



State Profiles FISCAL YEAR 2018

The complete FY 2018 State Profiles comprise individual state-specific documents along with four other accompanying documents. The Executive Summary details the current state of sex 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 sex education trends:

- [Executive Summary](#)
- [Federal Funding Overview](#) – compared to [Montana’s federal funding](#)
- [Sex/Sexuality and human immunodeficiency virus \(HIV\) and other sexually transmitted infections \(STIs\) Education Laws by State](#) – compared to [Montana’s education laws](#)
- [Descriptions of Curricula and Programs across the United States.](#)

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For the last 15 years, SIECUS has released the SIECUS State Profiles to provide an overview of federally funded adolescent sexual health promotion and abstinence-only-until-marriage (AOUM) programs in the United States. Indeed, the SIECUS State Profiles’ annual reporting provides invaluable insight into how funds for these programs are used and implemented in every state, the District of Columbia, and U.S. territories.

Unfortunately, the 2018 SIECUS State Profiles do not include the level of information that readers have come to expect. SIECUS has been unable to obtain information detailing federal funds issued through the Department of Health and Human Services’ (HHS) Office of Adolescent Health (OAH) and Federal Youth Service Bureau (FYSB). In February 2019, new information regarding FYSB FY 2019 grantees was released, but FY 2018 award amounts and grantee profiles for FYSB programs remain publicly unavailable.

The information SIECUS seeks to obtain is imperative for understanding how federal funding is used and the ways in which adolescent sexual health promotion and AOUM programs are designed and implemented. In place of the missing data, this report will instead highlight some of the adverse, and potentially unlawful, actions that agencies under the Trump administration have taken to subvert the commitment to adolescent sexual health information that these programs were founded upon.

This omission of information reinforces the need to broadcast this well-documented truth: AOUM programs (now being called “Sexual Risk Avoidance”) are ineffective.¹

Furthermore, SIECUS will continue to seek full transparency in reporting; push Congress to pursue its oversight authority; and ensure that policymakers and the public continue to receive accurate, up-to-date information needed to inform appropriate and effective use of public resources to advance the health and well-being of our nation’s youth.

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 §§ 10.53.101](#) requires schools to use the content standards for the health enhancement graduation requirement. [Administrative Rules §§ 10.53.701-709](#) 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 [Montana K-12 Health Enhancement Content Standards](#), students should “comprehend concepts related to health promotion and disease prevention to enhance personal health,” as well as “demonstrate the ability to practice health-enhancing behaviors and avoid or reduce health risks.”² Specifically, by the end of fourth grade, students should be able to “identify personal health-enhancing strategies that encompass ... injury/disease 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 disease 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 disease prevention.⁵

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 sex education that were introduced or passed by May 31, 2018, please see the most recent analysis of state legislative activity, [SIECUS’ 2018 Sex Ed State Legislative Mid-Year Report](#).

YOUTH SEXUAL HEALTH DATA

Young people are more than their health behaviors and outcomes. For those working to support the sexual health and well-being 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 sex 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 well-being. 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 2018 Executive Summary, [A Portrait of Sex Education in the States](#).

MONTANA TEEN PREGNANCY, HUMAN IMMUNODEFICIENCY VIRUS (HIV)/ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS), AND OTHER SEXUALLY TRANSMITTED DISEASE (STD) DATA

The following data from the Centers for Disease Control and Prevention (CDC) and the Guttmacher Institute represent the most recent, uniform, state-specific statistics documenting teen pregnancy, birth, abortion, HIV/AIDS, and other sexually transmitted diseases (STDs).⁶ While certain individual states may have more recent teen pregnancy or abortion data available, the data provided here represent cohesive information available for states across the nation. For those supporting the sexual health and well-being of young people, it is important to use the data to advance their access to comprehensive education, resources, and services. However, the data are not intended to be used in a manner that is stigmatizing or shaming: Young people have the right to make informed decisions about their health and well-being, 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 rate⁷ 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 1,000.⁸ There were a total of 1,270 pregnancies among young women ages 15–19 reported in Montana in 2013.⁹
- In 2016, Montana had the 15th highest reported teen birth rate in the United States, with a rate of 23.7 births per 1,000 young women ages 15–19, compared to the national rate of 22.3 per 1,000.¹⁰ There were a total of 720 live births to young women ages 15–19 reported in Montana in 2016.¹¹
- In 2013, Montana had the 28th highest reported teen abortion rate¹² 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 1,000.¹³ There were a total of 220 abortions among young women ages 15–19 reported in Montana in 2013.¹⁴

