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July 17, 2025

Minnesota Department of Education
400 Stinson Blvd NE
Minneapolis, MN 55413

Re: Draft 2 of the Minnesota K–12 Academic Standards in Health

To the Department of Education:

Minnesota Family Council submits this comment of feedback regarding Draft 2 of the Minnesota K-12 Academic Standards in Health.

Until the statutory change enacted by the Minnesota legislature in 2024, health education standards were developed by local school districts, as indicated. In 2024, the legislature amended Minnesota statutes to require health standards and benchmarks to be adopted at the state level by the commissioner of education. Laws of Minnesota 2024, ch. 115, art. 2, § 2 (amending Minn. Stat. § 120B.021, subdiv. 1). We respond now to the Draft 2 health standards and benchmarks created by the committee appointed by the commissioner of education as the draft travels in the state rulemaking process.

State statute requires academic standards to be clear, concise, objective, measurable, and grade-level appropriate. Minn. Stat. § 120B.021, subdiv. 2(b)(1). An academic standard is the rule of learning expectation, and benchmarks are the detailed teachings students must master to meet the academic standard. According to the framework outlined in Draft 2 before the delineation of the standards and benchmarks, the various strands of education under the umbrella of health include Food and Nutrition, Mental and Emotional Health, Personal Health and Wellness, Sex Education, Substance Use Prevention and Violence Prevention at each grade.

A brief review of the department's drafted benchmarks reveals misalignment among the required provisions with a prioritization on Sexual Health, particularly for elementary and middle grade benchmarks. For example, we count 70 benchmarks of learning allocated to Sexual Health in the Grade 6-8 benchmarks, while the next highest strand, Mental and Emotional Health, has 48 benchmarks of learning. For contrast, Food and Nutrition has 13 benchmarks allocated for the Grade 6-8 band.

Within Draft 2 of the health standards, under the heading "Organization of the Standards", the document stresses the importance of "developmental appropriateness", "age-appropriate expectations", and "systematic development of health competencies." But in many cases, the Sexual Health benchmarks are not clear and objective, as required by Minnesota law.

For example, many of the benchmarks for elementary and middle grade Sexual Health introduce concepts too early, educate with technical inaccuracy on concepts, and **educate students on sexual relationships at least 4 years before the legal age of consent in Minnesota**:

- 3.4.1.02 Describe internal and external reproductive body parts using medically accurate terms in a gender-neutral way.
- 3.4.1.04 Describe consent and its importance in all relationships.
- 3.4.1.05 Define gender identity and expression.

- 3.4.1.06 Explain the difference between sex assigned at birth and gender identity and expression.
- 5.4.1.04 Define sexual orientation including sense of identity, attractions and related behaviors.
- 5.4.1.05 Describe the differences between sexual orientation, and gender identity and expression.
- 6.4.1.07 Explain the qualities of a healthy dating or sexual relationship.
- 6.4.1.18 Define consent and its importance for decisions about sexual behaviors.
- 6.4.1.19 Describe how to communicate consent for all sexual behaviors.
- 6.4.1.20 Explain how to receive consent and accept a lack or retraction of consent for sexual behaviors.
- 6.4.1.35 Describe the effectiveness of condoms in reducing the transmission of HIV and other STIs.
- 6.4.1.36 Describe how pre-exposure prophylaxis [PrEP] and post-exposure prophylaxis (PEP) are safe and effective ways to prevent HIV infection and transmission.
- 6.4.1.40 Describe the importance of using a condom for STI/HIV prevention while also using a more effective contraceptive method for pregnancy prevention.
- 6.4.1.41 Explain the importance of using a condom for STI prevention while also using other effective HIV prevention options including antiretroviral therapy (ART), PrEP, or PEP.
- 6.4.1.47 Describe young people's legal rights to consent to sexual and reproductive health services, including STI/HIV testing, treatment (including ART, PrEP, PEP), and contraception.
- 6.4.1.48 Explain what to expect from youth-friendly sexual health services and providers.
- 6.4.1.49 Describe the importance of "time-alone" between young people and the healthcare provider to discuss sexual and reproductive health and other sensitive health topics.

