

State Profiles FISCAL YEAR 2017

The complete FY 2017 State Profiles comprises individual state-specific documents along with four other accompanying documents. The Executive Summary details the current state of sexuality education across the country, highlighting trends observed over the past few decades. Additionally, it is critical to examine the information from each state within the larger context of the laws and federal funding streams across the country. Please reference the following documents to inform and contextualize broader sexuality education trends:

- [Executive Summary](#)
- [Federal Funding Overview](#) – compared to [Montana's federal funding](#)
- [Sex/Sexuality and HIV and other STIs Education Laws by State](#) – compared to [Montana's education laws](#)
- [Descriptions of Curricula and Programs across the United States](#)

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In Fiscal Year 2017,¹ the state of Montana received:

- **Division of Adolescent and School Health funds totaling \$75,000**
- **Personal Responsibility Education Program funds totaling \$250,000**

SEXUALITY EDUCATION LAW AND POLICY

STATE LAW

[Montana Code Annotated § 20-2-121](#) requires the board of public education to adopt content standards for school districts to follow in their curriculum development, and Administrative Rule [10.55.905](#) states that “health enhancement” is a required subject for graduation. [Montana Administrative Rule §§ 10.54.2501](#) requires schools to use the content standards for the health enhancement graduation requirement. [Administrative Rules §§ 10.54.7010, 7011, 7012, and 7013](#) codify the health content standards into law. Montana does not require parental permission for students to participate in sexuality or human immunodeficiency virus (HIV)/acquired immunodeficiency syndrome (AIDS) education, nor does it say whether parents or guardians may remove their children from such classes.

STATE STANDARDS

According to the health enhancement program’s content standards, “a student must have a basic knowledge and understanding of concepts that promote comprehensive health.”² Specifically, by the end of fourth grade, students should be able to “identify personal health-enhancing strategies that encompass ... injury/disease prevention, including HIV/AIDS prevention.”³ By the end of eighth grade, students should be able to understand the reproductive system, as well as personal, health-enhancing strategies about sexual activity and HIV/AIDS prevention.⁴ By graduation, students should be able to understand the impact of personal behaviors on the body, including the reproductive system, and have personal, health-enhancing strategies about sexual activity and HIV/AIDS prevention.⁵

The Montana Board of Public Education also provides [*Communicable Diseases: Model Policies and Procedures for HIV Education, Infected Students and Staff, and Work Site Safety*](#), designed to aid school districts in developing their HIV-education programs, and recommends that “students receive proper education about HIV before they reach the age when they may adopt behaviors which put them at risk of contracting the disease.”⁶

While the Office of Public Instruction acknowledges that sexuality education programs may be “abstinence-based, abstinence-until-marriage, or abstinence-only,” the [*Montana Accreditation Standards for Health Enhancement*](#) also recommends that the programs be “consistent with the most reasoned approach of public health and health education professionals.”⁷

STATE LEGISLATIVE SESSION ACTIVITY

SIECUS tracks all state legislative session activity in our state legislative reports. For more information on bills related to school-based sexuality education that were introduced or passed in 2016, please see the most recent analysis of state legislative activity, [*SIECUS’ 2016 Sex Ed State Legislative Year-End Report: Top Topics and Takeaways*](#).

YOUTH SEXUAL HEALTH DATA

Young people are more than their health behaviors and outcomes. For those wishing to support the sexual health and wellbeing of young people, it is important to utilize available data in a manner that tracks our progress and pushes policies forward while respecting and supporting the dignity of all young lives.

While data can be a powerful tool to demonstrate the sexuality education and sexual health care needs of young people, it is important to be mindful that these behaviors and outcomes are impacted by systemic inequities present in our society that affect an individual’s sexual health and wellbeing. That is, the context in which a young person’s health behavior and decision-making happens is not reflected in individual data points. Notably, one example demonstrating such inequities are the limitations as to how and what data are currently collected; please be mindful of populations who may not be included in surveys or who may be misrepresented by the data. The data categories and any associated language are taken directly from the respective surveys and are not a representation of SIECUS’ positions or values. For more information regarding SIECUS’ use of data, please read the FY 2017 Executive Summary, [*A Portrait of Sexuality Education in the States*](#).