HIV and AIDS

- In 2016, the reported rate of diagnoses of HIV infection among adolescents ages 13–19 in Montana was 0.0 per 100,000, compared to the national rate of 5.7 per 100,000.¹⁵
- In 2016, the reported rate of AIDS diagnoses among adolescents ages 13–19 in Montana was 0.0 per 100,000, compared to the national rate of 0.8 per 100,000.¹⁶
- In 2016, the reported rate of diagnoses of HIV infection among young adults ages 20–24 in Montana was 1.4 per 100,000, compared to the national rate of 30.2 per 100,000.¹⁷
- In 2016, the reported rate of AIDS diagnoses among young adults ages 20–24 in Montana was 0.0 per 100,000, compared to the national rate of 5.6 per 100,000.¹⁸

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STDs

- In 2016, 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 1,950 cases per 100,000, compared to the national rate of 1,929.2 per 100,000. In 2016, there were a total of 1,245 cases of chlamydia among young people ages 15–19 reported in Montana.¹⁹
- In 2016, Montana had the 38th highest rate of reported cases of gonorrhea among young people ages 15–19 in the United States, with an infection rate of 198.9 cases per 100,000, compared to the national rate of 379.8 per 100,000. In 2016, there were a total of 127 cases of gonorrhea among young people ages 15–19 reported in Montana.²⁰
- In 2016, Montana had the 45th 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 0 cases per 100,000, compared to the national rate of 6.1 per 100,000. In 2016, there were a total of 0 cases of syphilis reported among young people ages 15–19 in Montana.²¹

Visit OAH's [Montana Adolescent Health Facts](#) for additional information.

MONTANA YOUTH RISK BEHAVIOR SURVEY (YRBS) DATA²²

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 Youth Risk Behavior Survey (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 CDC for conducting decades' worth of field studies to improve the accuracy and relevancy of the YRBS. Like the CDC, SIECUS underlines that “school and community interventions should focus not only on behaviors but also on the determinants of those behaviors.”²³

Reported ever having had sexual intercourse

- In 2017, 44.8% of female high school students and 41.6% of male high school students in Montana reported ever having had sexual intercourse, compared to 37.7% of female high school students and 41.4% of male high school students nationwide.
- In 2017, 56.3% of American Indian/Alaska Native (AI/AN) high school students, 51% of Hispanic high school students, 41.1% of white high school students, and 47.1% of high school students who identified as multiple races in Montana reported ever having had sexual intercourse, compared to 49.7% of AI/AN high school students, 41.1% of Hispanic high school students, 38.6% of white high school students, and 41.6% of high school students who identified as multiple races nationwide.

Reported having had sexual intercourse before age 13

- In 2017, 2.3% of female high school students and 3.4% of male high school students in Montana reported having had sexual intercourse before age 13, compared to 2% of female high school students and 4.8% of male high school students nationwide.

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- In 2017, 6.2% of AI/AN high school students, 4.6% of Hispanic high school students, 2.4% of white high school students, and 1.8% of high school students who identified as multiple races in Montana reported having had sexual intercourse before age 13, compared to 8.4% of AI/AN high school students, 4% of Hispanic high school students, 2.1% of white high school students, and 5% of high school students who identified as multiple races nationwide.

Reported being currently sexually active

- In 2017, 34.2% of female high school students and 28.9% of male high school students in Montana reported being currently sexually active, compared to 28.8% of female high school students and 28.6% of male high school students nationwide.
- In 2017, 42.4% of AI/AN high school students, 37.1% of Hispanic high school students, 30.1% of white high school students, and 32.5% of high school students who identified as multiple races in Montana reported being currently sexually active, compared to 38.6% of AI/AN high school students, 29.2% of Hispanic high school students, 28.8% of white high school students, and 29.2% of high school students who identified as multiple races nationwide.

Reported not using a condom during last sexual intercourse

- In 2017, 49.3% of female high school students and 39.1% of male high school students in Montana reported not using a condom during their last sexual intercourse, compared to 53.1% of female high school students and 38.7% of male high school students nationwide.
- In 2017, 50.4% of AI/AN high school students, 46.2% of Hispanic high school students, and 43.4% of white high school students in Montana reported not using a condom during their last sexual intercourse, compared to 45.1% of Hispanic high school students and 45.9% of white high school students nationwide. Comparative national data for AI/AN high school students are unavailable.

