www.emc.cmich.edu/ (accessed March 10, 2013).

[31] Mark Bloodworth and Rebecca Johns-Wommack, interview, Oct. 8, 2012.

[32] Mark Bloodworth and Rebecca Johns-Wommack, interview, Dec. 19, 2012.

[33] Mark Bloodworth and Rebecca Johns-Wommack, interview, Oct. 8, 2012.

[34] Centers for Disease Control and Prevention, "HIV, Other STD, and Pregnancy Prevention Education in Public Secondary Schools – 45 States, 2008-2010," *Morbidity and Mortality Weekly Report,* Vol. 61, No. 13, April 6, 2012, pp. 222-228, http://www.cdc.gov/ (accessed Dec. 14, 2012).

[35] Tennessee Department of Education, "Tennessee 2010 School Health Profiles Report Weighted Lead Health Education Teacher Survey Results," http://www.tennessee.gov/ (accessed March 5, 2013), p. 12.

[36] Tennessee Department of Education, "Tennessee 2010 School Health Profiles Report Weighted Lead Health Education Teacher Survey Results," p. 15.

[37] Tennessee Department of Education, "Graduation Requirements," not dated, http://www.state.tn.us/ (accessed March 1, 2013).

[38] Tennessee Department of Education, "Tennessee 2010 School-Level Impact Measures (SLIMs) Weighted Principal and Teacher Survey Results," p. 3.

[39] Mark Bloodworth and Rebecca Johns-Wommack, interview, Oct. 8, 2012.

[40] Mark Bloodworth and Rebecca Johns-Wommack, interview, Dec. 19, 2012.

[41] Tennessee Department of Health, "Tennessee Adolescent Pregnancy Summary Data 2010," Feb. 2012, http://health.state.tn.us/ (accessed Dec. 2012).

[42] Tennessee Department of Education, "HIV Education, Family Life and Teen Pregnancy Prevention," http://www.state.tn.us/ (accessed March 1, 2013).

[43] Mark Bloodworth and Rebecca Johns-Wommack, interview, Oct. 8, 2012.

[44] Public Chapter 973 (2012) allows for a parent or legal guardian of a student enrolled in family life to file a complaint with the director of schools if they believe that a teacher, instructor, or representative of an organization has not complied with the requirements set forth in *TCA* 49-6-1301, et seq., regarding the promotion of gateway sexual activity.

[45] *Tennessee Code Annotated* 49-6-1301(7).

[46] Mark Bloodworth and Rebecca Johns-Wommack, interview, Oct. 8, 2012.

Appendix A: Adolescent pregnancy rate (the number of pregnancies per 1,000 females ages 15–17), Resident Data, Tennessee, 2010

County	Pregnancy Rate	Rank
Anderson	25.2	25 (tie)
Bedford	20.5	47 (tie)
Benton	23.3	33 (tie)
Bledsoe	7.9	79
Blount	18.4	57
Bradley	23	35
Campbell	25.9	23
Cannon	13.7	70
Carroll	25.2	25 (tie)
Carter	24.3	29
Cheatham	19.1	54
Chester	11.6	75
Claiborne	19.3	53
Clay	20.3	48
Cocke	29.8	18
Coffee	34	9
Crockett	39.9	4
Cumberland	45.6	2
Davidson	29.3	19
Decatur	13.2	72
Dekalb	20.8	45
Dickson	17.2	61
Dyer	26.6	22
Fayette	23.2	34
Fentress	22.5	38
Franklin	16.3	63
Gibson	14.7	67
Giles	24.8	27
Grainger	22.6	37
Greene	19.6	52
Grundy	18.5	56
Hamblen	33.1	11
Hamilton	17.8	58
Hancock	0	83
Hardeman	32.6	12
Hardin	21.5	42
Hawkins	18.8	55
Haywood	41.7	3
Henderson	25	26
Henry	14.6	68
Hickman	20.7	46
Houston	6	81
Humphreys	23.3	33 (tie)
Jackson	9.1	78
Jefferson	22.7	36
Johnson	30.2	17
Knox	21.4	43 (tie)
Lake	10.2	77 (tie)
Lauderdale	37	7
Lawrence	24.1	30 (tie)
Lewis	36	8
Lincoln	25.2	25 (tie)
Loudon	17.6	60 (tie)
Macon	32.3	13
Madison	24.5	28 (tie)
Marion	27.6	20
Marshall	23.3	33 (tie)
Maury	32	14
McMinn	21.7	41
McNairy	10.4	76
Meigs	20.2	49
Monroe	33.8	10
Montgomery	21.4	43 (tie)
Moore	20	50
Morgan	21.3	44
Obion	27.1	21
Overton	17.7	59 (tie)
Perry	13.1	73
Pickett	16.9	62
Polk	17.7	59 (tie)
Putnam	22	40
Rhea	25.6	24
Roane	16.2	64
Robertson	23.7	31
Rutherford	19.9	51 (tie)
Scott	14	69
Sequatchie	30.7	16
Sevier	31.5	15
Shelby	38.5	5
Smith	20.5	47 (tie)
Stewart	3.4	82
Sullivan	24.1	30 (tie)
Sumner	17.6	60 (tie)
Tipton	16.1	65
Trousdale	13.6	71
Unicoi	22.4	39
Union	37.7	6
Van Buren	58.8	1