MONTANA YOUTH RISK BEHAVIOR SURVEY (YRBS) DATA⁸

The following sexual health behavior and outcome data represent some of the most recent information available on the health of young people who attend high schools in Montana. Though not perfect—for instance, using broad race and ethnicity categories can often distort and aggregate the experiences of a diverse group of respondents—the YRBS is a critical resource for understanding the health behaviors of young people when used carefully and with an awareness of its limitations. Any missing data points indicate either a lack of enough respondents for a subcategory or the state’s decision not to administer a question on the survey. SIECUS commends the Centers for Disease Control and Prevention (CDC) for conducting decades’ worth of field studies to improve the accuracy and relevancy of the YRBS. Like the

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CDC, SIECUS underlines that “school and community interventions should focus not only on behaviors but also on the determinants of those behaviors.”⁹

Reported ever having had sexual intercourse

- In 2015, 44.5% of female high school students and 43.6% of male high school students in Montana reported ever having had sexual intercourse, compared to 39.2% of female high school students and 43.2% of male high school students nationwide.
- In 2015, 58.1% of American Indian/Alaska Native (AI/AN) high school students, 52% of Hispanic high school students, 42.2% of white high school students, and 47.9% of high school students who identified as multiple races in Montana reported ever having had sexual intercourse, compared to 39.1% of AI/AN high school students, 42.5% of Hispanic high school students, 39.9% of white high school students, and 49.2% of high school students who identified as multiple races nationwide.

Reported having had sexual intercourse before age 13

- In 2015, 2.5% of female high school students and 3.6% of male high school students in Montana reported having had sexual intercourse before age 13, compared to 2.2% of female high school students and 5.6% of male high school students nationwide.
- In 2015, 4% of AI/AN high school students, 8.2% of Hispanic high school students, 2.6% of white high school students, and 6.2% of high school students who identified as multiple races in Montana reported having had sexual intercourse before age 13, compared to 1.8% of AI/AN high school students, 5% of Hispanic high school students, 2.5% of white high school students, and 5.8% of high school students who identified as multiple races nationwide.

Reported being currently sexually active

- In 2015, 34.9% of female high school students and 30% of male high school students in Montana reported being currently sexually active, compared to 29.8% of female high school students and 30.3% of male high school students nationwide.
- In 2015, 42.7% of AI/AN high school students, 37.1% of Hispanic high school students, 31% of white high school students, and 34.7% of high school students who identified as multiple races in Montana reported being currently sexually active, compared to 31.5% of AI/AN high school students, 30.3% of Hispanic high school students, 30.3% of white high school students, and 35.7% of high school students who identified as multiple races nationwide.

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Reported not using a condom during last sexual intercourse

- In 2015, 44.6% of female high school students and 36.4% of male high school students in Montana reported not using a condom during their last sexual intercourse, compared to 48% of female high school students and 38.5% of male high school students nationwide.
- In 2015, 34.7% of AI/AN high school students and 41.1% of white high school students in Montana reported not using a condom during their last sexual intercourse, compared to 43.2% of white high school students nationwide.

Reported not using any method to prevent pregnancy during last sexual intercourse

- In 2015, 9.1% of female high school students and 8.4% of male high school students in Montana reported not using any method to prevent pregnancy during their last sexual intercourse, compared to 15.2% of female high school students and 12.2% of male high school students nationwide.
- In 2015, 16.8% of AI/AN high school students and 7.2% of white high school students in Montana reported not using any method to prevent pregnancy during their last sexual intercourse, compared to 10.4% of white high school students nationwide.

Reported having had drunk alcohol or used drugs during last sexual intercourse¹⁰

- In 2015, 17.3% of female high school students and 22.5% of male high school students in Montana reported having had drunk alcohol or used drugs during their last sexual intercourse, compared to 16.4% of female high school students and 24.6% of male high school students nationwide.
- In 2015, 23.6% of AI/AN high school students, 27.6% of Hispanic high school students, and 18.8% of white high school students in Montana reported having had drunk alcohol or used drugs during their last sexual intercourse, compared to 22.8% of Hispanic high school students and 19.3% of white high school students nationwide.

Reported having been physically forced to have sexual intercourse

- In 2015, 12.7% of female high school students and 5% of male high school students in Montana reported having been physically forced to have sexual intercourse, compared to 10.3% of female high school students and 3.1% of male high school students nationwide.
- In 2015, 11.4% of AI/AN high school students, 13.2% of Hispanic high school students, 8.1% of white high school students, and 12.7% of high school students who identified as multiple races in Montana reported having been physically forced to have sexual intercourse, compared to 6.6% of AI/AN high school students, 7% of Hispanic high school students, 6% of white high school students, and 12.1% of high school students who identified as multiple races nationwide.

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Reported experiencing physical dating violence

- In 2015, 10.8% of female high school students and 5.5% of male high school students in Montana reported experiencing physical dating violence in the prior year, compared to 11.7% of female high school students and 7.4% of male high school students nationwide.
- In 2015, 8.7% of AI/AN high school students, 15.1% of Hispanic high school students, 7.4% of white high school students, and 11.6% of high school students who identified as multiple races in Montana reported experiencing physical dating violence in the prior year, compared to 9.7% of Hispanic high school students, 9% of white high school students, and 16% of high school students who identified as multiple races nationwide.