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

- In 2017, 8.7% of female high school students and 8.7% of male high school students in Montana reported not using any method to prevent pregnancy during their last sexual intercourse, compared to 16.7% of female high school students and 10.5% of male high school students nationwide.
- In 2017, 17.5% of AI/AN high school students, 9.4% of Hispanic 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 19% of Hispanic high school students and 10% of white high school students nationwide. Comparative national data for AI/AN high school students are unavailable.

Reported having had alcohol or used drugs during last sexual intercourse²⁴

- In 2017, 15.4% of female high school students and 20.5% of male high school students in Montana reported having had alcohol or used drugs during their last sexual intercourse, compared to 15.9% of female high school students and 21.6% of male high school students

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nationwide.

- In 2017, 18.7% of AI/AN high school students, 19.8% of Hispanic high school students, 17% of white high school students in Montana reported having had alcohol or used drugs during their last sexual intercourse, compared to 17.7% of Hispanic high school students and 18.7% of white high school students nationwide. Comparative national data for AI/AN high school students are unavailable.

Reported having been physically forced to have sexual intercourse

- In 2017, 14% of female high school students and 4.8% of male high school students in Montana reported having been physically forced to have sexual intercourse, compared to 11.3% of female high school students and 3.5% of male high school students nationwide.
- In 2017, 10.6% of AI/AN high school students, 15.5% of Hispanic high school students, 8.7% of white high school students, and 9.1% of high school students who identified as multiple races in Montana reported having been physically forced to have sexual intercourse, compared to 11.4% of AI/AN high school students, 7.3% of Hispanic high school students, 7.3% of white high school students, and 9.6% of high school students who identified as multiple races nationwide.

Reported experiencing sexual dating violence

- In 2017, 10% of female high school students and 2.9% of male high school students in Montana reported experiencing sexual dating violence in the prior year, compared to 10.7% of female high school students and 2.8% of male high school students nationwide.
- In 2017, 6.5% of AI/AN high school students, 6.7% of Hispanic high school students, 6.1% of white high school students, and 8.3% of high school students who identified as multiple races in Montana reported experiencing sexual dating violence in the prior year, compared to 6.9% of Hispanic high school students, 6.9% of white high school students, and 9.6% of high school students who identified as multiple races nationwide. Comparative national data for AI/AN high school students are unavailable.

Reported experiencing physical dating violence

- In 2017, 9% of female high school students and 5.4% of male high school students in Montana reported experiencing physical dating violence in the prior year, compared to 9.1% of female high school students and 6.5% of male high school students nationwide.
- In 2017, 11.3% of AI/AN high school students, 9.9% of Hispanic high school students, 6.3% of white high school students, and 11.8% of high school students who identified as multiple races in Montana reported experiencing physical dating violence in the prior year, compared to 7.6% of Hispanic high school students, 7% of white high school students, and 11.8% of high school students who identified as multiple races nationwide. Comparative national data for AI/AN high school students are unavailable.

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

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MONTANA SCHOOL HEALTH PROFILES DATA²⁵

In 2017, the CDC released the School Health Profiles, which measure school health policies and practices and highlight which health topics were taught in schools across the country. Since the data were 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.²⁶ In the School Health Profiles, the CDC identifies 19 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 2015–2016 school year.

19 CRITICAL SEXUAL EDUCATION TOPICS IDENTIFIED BY THE CDC

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

Source: School Health Profiles, 2016

Reported teaching all 19 critical sexual health education topics

- 11.7% of Montana secondary schools taught students all 19 critical sexual health education topics in a required course in any of grades 6, 7, or 8.²⁷
- 22.6% of Montana secondary schools taught students all 19 critical sexual health education topics in a required course in any of grades 9, 10, 11, or 12.²⁸

Reported teaching about the benefits of being sexually abstinent

- 79.5% of Montana secondary schools taught students about the benefits of being sexually abstinent in a required course in any of grades 6, 7, or 8.²⁹
- 86.4% 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 12.³⁰

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Reported teaching how to access valid and reliable information, products, and services related to HIV, other STDs, and pregnancy

- 64.3% 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 8.³¹
- 79.6% 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 12.³²

Reported teaching how to create and sustain healthy and respectful relationships

- 74.6% 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 8.³³
- 86.5% 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 12.³⁴