Counties in bold are required by T.C.A. 49-6-1302 to provide Family Life Education.

Source: Tennessee Department of Health, "Tennessee Adolescent Pregnancy Summary Data 2010," Feb. 2012, http://health.state.tn.us/ (accessed Dec. 2012).

Appendix B: Tennessee High School Youth Risk Behavior Survey, 2011

Question	Grade Level				
Sexual Behaviors	**Total**	**9th**	**10th**	**11th**	**12th**
Ever had sexual intercourse	52.4	37.1	48.0	59.6	68.2
Had sexual intercourse for the first time before age 13 years	7.2	8.1	6.2	7.8	6.5
Had sexual intercourse with four or more persons (during their life)	17.2	8.1	14.3	23.1	25.2
Had sexual intercourse with at least one person (during the 3 months before the survey)	37.1	23.0	32.3	43.7	52.7
Drank alcohol or used drugs before last sexual intercourse (among students who were currently sexually active)	22.5	20.5	29.8	17.9	21.9
Did not use a condom during last sexual intercourse (among students who were currently sexually active)	41.3	33.4	40.2	42.0	45.4
Did not use birth control pills before last sexual intercourse (to prevent pregnancy, among students who were currently sexually active)	82.7	85.2	82.7	85.7	78.5
Were never taught in school about AIDS or HIV infection	19.4	27.0	16.2	15.3	17.4
Did not use Depo-Provera (or any injectable birth control), Nuva Ring (or any birth control ring), implantation (or any implant), or any IUD use before last sexually intercourse (to prevent pregnancy, among students who were currently sexually active)	93.8	96.8	91.4	93.4	94.5
Did not use birth control pills or Dep-Provera (or any injectable birth control), Nuva Ring (or any birth control ring), implantation (or any implant) or any IUD before last sexual intercourse (to prevent pregnancy, among students who were currently sexually active)	76.5	82.0	74.1	79.1	73.0
Did not use both a condom during last sexual intercourse and birth control pills or Dep-Provera (or any injectable birth control), Nuva Ring (or any birth control ring), implantation (or any implant), or any IUD before last sexual intercourse (to prevent pregnancy, among students who were currently sexually active)	90.7	90.1	88.1	92.9	90.7
Did not use any method to prevent pregnancy during last sexual intercourse (among students who were currently sexually active)	13.3	11.3	11.0	11.3	17.4

Figures shown are percentages.