Reported experiencing sexual dating violence

- In 2015, 14.4% of female high school students and 5.6% of male high school students in Montana reported experiencing sexual dating violence in the prior year, compared to 15.6% of female high school students and 5.4% of male high school students nationwide.
- In 2015, 10.1% of AI/AN high school students, 16.6% of Hispanic high school students, 9.1% of white high school students, and 15.4% of high school students who identified as multiple races in Montana reported experiencing sexual dating violence in the prior year, compared to 10.5% of AI/AN high school students, 10.6% of Hispanic high school students, 10.1% of white high school students, and 14.2% of high school students who identified as multiple races nationwide.

Visit the CDC [Youth Online](#) database for additional information on sexual behaviors.

MONTANA SCHOOL HEALTH PROFILES DATA¹¹

In 2015, the CDC released the School Health Profiles, which measures school health policies and practices and highlights which health topics were taught in schools across the country. Since the data was collected from self-administered questionnaires completed by schools' principals and lead health education teachers, the CDC notes that one limitation of the School Health Profiles is bias toward the reporting of more positive policies and practices.¹² In the School Health Profiles, the CDC identifies 16 sexual education topics that it believes are critical to a young person's sexual health. Below are key instruction highlights for secondary schools in Montana as reported for the 2013–2014 school year.

16 CRITICAL SEXUAL EDUCATION TOPICS IDENTIFIED BY THE CDC

- 1) How to create and sustain healthy and respectful relationships
- 2) Influences of family, peers, media, technology, and other factors on sexual risk behavior
- 3) Benefits of being sexually abstinent
- 4) Efficacy of condoms
- 5) Importance of using condoms consistently and correctly
- 6) Importance of using a condom at the same time as another form of contraception to prevent both STDs and pregnancy
- 7) How to obtain condoms
- 8) How to correctly use a condom
- 9) Communication and negotiation skills
- 10) Goal-setting and decision-making skills
- 11) How HIV and other STDs are transmitted
- 12) Health consequences of HIV, other STDs, and pregnancy
- 13) Influencing and supporting others to avoid or reduce sexual risk behaviors
- 14) Importance of limiting the number of sexual partners
- 15) How to access valid and reliable information, products, and services related to HIV, STDs, and pregnancy
- 16) Preventive care that is necessary to maintain reproductive and sexual health.

Source: School Health Profiles, 2014

Reported teaching all 16 critical sexual health education topics

- 12.2% of Montana secondary schools taught students all 16 critical sexual health education topics in a required course in any of grades 6, 7, or 8.¹³
- 45.1% of Montana secondary schools taught students all 16 critical sexual health education topics in a required course in any of grades 9, 10, 11, or 12.¹⁴

Reported teaching about the benefits of being sexually abstinent

- 79.1% of Montana secondary schools taught students about the benefits of being sexually abstinent in a required course in any of grades 6, 7, or 8.¹⁵
- 91.6% of Montana secondary schools taught students about the benefits of being sexually abstinent in a required course in any of grades 9, 10, 11, or 12.¹⁶

Reported teaching how to access valid and reliable information, products, and services related to HIV, other sexually transmitted diseases (STDs), and pregnancy

- 62.7% of Montana secondary schools taught students how to access valid and reliable information, products, and services related to HIV, other STDs, and pregnancy in a required course in any of grades 6, 7, or 8.¹⁷
- 87.5% of Montana secondary schools taught students how to access valid and reliable information, products, and services related to HIV, other STDs, and pregnancy in a required course in any of grades 9, 10, 11, or 12.¹⁸

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Reported teaching how to create and sustain healthy and respectful relationships

- 78.8% of Montana secondary schools taught students how to create and sustain healthy and respectful relationships in a required course in any of grades 6, 7, or 8.¹⁹
- 92.3% of Montana secondary schools taught students how to create and sustain healthy and respectful relationships in a required course in any of grades 9, 10, 11, or 12.²⁰

Reported teaching about preventive care that is necessary to maintain reproductive and sexual health

- 56.2% of Montana secondary schools taught students about preventive care that is necessary to maintain reproductive and sexual health in a required course in any of grades 6, 7, or 8.²¹
- 83.3% of Montana secondary schools taught students about preventive care that is necessary to maintain reproductive and sexual health in a required course in any of grades 9, 10, 11, or 12.²²

Reported teaching how to correctly use a condom

- 15.7% of Montana secondary schools taught students how to correctly use a condom in a required course in any of grades 6, 7, or 8.²³
- 50.1% of Montana secondary schools taught students how to correctly use a condom in a required course in any of grades 9, 10, 11, or 12.²⁴