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

- 49.2% 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 8.³⁵
- 72.7% 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 12.³⁶

Reported teaching how to correctly use a condom

- 19% of Montana secondary schools taught students how to correctly use a condom in a required course in any of grades 6, 7, or 8.³⁷
- 41.3% of Montana secondary schools taught students how to correctly use a condom in a required course in any of grades 9, 10, 11, or 12.³⁸

Reported teaching about methods of contraception other than condoms

- 37.6% of Montana secondary schools taught students about methods of contraception other than condoms in a required course in any of grades 6, 7, or 8.³⁹
- 68.2% of Montana secondary schools taught students about methods of contraception other than condoms in a required course in any of grades 9, 10, 11, or 12.⁴⁰

Reported teaching about sexual orientation

- 26.9% of Montana secondary schools taught students about sexual orientation in a required course in any of grades 6, 7, or 8.⁴¹
- 41.1% of Montana secondary schools taught students about sexual orientation in a required course in any of grades 9, 10, 11, or 12.⁴²

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Reported teaching about gender roles, gender identity, or gender expression

- 30.1% of Montana secondary schools taught students about gender roles, gender identity, or gender expression in a required course in any of grades 6, 7, or 8.⁴³
- 47.5% of Montana secondary schools taught students about gender roles, gender identity, or gender expression in a required course in any of grades 9, 10, 11, or 12.⁴⁴

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

- 34.3% of Montana secondary schools provided students with curricula or supplementary materials that included HIV, STD, or pregnancy prevention information relevant to LGBTQ youth.⁴⁵

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

FEDERAL FUNDING FOR SEX EDUCATION, UNINTENDED TEEN PREGNANCY, HUMAN IMMUNODEFICIENCY VIRUS (HIV) AND OTHER SEXUALLY TRANSMITTED DISEASE (STD) PREVENTION, AND ABSTINENCE-ONLY-UNTIL-MARRIAGE (AOUM) PROGRAMS

Congress provides funding for evidence-based and innovative approaches to sex education through the CDC, OAH, and FYSB. These programs support the implementation of comprehensive sexuality education components and prioritize prevention of unintended pregnancy, HIV, and other sexually transmitted infections (STIs) among young people. The following is an overview of the federal programs and funding awarded to this state. Throughout this section, all programs are identified as they appear in official, federal documentation. However, SIECUS believes that AOUM, or so-called “Sexual Risk Avoidance,” programs are not to be identified as “educational.” These programs’ practice of withholding information from young people is not education but is, rather, the absence of education.

FEDERAL FUNDING IN MONTANA

Grantee	FY17 Award	FY18 Award
Division of Adolescent and School Health (DASH)		
Montana Office of Public Instruction	\$75,000	\$100,000
TOTAL	\$75,000	\$100,000
Teen Pregnancy Prevention Program (TPPP)		
Montana Department of Public Health Services	N/A	\$375,000
TOTAL	N/A	\$375,000
Personal Responsibility Education Program (PREP)		
PREP State-Grant Program		
Montana Department of Public Health and Human Services (federal grant)	\$250,000	Data withheld
TOTAL	\$250,000	Data withheld
Title V Sexual Risk Avoidance Education Program (Title V SRAE)		

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State of Montana (federal grant)	N/A	\$171,036
TOTAL	N/A	\$171,036
GRAND TOTAL		
	\$325,000	\$646,036

DIVISION OF ADOLESCENT AND SCHOOL HEALTH (DASH)

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 2018, through the CDC’s Division of Adolescent and School Health (DASH), 28 school districts received funding to help the districts and schools strengthen student health through sexual health education (SHE) that emphasizes HIV and other STD prevention, increases access to key sexual health services (SHS), and establishes safe and supportive environments (SSEs) for students and staff. DASH funded six national, non-governmental organizations (NGOs) to help state and local education agencies achieve these goals.

- In FY 2018, there were no DASH grantees in Montana funded to strengthen student health through SHE, SHS, and SSEs (1807 Component 2).

DASH also provides funding for state, territorial, local, and tribal 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 2018, there was one DASH grantee in Montana funded to collect and report YRBS and School Health Profiles data (1807 Component 1): The Montana Office of Public Instruction (\$100,000).