Memphis, Tennessee Youth Risk Behavior Survey, 2011

Question	Grade Level				
Sexual Behaviors	**Total**	**9th**	**10th**	**11th**	**12th**
Ever had sexual intercourse	62.2	48.5	59.1	70.3	73.1
Had sexual intercourse for the first time before age 13 years	15.6	18.5	16.3	13.2	14.0
Had sexual intercourse with four or more persons (during their life)	25.3	15.2	22.6	29.3	35.4
Had sexual intercourse with at least one person (during the 3 months before the survey)	41.4	29.7	34.4	48.0	55.5
Drank alcohol or used drugs before last sexual intercourse (among students who were currently sexually active)	14.6	N/A	16.3	13.3	15.9
Did not use a condom during last sexual intercourse (among students who were currently sexually active)	27.9	N/A	27.0	23.4	33.4
Did not use birth control pills before last sexual intercourse (to prevent pregnancy, among students who were currently sexually active)	91.2	N/A	97.5	91.3	87.7
Were never taught in school about AIDS or HIV infection	22.8	22.9	25.4	24.8	17.9
Did not use Depo-Provera (or any injectable birth control), Nuva Ring (or any birth control ring), implantation (or any implant), or any IUD use before last sexually intercourse (to prevent pregnancy, among students who were currently sexually active)	97.2	N/A	97.9	95.0	97.1
Did not use birth control pills or Dep-Provera (or any injectable birth control), Nuva Ring (or any birth control ring), implantation (or any implant) or any IUD before last sexual intercourse (to prevent pregnancy, among students who were currently sexually active)	88.4	N/A	95.4	86.3	84.8
Did not use both a condom during last sexual intercourse and birth control pills or Dep-Provera (or any injectable birth control), Nuva Ring (or any birth control ring), implantation (or any implant), or any IUD before last sexual intercourse (to prevent pregnancy, among students who were currently sexually active)	94.1	N/A	96.8	92.4	93.2
Did not use any method to prevent pregnancy during last sexual intercourse (among students who were currently sexually active)	12.5	N/A	15.7	9.6	14.0

Figures shown are percentages.

Appendix C: OREA questionnaire to Directors of Schools

Dear Director of Schools,

The Comptroller's Offices of Research and Education Accountability appreciate your help in providing the most accurate information possible to the Tennessee General Assembly. This survey is intended to collect information regarding HIV/AIDS education in Tennessee schools as required by Public Chapter 585 (2012). **Please distribute the survey to appropriate personnel within your district. We are requesting only one survey response per district, not one per school. Please e-mail responses to Kim Potts at kim.potts@cot.tn.gov or Tara Bergfeld at tara.bergfeld@cot.tn.gov. If possible, we would like to receive responses no later than January 18, 2013. Feel free to contact us if you have any questions.**

T.C.A. 49-6-1302 (a)(1) requires that "if the most recent, annual data maintained by the department of health, state center for health statistics, indicate that pregnancy rates in any county exceeded nineteen and five tenths (19.5) pregnancies per one thousand (1,000) females aged fifteen (15) through seventeen (17), then every LEA within the county shall locally devise, adopt and implement a program of family life education in conformance with the curriculum guidelines established for such programs" by the state board of education. To see your county's most recent (2010) adolescent pregnancy rate, please see page 3 of the Tennessee Department of Health's Tennessee Adolescent Pregnancy Summary Data 2010 and refer to the column titled "Ages 15-17."

If your county exceeds the 19.5 per 1,000 threshold for adolescent pregnancies ages 15-17, every LEA in the county is required to implement a locally devised program of family life education.

1. Is your district implementing a family life and wellness curriculum? If so, please list the course title(s) and grade level(s).

2. Does your family life and wellness curriculum specifically address HIV/AIDS related standards? If so, please identify which standards are covered. See PreK-2 Health Standards, Grades 3-5 Health Standards, Grades 6-8 Health Standards, and Grades 9-12 Lifetime Wellness Standards for a list of standards by grade level.

3. In your district, at what grade level does instruction begin to explicitly address HIV/AIDS related topics?

4. Please identify the curriculum used to teach HIV/AIDS related topics (for example, Michigan Model). Is this curriculum different than the one used for other health and/or family wellness topics?