Reported teaching about all seven contraceptives

- 39.5% of Montana secondary schools taught students about all seven contraceptives—birth control pill, patch, ring, and shot; implants; intrauterine device; and emergency contraception—in a required course in any of grades 9, 10, 11, or 12.²⁵

Reported providing curricula or supplementary materials relevant to lesbian, gay, bisexual, transgender, and questioning (LGBTQ) youth

- 21.3% of Montana secondary schools provided students with curricula or supplementary materials that included HIV, STD, or pregnancy prevention information relevant to LGBTQ youth.²⁶

Visit the CDC's [School Health Profiles](#) report for additional information on school health policies and practices.

MONTANA TEEN PREGNANCY, HIV/AIDS, AND OTHER STD DATA

The following data from the CDC and the Guttmacher Institute represent the most recent state-specific statistics documenting teen pregnancy, birth, abortion, HIV/AIDS, and other STDs. For those wishing to support the sexual health and wellbeing of young people, it is important to use the data to advance their access to comprehensive education, resources, and services. However, the data is not intended to

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be used in a manner that is stigmatizing or shaming: Young people have the right to make informed decisions about their health and wellbeing, but this right must be accompanied by the ability to access and understand all available choices. Therefore, the following data should be used to advance a young person's right to make informed decisions about their body and health.

Teen Pregnancy, Birth, and Abortion

- In 2013, Montana had the 26th highest reported teen pregnancy rate in the United States, with a rate of 41 pregnancies per 1,000 young women ages 15–19, compared to the national rate of 43 per 1,000.²⁷ There were a total of 1,270 pregnancies among young women ages 15–19 reported in Montana in 2013.²⁸
- In 2015, Montana had the 20th highest reported teen birth rate in the United States, with a rate of 25.3 births per 1,000 young women ages 15–19, compared to the national rate of 22.3 per 1,000.²⁹ There were a total of 770 live births to young women ages 15–19 reported in Montana in 2015.³⁰
- In 2013, Montana had the 28th highest reported teen abortion rate³¹ in the United States, with a rate of 7 abortions per 1,000 young women ages 15–19, compared to the national rate of 11 per 1,000.³² There were a total of 220 abortions among young women ages 15–19 reported in Montana in 2013.³³

HIV and AIDS

- In 2015, the reported rate of diagnoses of HIV infection among adolescents ages 13–19 in Montana was 2.3 per 100,000, compared to the national rate of 5.8 per 100,000.³⁴
- In 2015, the reported rate of AIDS diagnoses among adolescents ages 13–19 in Montana was 1.1 per 100,000, compared to the national rate of 0.7 per 100,000.³⁵
- In 2015, the reported rate of diagnoses of HIV infection among young adults ages 20–24 in Montana was 5.4 per 100,000, compared to the national rate of 31.1 per 100,000.³⁶
- In 2015, the reported rate of AIDS diagnoses among young adults ages 20–24 in Montana was 1.3 per 100,000, compared to the national rate of 5.6 per 100,000.³⁷

STDs

- In 2015, Montana had the 22nd highest rate of reported cases of chlamydia among young people ages 15–19 in the United States, with an infection rate of 1,781.9 cases per 100,000, compared to the national rate of 1,857.8 per 100,000. In 2015, there were a total of 1,139 cases of chlamydia among young people ages 15–19 reported in Montana.³⁸
- In 2015, Montana had the 30th highest rate of reported cases of gonorrhea among young people ages 15–19 in the United States, with an infection rate of 242.5 cases per 100,000, compared to

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the national rate of 341.8 per 100,000. In 2015, there were a total of 155 cases of gonorrhea among young people ages 15–19 reported in Montana.³⁹

- In 2015, Montana had the 22nd highest rate of reported cases of primary and secondary syphilis among young people ages 15–19 in the United States, with an infection rate of 4.7 cases per 100,000, compared to the national rate of 5.4 per 100,000. In 2015, there were a total of 3 cases of syphilis reported among young people ages 15–19 in Montana.⁴⁰

Visit the Office of Adolescent Health’s (OAH) [Montana Adolescent Health Facts](#) for additional information.