When creating developmentally appropriate Sexual Health standards, the Department of Education must consider existing state law which sets the age of consent for sex at 16 years old. Minnesota Family Council knows that the safest legal age of consent is adulthood—18 years old. Regardless, the context of state law shows that teaching students the concept of consent starting around 9 years old is clearly not developmentally appropriate. Consent is an agreement *for* sex and sexual activity. No sexual relationship is healthy for adolescents and school-aged children; therefore, it is not health-promoting for the Department of Education to require teaching young students how to consent for sex. We urge the Department of Education to align Sexual Health benchmarks with existing statute and delay teaching on sexual relationships to students in 6th grade (roughly 11 to 12 years old,) teaching refusal and resistance skills instead at the appropriate time.

In addition, several of the benchmarks regarding STI prevention are technically inaccurate. As shared by the U.S. Centers for Disease Control, "Condoms will not provide protection against STDs spread by skin-to-skin contact (genital herpes or syphilis)."[1] Education for 6th graders on ART, PrEP, and PEP is not developmentally appropriate. According to the 2022 Minnesota Student Statewide Survey conducted by an interagency team in collaboration with the Wilder Foundation and others, only 9% of 9th graders reported ever having sex, and 29% of 11th graders reported ever having sex.[2] The survey denotes that 5th and 8th grade students were not asked these questions.

[1] "Condom Use: An Overview," Condom Use, January 19, 2024, https://www.cdc.gov/condom-use/index.html.
[2] Minnesota Student Survey Interagency Team et al., "2022 Minnesota Student Survey Statewide Tables," *Minnesota Student Survey*, 2022, https://www.lrl.mn.gov/docs/2023/other/239996/statetablesbygender22.pdf.

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Minnesota statute also requires that education programs to prevent and reduce the risks of sexually transmitted infections and diseases be "technically accurate", "helping students to abstain from sexual activity until marriage", and "involving parents" on this education of students. Minn. Stat. § 121A.23, subdiv. 1. As abstinence until marriage is the healthiest option, and indeed the choice for many Minnesotans of various religious and cultural backgrounds, the standards as drafted do not account for these values. In addition, several of the benchmarks provide instruction on how students can receive sexual and reproductive care without parental knowledge. Education on STIs must include parents, as outlined by the above statute.

Finally, the benchmarks containing the language regarding "gender identity", "gender expression", and "sex assigned at birth" contain unclear, subjective, or inaccurate language and should be removed from the education benchmarks. Internal and external reproductive organs are sexed male or female. Reproductive organs cannot be described using "medically accurate terms in a gender-neutral way", as required by the draft benchmark. The descriptions must *either* be medically accurate *or* gender neutral. We recommend that the descriptions be medically accurate, as this aligns with both scientific and technical accuracy. The existence of an intersex condition indicates a need for medical care; it does not indicate additional sexes. Personalities are diverse, but bodies are sexed male and female.

We are concerned by the Department of Education's outsized focus on Sexual Health education at the expense of other strands and the emphasis on consent-based education from elementary education onward. Many of the benchmarks are not developmentally appropriate, teaching even elementary students the concept of consent. Benchmarks on STI prevention in some cases are technically inaccurate, and benchmarks including the language of "gender identity and expression" and "sex assigned at birth" are not medically accurate, scientific terms.

Rather than providing education on consent for sex, we recommend that the Department of Education focus on the development of refusal and resistance skills and boundaries. No sexual relationship is healthy for adolescents and school-grade children; therefore, educators should not train them to consent for sex. We also recommend that the Department of Education include benchmarks to teach abstinence from sexual activity until marriage as the healthiest option both physically and emotionally. To align with state statute, the Department should also consider how to involve parents in education on the prevention of sexually transmitted infections.

Thank you for your consideration,

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