5. Related to course instructors:

   a) Who in your district typically teaches health and/or family wellness (health teacher, physical education teacher, etc.)?

   b) Do the same instructors provide HIV/AIDS related instruction and if not, who provides HIV/AIDS instruction?

   c) Have your instructors had any professional development specifically addressing HIV/AIDS education? If so, when?

Sources:

107th Tennessee General Assembly, Public Acts, 2012, Chapter No. 585, An act to amend Tennessee Code Annotated, Title 49, relative to AIDS education, http://www.tn.gov/ (accessed Jan. 3, 2013).
Tennessee Department of Health Policy, Planning and Assessment, Division of Health Statistics, "Tennessee Adolescent Summary Data 2010," http://health.state.tn.us/ (accessed Jan. 3, 2013).
Tennessee Department of Education, "Health, P.E., and Wellness Curriculum Standards," http://state.tn.us/ (accessed Jan. 3, 2013).

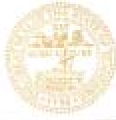
Appendix D: Select Tennessee Health Education and Lifetime Wellness standards pertaining to HIV/AIDS education

<table>
<tr><th>Grade Levels</th><th>Standard</th><th>Performance Indicators or Learning Expectations Pertaining to HIV/AIDS and/or abstinence</th></tr>
<tr><td rowspan="2">Grades PreK-2</td><td>Standard 9: Understand attitudes and behaviors for preventing and controlling disease.</td><td>Identify and describe common communicable diseases (e.g. HIV, hepatitis, flu, pink eye, and head lice)</td></tr>
<tr><td>Standard 13: Understand appropriate and inappropriate uses of chemical substances and the effects of substance use and abuse.</td><td>Practice refusal skills to avoid harmful substances</td></tr>
<tr><td rowspan="5">Grades 3-5</td><td rowspan="2">Standard 9: Understand attitudes and behaviors for preventing and controlling disease.</td><td>Describe the risk-reduction behaviors that prevent the spread of germs and pathogens including HIV</td></tr>
<tr><td>Relate factual information about HIV/AIDS</td></tr>
<tr><td rowspan="3">Standard 13: Understand appropriate and inappropriate uses of chemical substances and the effects of substance use and abuse</td><td>Demonstrate decision making and refusal skills</td></tr>
<tr><td>Explain how personal choices relate to health and wellness</td></tr>
<tr><td>Practice skills needed to avoid risk-taking behaviors (e.g. decision making, conflict resolution, and refusal skills)</td></tr>
<tr><td rowspan="11">Grades 6-8</td><td>Standard 3: Understand the role of body systems as related to healthful living.</td><td>Explain repercussions of risky behaviors on body systems (e.g. smoking, drug use, alcohol, sexual activity, and high fat diet)</td></tr>
<tr><td rowspan="3">Standard 7: Understand the stages of human growth and development</td><td>Identify abstinence from sexual activity as the responsible and preferred choice for adolescents</td></tr>
<tr><td>Prepare a chart that lists HIV/STI (sexually transmitted infection) symptoms, treatments, and complications</td></tr>
<tr><td>Identify reasons for abstaining from sexual activity; (e.g. unplanned pregnancy, infection, infertility, life-long illness)</td></tr>
<tr><td rowspan="6">Standard 9: Understand attitudes and behaviors for preventing and controlling disease.</td><td>Identify and define common pathogens</td></tr>
<tr><td>Describe ways pathogens and diseases are spread, prevented, and managed</td></tr>
<tr><td>Describe signs, symptoms, and risk factors related to communicable and non-communicable diseases</td></tr>
<tr><td>Evaluate how heredity, environment, and lifestyle impact both the wellness and disease process</td></tr>
<tr><td>List communicable diseases including HIV/AIDS, and other STIs</td></tr>
<tr><td>Explain that in terms of the relationship between sexual activity and the risk of being infected with HIV/AIDS or STI's, abstinence from all genital contact is the only sure method of preventing sexual transmission.</td></tr>
<tr><td>Standard 13: Understand appropriate and inappropriate uses of chemical substances and the effects of substance use and abuse</td><td>Understand the relationship between substance abuse and other high risk behaviors (e.g. unintended sexual activity, car crashes, self-injury, and physical and mental abuse toward others).</td></tr>
</table>