FEDERAL FUNDING FOR SEXUALITY EDUCATION, UNINTENDED TEEN PREGNANCY, HIV AND OTHER STD PREVENTION, AND ABSTINENCE-ONLY-UNTIL-MARRIAGE (AOUM) PROGRAMS

FISCAL YEAR 2017 FEDERAL FUNDING IN MONTANA

Grantee	Award
Division of Adolescent and School Health (DASH)	
Montana Office of Public Instruction	\$75,000
TOTAL	\$75,000
Personal Responsibility Education Program (PREP)	
PREP State-Grant Program	
Montana Department of Public Health and Human Services (federal grant)	\$250,000
TOTAL	\$250,000
GRAND TOTAL	
\$325,000	

DIVISION OF ADOLESCENT AND SCHOOL HEALTH

The CDC’s school-based HIV prevention efforts include funding and technical assistance to state and local education agencies through several funding streams to better student health, implement HIV/STD prevention programs, collect and report data on young people’s risk behaviors, and expand capacity-building partnerships. In FY 2017, through the CDC’s Division of Adolescent and School Health (DASH), 18 state education agencies and 17 school districts received funding to help the districts and schools strengthen student health through exemplary sexual health education (ESHE) that emphasizes HIV and other STD prevention, increases access to key sexual health services (SHS), and establishes safe and supportive environments (SSE) for students and staff. DASH funded six national, non-governmental organizations (NGOs) to help state and local education agencies achieve these goals.

- In FY 2017, there were no DASH grantees in Montana funded to strengthen student health through ESHE, SHS, and SSE (1308 Strategy 2).

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In addition, DASH funds local education agencies and NGOs to implement multiple program activities to meet the HIV- and other STD-prevention needs of young men who have sex with men (YMSM) and to develop strategic partnerships and collaborations between schools and community-based, mental health, and social services organizations to accomplish this work.

- In FY 2017, there were no DASH grantees in Montana funded to deliver YMSM programming (1308 Strategy 4).

DASH also provides funding for state, territorial, and local education agencies and state health agencies to establish and strengthen systematic procedures to collect and report YRBS and School Health Profiles data for policy and program improvements.

- In FY 2017, there was one DASH grantee in Montana funded to collect and report YRBS and School Health Profiles data (1308 Strategy 1): The Montana Office of Public Instruction (\$75,000).

TEEN PREGNANCY PREVENTION PROGRAM (TPPP)

The OAH, within the U.S. Department of Health and Human Services (HHS), administers TPPP, which funds evidence-based or innovative evidence-informed, medically accurate, and age-appropriate programs to reduce teen pregnancy. In FY 2017, total funding for TPPP was \$101 million, supporting 84 states, cities, non-profit organizations, school districts, universities, community-based organizations, and tribal organizations. These grantees were in year three of five TPPP funding tiers' five-year cooperative agreements in 33 states, the District of Columbia, and the Marshall Islands. In June 2017, however, 81 of the 84 grantees were notified, without cause or explanation, that their project periods were shortened to just three years, to end on June 30, 2018. Since the other three grantees are on a different grant cycle, they had not yet received notice on the status of their funding at the time of publication. OAH provides program support, implementation evaluation, and technical assistance to grantees and receives an additional \$6.8 million in funding for evaluation purposes. Below is information on the five TPPP funding tiers:

Tier 1A: Capacity building to support replication of evidence-based TPP programs.

Tier 1B: Replicating evidence-based TPP programs to scale in communities with the greatest need.

Tier 2A: Supporting and enabling early innovation to advance adolescent health and prevent teen pregnancy.

Tier 2B: Rigorous evaluation of new or innovative approaches to prevent teen pregnancy.

Tier 2C: Effectiveness of TPP programs designed specifically for young males.

- In FY 2017, there were no TPPP grantees in Montana.

PERSONAL RESPONSIBILITY EDUCATION PROGRAM (PREP)

The Family and Youth Services Bureau (FYSB), within the Administration for Children and Families (ACF) division of HHS, administers PREP, which was authorized for a total of \$75 million in FY 2017 for the state-grant program; local entities through the competitively awarded Personal Responsibility Education Innovative Strategies (PREIS) program; and the Tribal PREP, which funds tribes and tribal organizations. In addition, provisions within the PREP statute enable a competitive application process for community- and faith-based organizations within states and territories that do not directly seek PREP state grants to apply for funding through the Competitive Personal Responsibility Education Program (CPREP).

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Similar to other programs highlighted in the State Profiles, the grants for the various PREP programs are awarded throughout the year, with several awarded in the final month of the fiscal year for use and implementation throughout the following year. SIECUS reports on funding amounts appropriated in FY 2017 and any programmatic activities that occurred during FY 2017, or October 1, 2016–September 30, 2017. It is important to remember, however, that reported programmatic activities for this period may have utilized FY 2016 funds. Details on the state grants, PREIS, Tribal PREP, and CPREP are included below. More information and clarification surrounding funding announcements are also included below, as well as in the FY 2017 Executive Summary, [A Portrait of Sexuality Education in the States](#).