TEEN PREGNANCY PREVENTION PROGRAM (TPPP)

OAH, within the U.S. Department of Health and Human Services (HHS), administers the Teen Pregnancy Prevention Program (TPPP), which, according to FY 2018 appropriations language, funds evidence-based (Tier 1) or innovative evidence-informed (Tier 2), medically accurate, and age-appropriate programs to reduce teen pregnancy. In FY 2018, total funding for TPPP was \$101 million. OAH also provides program support, implementation evaluation, and technical assistance to grantees and receives an additional \$6.8 million in funding for evaluation purposes. For detailed information on the current status of TPPP funding, please refer to the explanation below.

Tier 1: Replicating programs – evidence-based,⁴⁶ medically accurate, and age-appropriate programs to reduce teen pregnancy.

- OAH, under the Trump administration, has refused to fund TPPP Tier 1 grantees in accordance with the law.

Tier 2: New and innovative strategies – evidence-informed, medically accurate, and age-appropriate programs to reduce teen pregnancy.

- In FY 2018, there was one TPPP Tier 2 grantee in Montana: Montana Department of Public Health Services (\$375,000).⁴⁷

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MONTANA DEPARTMENT OF PUBLIC HEALTH SERVICES, \$375,000 (FY 2018)

The Montana Department of Public Health and Human Services will implement the Montana Adolescent Health Program (MAHP) with rural and AI middle school students in eight counties in Montana. MAHP will develop and evaluate emerging and promising strategies to prevent teen pregnancy, promote adolescent health, and encourage healthy decision-making by holistically addressing youth sexual risk and increasing protective factors among youth. MAHP is undergoing an evaluation to determine its effectiveness and to contribute knowledge to the teen pregnancy prevention evidence base, which currently includes few programs that target youth in rural counties and AI youth.⁴⁸

Trump Administration Attempts to Undermine Teen Pregnancy Prevention Program

The Trump administration has subjected the Teen Pregnancy Prevention Program (TPPP) to a wide variety of unlawful attacks, attempting to transform the program into an additional funding stream for abstinence-only-until-marriage (AOUM) (now being called “Sexual Risk Avoidance”) programs. Attacks to TPPP have largely been led by Trump-appointed ideologues who are known to be leading opponents of comprehensive sexuality education, despite objections of career staff at HHS.

Since taking office, the Trump administration has called for the elimination of TPPP through the president’s initial budget request, attempted to illegally shorten TPPP grant periods, and violated Congressional intent in attempts to shift programmatic guidelines—all in an effort to prioritize their abstinence-only ideology over evidence of what works best to ensure the sexual health and well-being of young people.

In June and July 2017, all 84 TPPP grantees were notified, without cause or explanation, that their five-year project periods would be shortened to three. Four legal challenges were filed against the Trump administration in response to the early termination of the TPPP grants. The courts ruled in favor of the plaintiffs, stating that the Trump administration’s action was unlawful.

In April 2018, the Office of Adolescent Health (OAH) released new funding opportunity announcements (FOAs) for TPPP Tier 1 (Replicating Programs) and Tier 2 (New and Innovative Strategies). The new FOAs represented a significant shift from funding evidence-based programs with a focus on evaluation toward the prioritization of abstinence-only ideology. Like the unlawful grant termination, the Tier 1 FOA was also challenged in court and ruled illegal for violating Congressional intent. The Tier 2 FOA, however, was not vacated by the courts, and SIECUS was able to obtain FY 2018 data for the Tier 2 grantees.

Fortunately, the Trump administration’s unlawful efforts to subvert TPPP funding have been consistently constrained by federal courts. However, HHS recently announced a list of grantees that, they claim, would have been awarded a total of \$19.4 million in FY 2018 TPPP Tier 1 funding – had the courts not determined it was an illegal attempt to subvert the will of Congress. The same announcement also attempted to blame the plaintiffs who sued the administration over its act of subterfuge. Furthermore, SIECUS’ attempts to identify how the missing \$19.4 million in designated TPPP Tier 1 funds have been reallocated or otherwise used have been blocked by the Trump administration. Currently, Congress is reasserting its oversight authority over the program, particularly since any use of these funds beyond what TPPP requires would be unlawful. Because information regarding the Tier 1 funds are being withheld, this year’s *State Profiles* only contain Tier 2 data.