Grades 9-12	Standard 1: Disease prevention and control	Explain causes, modes of transmission, signs and symptoms, treatments and prevention of Communicable diseases (e.g., STIs, HIV/AIDS, mononucleosis)
		Determine heredity, environmental and lifestyle factors which place the student at risk for disease.
		Differentiate HIV and AIDS
	Standard 6: Sexuality and Family Life	Recognize abstinence from all sexual activity as a positive choice
		Identify the potential outcomes of engaging in sexual behaviors (e.g., pregnancy, STIs including HIV/AIDS, emotional)
		Identify and practice skills needed to resist persuasive tactics regarding sexual activity
		Identify causes, modes of transmission, treatment and prevention measures associated with STIs, including HIV/AIDS
	Standard 7: Substance Use & Abuse	Identify the effects of substance misuse and abuse on society (e.g., school, crime, disease, pregnancy, STI, job, personal relationships, physical enhancement, athletic performance

Source: Tennessee Department of Education, "Health, P.E., and Wellness Curriculum Standards," not dated, http://www.tn.gov/ (accessed March 2013).

Appendix E: Letter from Commissioner of Tennessee Department of Health and spreadsheet of school-based presentations by TDOH regional offices



STATE OF TENNESSEE
DEPARTMENT OF HEALTH

JOHN J. DREYZEHNER, MD, MPH
COMMISSIONER

BILL HASLAM
GOVERNOR

March 6, 2013

MAR 1 1 2013

Ms. Tara Bergfeld
Office of the Comptroller of the Treasury
First Floor, State Capitol
Nashville, TN 37243-9034

Dear Ms. Bergfeld:

Per your request from February 2013, you will find attached a summary of school-based presentations/events conducted by local health departments in FY2012 and activities to date in FY2013. Specifically, we queried the thirteen regional health offices to ascertain many school-based presentations/events were conducted related to topics covered under the Gateway Sexual Activity Law (2012, PC 973) as well as on topics not related to the law.

As you can see in the attached spreadsheet, there has been a 91.4% decline in the number of school-based presentations/events on topics related to the Gateway Sexual Activity Law in FY2013 as compared to FY2012 (105 vs. 1,227). It is important to note that our staff continue to partner with schools to provide presentations on a variety of other health topics (such as tobacco, injury prevention, nutrition, etc) not excluded under the law.

We appreciate your interest in this matter. Please do not hesitate to contact me if our team can be of more assistance.

Sincerely,

John J. Dreyzehner, MD MPH FACOEM
Commissioner

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Questions asked of the TDOH Regional offices	Tennessee Department of Health Regions							
	MCR	UCR	East	West	SCR	SER	NER	Total
What are the total number of presentations/events you did in the schools from July 1, 2011-June 30, 2012 related to Gateway Sexual Activity Law Topics?	164	36	108	154	8	67	405	942
What are the total number of presentations/events you are currently doing in the schools from July 1, 2012 to current that are related to Gateway Sexual Activity?	0	0	0	0	0	0	0	0
What are the total number of presentations/events you did in the schools from July 1, 2011-June 30, 2012 that include topics other than Gateway Sexual Activity Law?	274	34	332	147	65	50	412	1314
What are the total number of presentations/events you are doing in schools from July 1, 2012 to current that are NOT related to Gateway Sexual Activity?	173	23	244	65	45	50	154	754

Notes:
MCR = Mid-Cumberland Regional Health Office; UCR = Upper Cumberland Regional Health Office; East = East Tennessee Regional Health Office; West = West Tennessee Regional Health Office; SCR = South Central Regional Health Office; SER = Southeast Regional Health Office; NER = Northeast Regional Health Office.

The figures represented in this table are reflective of TDOH Regional Offices only; the figures included in the March 6, 2013, letter from the Commissioner represent presentations and events from both TDH Regional offices as well as the six Metro Health Departments, which were not addressed in the scope of this brief.

Source: Tennessee Department of Health, attachment to memo, March 6, 2013.

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