PREP State-Grant Program

State-grant PREP supports evidence-based programs that provide young people with medically accurate and age-appropriate information for the prevention of unintended pregnancy, HIV, and other STDs. In FY 2017, 44 states, the District of Columbia, the Federated States of Micronesia, Guam, Puerto Rico, the Republic of Palau, and the Virgin Islands received PREP state-grant funds. Funded programs must discuss abstinence and contraception and place substantial emphasis on both. Programs must also address at least three of the following adulthood preparation subjects: healthy relationships, positive adolescent development, financial literacy, parent-child communication skills, education and employment skills, and healthy life skills.

- In FY 2017, the Montana Department of Public Health and Human Services received \$250,000 in federal PREP funds.⁴¹
- At the time of publication, information as to Minnesota’s use of FY 2017 state-grant PREP funding was unknown. The following information reflects implementation of FY 2016 funds during FY 2017.
- The agency provides sub-grants to six local public and private entities. The sub-grantee information is listed below.⁴²

Sub-grantee	Serving	Amount
Anaconda Family Resource Center	Anaconda High School (HS), Deer Lodge County, and Fred Moodry Middle School (MS)	Not reported
Anaconda-Deer Lodge County Health Department	Anaconda County, Anaconda HS, Deer Lodge County, and Job Corps	Not reported
Butte Silver-Blow County Health Department	Beaverhead County, Beaverhead HS, Butte HS, Dillon MS, East Junior High, Emerson Elementary School (ES), Hillcrest ES, Jefferson County, Jefferson HS, Kennedy ES, Margaret Leary ES, Ramsay MS, Silver Bow County, West ES, and Whittier ES	Not reported
Flathead County Health Department	Cayuse Prairie, Center for Restorative Youth Justice, Flathead County, Helena Flats MS, Linderman Educational Center, MT Academy, and West Valley	Not reported

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Northern Cheyenne Reservation	Lame Deer ES, Lame Deer MS, Lame Deer Public HS, Northern Cheyenne Tribal School, Rosebud County, St. Labre Academy, Youth Detention Center	Not reported
Planned Parenthood of Montana	Browning MS, Cascade County, Glacier County, and Great Falls Juvenile Detention Center	Not reported

The Montana Department of Public Health and Human Services implements the PREP state grant and has awarded sub-grants to local public and private entities to implement both school- and community-based programming. Funded programs serve young people ages 11-18, young people in grades 6-9, young people in the juvenile justice system, and young Native Americans. Sub-grantees implement the following evidence-based curricula: [*Draw the Line/Respect the Line*](#), [*Making Proud Choices!*](#), and [*Reducing the Risk*](#). In addition, programs are required to address education and employment success or healthy life skills. They are also required to address the following three adulthood preparation subjects: healthy relationships, healthy life skills, and adolescent development.⁴³

Personal Responsibility Education Innovative Strategies (PREIS)

PREIS supports research and demonstration programs to develop, replicate, refine, and test innovative models for preventing unintended teen pregnancy, HIV, and other STDs.

- In FY 2017, there were no PREIS grantees in Montana.

Tribal Personal Responsibility Education Program (Tribal PREP)

Tribal PREP supports the development and implementation of pregnancy-, HIV-, and other STD-prevention programs among young people within tribes and tribal communities. Tribal PREP programs target young people ages 10–19 who are in or are aging out of foster care, young people experiencing homelessness, young people living with HIV, young people who live in areas with high rates of adolescent births, and young people under age 21 who are pregnant and/or parenting. In FY 2017, eight tribes and tribal organizations from seven states received a total of \$3,271,693.

- In FY 2017, there were no Tribal PREP grantees in Montana.

Competitive Personal Responsibility Education Program (CPREP)

CPREP grants support evidence-based programs that provide young people with medically accurate and age-appropriate information for the prevention of unintended pregnancy, HIV, and other STDs. Only organizations and institutions in states and territories that did not apply for PREP state grants are eligible to submit competitive applications for CPREP grants. In FY 2017, 21 CPREP grants, totaling \$10.2 million, were awarded to 21 organizations in Florida, Indiana, North Dakota, Texas, and Virginia, as well as in American Samoa, Guam, and the Northern Mariana Islands.

- In FY 2017, Montana received PREP state-grant funding; therefore, entities in Montana were not eligible for CPREP.

TITLE V “ABSTINENCE EDUCATION” STATE GRANT PROGRAM

The Title V “abstinence education” state grant program for AOUM programming, or the Title V AOUM program, is administered by FYSB, within ACF of HHS, and was authorized at \$75 million for FY 2017.