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PERSONAL RESPONSIBILITY EDUCATION PROGRAM (PREP)

FYSB, within the Administration for Children and Families (ACF) division of HHS, administers the Personal Responsibility Education Program (PREP), which was re-authorized for a total of \$75 million in FY 2018 and FY 2019. PREP funds a state-grant program, the Personal Responsibility Education Innovative Strategies (PREIS) program, which supports research and demonstration projects that implement innovative strategies for preventing pregnancy; and the Tribal Personal Responsibility Education Program (Tribal PREP), which funds tribes and tribal organizations. In addition, a provision within the PREP statute, called the Competitive Personal Responsibility Education Program (CPREP), enables community- and faith-based organizations within states and territories that do not directly seek PREP state grants to apply for funding through a competitive application process.

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 2018 and any programmatic activities that occurred during FY 2018 (October 1, 2017–September 30, 2018). It is important to remember, however, that reported programmatic activities for this period may have utilized FY 2017 funds. Details on the state grants, PREIS, Tribal PREP, and CPREP are included below. Please see below for detailed information on the PREP grantee data withheld by FYSB.

Missing: PREP Data

As of February 13, 2019, FYSB has not released the FY 2018 PREP award amounts or grantee profiles. Curiously, FY 2019 federal funding award amounts for State PREP and Title V SRAE have been released, but the FY 2018 funding data remains withheld from the public.

With a five-year reauthorization of PREP slated for 2019, SIECUS remains highly concerned about this missing data, as it is vital to understanding how adolescent sexual health promotion programs are designed and implemented.

Personal Responsibility Education Program (PREP) State-Grant Program

The PREP state-grant program 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. 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. PREP programs target young people who are experiencing homelessness, are in foster care, are living in rural areas or areas with high rates of adolescent births, and are from minority groups.

Personal Responsibility Education Innovative Strategies (PREIS)

PREIS funds local entities through a competitive grant program to support research and demonstration programs to develop, replicate, refine, and test innovative models for preventing unintended teen pregnancy, HIV, and other STDs among young people ages 10-19.

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Tribal Personal Responsibility Education Program (Tribal PREP)

Tribal PREP supports the development and implementation of pregnancy-, HIV-, and other STD-prevention programs among native young people within tribes and tribal communities. Tribal PREP programs are designed to honor tribal needs, traditions, and cultures.

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.

TITLE V SEXUAL RISK AVOIDANCE EDUCATION GRANT PROGRAM

The Title V Sexual Risk Avoidance Education Grant program (“Title V SRAE”), previously called the Title V AOUM program,⁴⁹ is administered by FYSB, within ACF of HHS, and was authorized at \$75 million for FY 2018. This state-based program must exclusively promote that “the unambiguous and primary emphasis and context” for each topic required to be taught in the new A–F definition⁵⁰ of “education on sexual risk avoidance” is a “message to youth that normalizes the optimal health behavior of avoiding nonmarital sexual activity.” While grantees were required from FYs 1998–2017 to provide three state-raised dollars, or the equivalent in services, for every four federal dollars received, the state-match provision is no longer required. In FY 2018, FYSB withheld detailed information about Title V SRAE grantees and provided only the dollar amount awarded to each state.

Unlike TPPP and PREP, the Title V SRAE grant program was always intended to promote failed⁵¹ abstinence-only programs, or so-called “Sexual Risk Avoidance” programs, rather than evidence-based sex education. However, what began as a tiny sliver of the federal budget has been funded at exponentially higher levels every year. As evidence-based programs like TPPP face continued threats of elimination, SRAE has seen a seven-fold increase in funding since its inception in 2012 (when it was known as the Competitive Abstinence Education program). The Trump administration claims that the government does not have funds to spend on adolescent sexual health. However, the numbers prove the baselessness of this claim: To date, more than \$2.2 *billion* have been wasted on failed AOUM programs like Title V SRAE.

- In FY 2018, the State of Montana received \$171,036 in federal Title V SRAE funding.⁵²

SEXUAL RISK AVOIDANCE EDUCATION (SRAE) PROGRAM

Administered by FYSB within ACF of HHS, the SRAE program—a rebranding of the Competitive Abstinence Education 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 2018, \$25 million was appropriated for the SRAE grant program, and \$11.9 million was awarded to 27 grantees in 15 states through a competitive application process.

- In FY 2018, there were no SRAE grantees in Montana.

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¹ Chin, H, et al. Community Preventive Services Task Force. *The Effectiveness of Group-based Comprehensive Risk-reduction and Abstinence Education Interventions to Prevent or Reduce the Risk of Adolescent Pregnancy, Human Immunodeficiency Virus, and Sexually Transmitted Infections: Two Systematic Reviews for the Guide to Community Preventive Services*. American Journal of Preventive Medicine. 2012;42(3):272-94; Trenholm, C, et al. *Impacts of Four Title V, Section 510 Abstinence Education Programs: Final Report*. Mathematica Policy Research Inc. April 2007.

² Mont. Admin. Rules § 10.53.701. <http://www.mtrules.org/gateway/ruleno.asp?RN=10.53.701>.

³ Mont. Admin. Rules § 10.53.706(1)(a)(iii), <http://www.mtrules.org/gateway/ruleno.asp?RN=10.53.706>.

⁴ Mont. Admin. Rules § 10.53.708, <http://www.mtrules.org/gateway/ruleno.asp?RN=10.53.708>.

⁵ Mont. Admin. Rules § 10.53.709, <http://www.mtrules.org/gateway/ruleno.asp?RN=10.53.709>.

⁶ SIECUS uses the term “sexually transmitted infections” (STIs). However, because the CDC uses “sexually transmitted diseases” (STDs), this report uses “STDs” when referencing their work for clarity purposes.

⁷ Teen pregnancy rates are reported as a whole and without distinction between unintended and intended pregnancies rates. At the time of publication, updated information on unintended teen pregnancy rates categorized by state and age was unavailable.

⁸ 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.

⁹ Ibid., Table 2.6.

¹⁰ “Teen Birth Rate Comparison, 2016 Among Girls Age 15-19,” Power to Decide, <https://powertodecide.org/what-we-do/information/national-state-data/teen-birth-rate>.

¹¹ United States Department of Health and Human Services (U.S. DHHS), Centers for Disease Control and Prevention (CDC), National Center for Health Statistics (NCHS), Division of Vital Statistics, Natality public-use data 2007-2016, on CDC WONDER Online Database, February 2018. Accessed at <http://wonder.cdc.gov/nativity-current.html>.

¹² “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.

¹³ 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.

¹⁴ Ibid., Table 2.6.

¹⁵ Slide 17: “Rates of Diagnosis of HIV Infection among Adolescents Aged 13–19 Years 2016—United States and 6 Dependent Areas,” *HIV Surveillance – Adolescents and Young Adults* (Atlanta, GA: Centers for Disease Control and Prevention), <https://www.cdc.gov/hiv/pdf/library/slidesets/cdc-hiv-surveillance-adolescents-young-adults-2016.pdf>.

¹⁶ Slide 20: “Rates of Diagnosed HIV Infection Classified as Stage 3 (AIDS) among Adolescents Aged 13–19 Years, 2016—United States and 6 Dependent Areas,” *HIV Surveillance – Adolescents and Young Adults* (Atlanta, GA: Centers for Disease Control and Prevention), <https://www.cdc.gov/hiv/pdf/library/slidesets/cdc-hiv-surveillance-adolescents-young-adults-2016.pdf>.

¹⁷ Slide 18: “Rates of Diagnoses of HIV Infection among Young Adults Aged 20–24 Years 2016—United States and 6 Dependent Areas,” *HIV Surveillance – Adolescents and Young Adults* (Atlanta, GA: Centers for Disease Control and Prevention), <https://www.cdc.gov/hiv/pdf/library/slidesets/cdc-hiv-surveillance-adolescents-young-adults-2016.pdf>.

¹⁸ Slide 21: “Rates of Diagnosed HIV Infection Classified as Stage 3 (AIDS) among Young Adults Aged 20–24, 2016—United States and 6 Dependent Areas,” *HIV Surveillance – Adolescents and Young Adults* (Atlanta, GA: Centers for Disease Control and Prevention), <https://www.cdc.gov/hiv/pdf/library/slidesets/cdc-hiv-surveillance-adolescents-young-adults-2016.pdf>.

¹⁹ NCHHSTP Atlas, “STD Surveillance Data” (Atlanta, GA: Centers for Disease Control and Prevention), <http://gis.cdc.gov/GRASP/NCHHSTPAtlas/main.html>.

²⁰ Ibid.

²¹ Ibid.

²² “Youth Online,” Centers for Disease Control and Prevention, <https://nccd.cdc.gov/youthonline/App/Default.aspx>.

²³ “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.

²⁴ 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 2018 Executive Summary, [A Portrait of Sex Education in the States](#), for more context.