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The Title V AOUM program requires states to provide three state-raised dollars, or the equivalent in services, for every four federal dollars received. The state match may be provided in part or in full by local groups. All programs funded by Title V AOUM must exclusively promote abstinence from sexual activity and may provide mentoring, counseling, and adult supervision toward this end.⁴⁴

- In FY 2017, Montana chose not to apply for Title V AOUM funds.

“SEXUAL RISK AVOIDANCE EDUCATION” (SRAE) GRANT PROGRAM

Administered by FYSB within ACF of HHS, the SRAE program—a rebranding of the competitive AOUM grant program—provides funding for public and private entities for programs that “teach young people to voluntarily refrain from non-marital sexual activity and prevent other youth risk behaviors.” These programs are also required by statute to “teach the benefits associated with self-regulation; success sequencing for poverty prevention; healthy relationships; goal setting and resisting sexual coercion; dating violence; and other youth risk behaviors, such as underage drinking or illicit drug use, without normalizing teen sexual activity.” In FY 2017, \$15 million was appropriated for the SRAE grant program, and \$13.5 million was awarded to 27 grantees in 14 states through a competitive application process.

- In FY 2017, there were no SRAE grantees in Montana.

POINTS OF CONTACT

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- ¹ This refers to the federal government’s fiscal year, which begins on October 1 and ends on September 30. The fiscal year is designated by the calendar year in which it ends; for example, FY 2017 began on October 1, 2016, and ended on September 30, 2017.
- ² Mont. Admin. Rules § 10.54.7010.
- ³ Mont. Admin. Rules § 10.54.7011(1)(d), www.mtrules.org/gateway/RuleNo.asp?RN=10.54.7011.
- ⁴ Mont. Admin. Rules § 10.54.7012, www.mtrules.org/gateway/RuleNo.asp?RN=10.54.7012.
- ⁵ Mont. Admin. Rules § 10.54.7013, www.mtrules.org/gateway/RuleNo.asp?RN=10.54.7013.
- ⁶ *Communicable Diseases: Model Policies and Procedures for HIV Education, Infected Students and Staff, and Work Site Safety* (Montana: Montana Board of Education, 2003), www.opi.mt.gov/pdf/HIVED/HIVModelPolicies_arch.pdf, 1.
- ⁷ *Montana Accreditation Standards for Health Enhancement* (Montana: Montana Board of Education), www.opi.mt.gov/pdf/HIVED/HEStandardsSexEd.pdf, 1–2.
- ⁸ “Youth Online,” Centers for Disease Control and Prevention, <https://nccd.cdc.gov/youthonline/App/Default.aspx>.
- ⁹ “Methodology of the Youth Risk Behavior Surveillance System – 2013,” pg. 17, Centers for Disease Control and Prevention, www.cdc.gov/mmwr/pdf/rr/rr6201.pdf.
- ¹⁰ It is critical to examine social determinants when analyzing potentially stigmatizing data. Accounting for differences in people’s lived experiences based on race, ethnicity, sexual orientation, socioeconomic status, etc., is a vital part of understanding the context in which the data exist. We encourage readers to exercise caution when using the data and warn readers against using the data in a manner that conflates correlation with causation. Please visit the FY 2017 Executive Summary, [A Portrait of Sexuality Education in the States](#), for more context.
- ¹¹ “School Health Profiles 2014,” Centers for Disease Control and Prevention, <https://nccd.cdc.gov/youthonline/App/Default.aspx>.
- ¹² *Ibid.*, pg. 51.
- ¹³ *Ibid.*, Table 9c.
- ¹⁴ *Ibid.*, Table 11c.
- ¹⁵ *Ibid.*, Table 9a.
- ¹⁶ *Ibid.*, Table 11a.
- ¹⁷ *Ibid.*, Table 9a.
- ¹⁸ *Ibid.*, Table 11a.
- ¹⁹ *Ibid.*, Table 9b.
- ²⁰ *Ibid.*, Table 11b.
- ²¹ *Ibid.*, Table 9b.
- ²² *Ibid.*, Table 11b.
- ²³ *Ibid.*, Table 9c.
- ²⁴ *Ibid.*, Table 11c.
- ²⁵ *Ibid.*, Table 13.
- ²⁶ *Ibid.*, Table 39.
- ²⁷ Arpaia, A., Kost, K., and Maddow-Zimet, I., *Pregnancies, Births and Abortions Among Adolescents and Young Women in the United States, 2013: State Trends by Age, Race, and Ethnicity* (New York: Guttmacher Institute, 2017), https://www.guttmacher.org/sites/default/files/report_downloads/us-adolescent-pregnancy-trends-2013_tables.pdf, Table 2.5.
- ²⁸ *Ibid.*, Table 2.6.
- ²⁹ “Teen Birth Rate Comparison, 2015 Among Girls Age 15-19,” The National Campaign to Prevent Teen and Unplanned Pregnancy, <https://thenationalcampaign.org/data/compare/1701>.

³⁰ United States Department of Health and Human Services (US DHHS), Centers for Disease Control and Prevention (CDC), National Center for Health Statistics (NCHS), Division of Vital Statistics, Natality public-use data 2007-2015, on CDC WONDER Online Database, February 2017. Accessed at <http://wonder.cdc.gov/natality-current.html>.

³¹ “Abortion” used in this context refers to legally induced abortions. This rate does not include abortions that occur outside of health care facilities or are unreported. Unfortunately, there is no reliable source of information for actual rates of abortion.

³² Arpaia, A., Kost, K., and Maddow-Zimet, I., *Pregnancies, Births and Abortions Among Adolescents and Young Women in the United States, 2013: State Trends by Age, Race, and Ethnicity* (New York: Guttmacher Institute, 2017), https://www.guttmacher.org/sites/default/files/report_downloads/us-adolescent-pregnancy-trends-2013_tables.pdf, Table 2.5.

³³ Ibid., Table 2.6.

³⁴ Slide 17: “Rates of Diagnoses of HIV Infection among Adolescents Aged 13–19 Years 2015—United States and 6 Dependent Areas,” *HIV Surveillance in Adolescents and Young Adults* (Atlanta, GA: Centers for Disease Control and Prevention), www.cdc.gov/hiv/pdf/library/slidesets/cdc-hiv-surveillance-adolescents-young-adults-2015.pdf.

³⁵ Slide 20: “Rates of Diagnosed HIV Infection Classified as Stage 3 (AIDS) among Adolescents Aged 13–19 Years, 2015—United States and 6 Dependent Areas,” *HIV Surveillance in Adolescents and Young Adults* (Atlanta, GA: Centers for Disease Control and Prevention), www.cdc.gov/hiv/pdf/library/slidesets/cdc-hiv-surveillance-adolescents-young-adults-2015.pdf.

³⁶ Slide 18: “Rates of Diagnoses of HIV Infection among Young Adults Aged 20–24 Years 2015—United States and 6 Dependent Areas,” *HIV Surveillance in Adolescents and Young Adults* (Atlanta, GA: Centers for Disease Control and Prevention), www.cdc.gov/hiv/pdf/library/slidesets/cdc-hiv-surveillance-adolescents-young-adults-2015.pdf.

³⁷ Slide 21: “Rates of Diagnosed HIV Infection Classified as Stage 3 (AIDS) among Young Adults Aged 20–24 Years, 2015—United States and 6 Dependent Areas,” *HIV Surveillance in Adolescents and Young Adults* (Atlanta, GA: Centers for Disease Control and Prevention), www.cdc.gov/hiv/pdf/library/slidesets/cdc-hiv-surveillance-adolescents-young-adults-2015.pdf.

³⁸ NCHHSTP Atlas, “STD Surveillance Data” (Atlanta, GA: Centers for Disease Control and Prevention), <http://gis.cdc.gov/GRASP/NCHHSTPAtlas/main.html>.

³⁹ Ibid.

⁴⁰ Ibid.

⁴¹ “2017 State Personal Responsibility Education Program (PREP) Awards,” Family and Youth Services Bureau, Administration for Children & Families, U.S. Department of Health & Human Services, www.acf.hhs.gov/fysb/resource/2017-state-prep-awards.

⁴² Information provided by Katie Cole, Health Education Specialist, Women’s and Men’s Health Section, Department of Public Health and Human Services, April 12, 2017.

⁴³ Ibid.

⁴⁴ 42 U.S.C. 710, Title V, Section 510 of the Social Security Act, the authorization for the Title V AOUM grant program, defines “abstinence education” as “an educational or motivational program which:

(A) has as its exclusive purpose, teaching the social, psychological, and health gains to be realized by abstaining from sexual activity;

(B) teaches abstinence from sexual activity outside marriage as the expected standard for all school-age children;

(C) teaches that abstinence from sexual activity is the only certain way to avoid out-of-wedlock pregnancy, sexually transmitted diseases, and other associated health problems;

(D) teaches that a mutually faithful monogamous relationship in context of marriage is the expected standard of human sexual activity;

(E) teaches that sexual activity outside of the context of marriage is likely to have harmful psychological and physical effects;

(F) teaches that bearing children out-of-wedlock is likely to have harmful consequences for the child, the child’s parents, and society;

(G) teaches young people how to reject sexual advances and how alcohol and drug use increases vulnerability to sexual advances; and

(H) teaches the importance of attaining self-sufficiency before engaging in sexual activity.”

www.ssa.gov/OP_Home/ssact/title05/0510.htm.