²⁵ “School Health Profiles 2016,” Centers for Disease Control and Prevention, https://www.cdc.gov/healthyyouth/data/profiles/pdf/2016/2016_Profiles_Report.pdf.

²⁶ Ibid., pg. 61.

²⁷ Ibid., Table 9c.

²⁸ Ibid., Table 11c.

²⁹ Ibid., Table 9a.

³⁰ Ibid., Table 11a.

³¹ Ibid., Table 9a.

³² Ibid., Table 11a.

³³ Ibid., Table 9b.

³⁴ Ibid., Table 11b.

³⁵ Ibid., Table 9b.

³⁶ Ibid., Table 11b.

³⁷ Ibid., Table 9c.

³⁸ Ibid., Table 11c.

³⁹ Ibid., Table 9c.

⁴⁰ Ibid., Table 11c.

⁴¹ Ibid., Table 9c.

⁴² Ibid., Table 11c.

⁴³ Ibid., Table 9c.

⁴⁴ Ibid., Table 11c.

⁴⁵ Ibid., Table 38.

⁴⁶ Evidence-informed curricula are intended to educate youth, building knowledge and skills, while evidence-based programs and interventions are focused solely on reducing “negative” health outcomes.

⁴⁷ “Current Teen Pregnancy Prevention Program (TPP) Grantees,” Office of Adolescent Health, U.S. Department of Health and Human Services, <https://www.hhs.gov/ash/oah/grant-programs/teen-pregnancy-prevention-program-tpp/current-grantees/index.html>.

⁴⁸ “Montana Department of Public Health Services,” Office of Adolescent Health, U.S. Department of Health and Human Services, <https://www.hhs.gov/ash/oah/grant-programs/teen-pregnancy-prevention-program-tpp/current-grantees/montana-department-of-public-health-services/index.html>.

⁴⁹ In the FY 2018 reauthorization, the “Title V State Abstinence Education Grant Program” was renamed the “Title V Sexual Risk Avoidance Education” (SRAE) program. The definition of the Title V program was changed to mandate that grantees adhere to a new A-F definition as opposed to the [old A-H definition](#) for Title V programs.

⁵⁰ 42 U.S.C. 710, Title V, Section 510 of the Social Security Act, the authorization for the Title V Sexual Risk Avoidance Education grant program, requires that “education on sexual risk avoidance” programs address each of the following topics: (A) the holistic individual and societal benefits associated with personal responsibility, self-regulation, goal setting, healthy decision-making, and a focus on the future;

(B) the advantage of refraining from nonmarital sexual activity in order to improve the future prospects and physical and emotional health of youth;

(C) the increased likelihood of avoiding poverty when youth attain self-sufficiency and emotional maturity before engaging in sexual activity;

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(D) the foundational components of healthy relationships and their impact on the formation of healthy marriages and safe and stable families;

(E) how other youth risk behaviors, such as drug and alcohol usage, increase the risk for teen sex; and

(F) how to resist and avoid, and receive help regarding, sexual coercion and dating violence, recognizing that, even with consent, teen sex remains a youth risk behavior.

Regarding contraception, Title V programs must also ensure that “students understand that contraception offers physical risk reduction, but not risk elimination” and that “the education does not include demonstrations, simulations, or distribution of contraceptive devices.”

[http://uscode.house.gov/view.xhtml?req=\(title:42%20section:710%20edition:prelim\)](http://uscode.house.gov/view.xhtml?req=(title:42%20section:710%20edition:prelim)).

⁵¹ Chin, H, et al. Community Preventive Services Task Force. *The Effectiveness of Group-based Comprehensive Risk-reduction and Abstinence Education Interventions to Prevent or Reduce the Risk of Adolescent Pregnancy, Human Immunodeficiency Virus, and Sexually Transmitted Infections: Two Systematic Reviews for the Guide to Community Preventive Services*. American Journal of Preventive Medicine. 2012;42(3):272-94; Trenholm, C, et al. *Impacts of Four Title V, Section 510 Abstinence Education Programs: Final Report*. Mathematica Policy Research Inc. April 2007.

⁵² “Title V State Sexual Risk Avoidance Education Awards FY2018,” Family and Youth Services Bureau, Administration for Children & Families, U.S. Department of Health & Human Services, <https://www.acf.hhs.gov/fysb/title-v-state-sexual-risk-avoidance-education>.