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The History of Sex Education in the United States: With Application to South Dakota

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THE HISTORY OF SEX EDUCATION IN THE UNITED STATES: WITH APPLICATION TO SOUTH DAKOTA

By
Lauren Lavin

A Thesis Submitted in Partial Fulfillment
Of the Requirements for the
University Honors Program

Department of Psychology
The University of South Dakota
August 2020
The members of the Honors Thesis Committee appointed to examine the thesis of Lauren Lavin find it satisfactory and recommend that it be accepted.

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Abstract

The History of Sex Education in the United States: With Application to South Dakota

Lauren Lavin

Director: Kathryn Birkeland, Ph.D.

Due to the lack of standards set forth by South Dakota, sex education is varied and non-standardized across the state. The goal of this study is to understand what a typical sex education class in South Dakota looks like. A survey was sent to sex educators in South Dakota to assess the demographics of educators, the amount of time spent on sex education, and what topics of sexual health they currently teach in grades 1-5, 6-8, and 9-12 in comparison with the topics they believe should be included in an ideal sex education program. The results show that ideal topic inclusion was higher or equal to current topic inclusion on all topics, suggesting a large disparity between what educators do teach versus what they think they should teach. In comparison to previous research, participants reported better topic inclusion in 6th-8th grade classes and overall worse rates of topic in 9th-12th grade classes. Further analysis showed that barriers to sex education in South Dakota include outdated curriculums, absence of government support, and lack of training for sex educators. The results of this study can be used to close the gap between the information that students currently receive in sex education classes and what they should be receiving, which could have a beneficial impact on the rates of risky sexual behavior and increase the health and wellbeing of students in South Dakota.

Keywords: sex education, sexual health, sexuality, South Dakota education
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I did not realize how little I understood about human sexuality until I was plopped into The Psychology of Sexuality with Dr. Struckman-Johnson. I was told it was a "must-take" class by my advisors, so there I sat as a first-semester freshman in a sea of upper-class students. I came from a conservative Christian high school where the most sexual education I received was our gym teacher telling us to read the sexually transmitted disease section of our health book since he was too uncomfortable to teach it. Or the bumper sticker pasted to the science teachers whiteboard “Premarital Sex Puts You on the Used Car Lot” (would not want to forget that sex education gem). Needless to say, the Psychology of Sexuality was eye-opening. Not only did I learn a great deal about human sexuality, but I also learned that sexuality permeates every facet of adult life. Not necessarily in a promiscuous, overly sexual way, but in a way that shows that our sexual drives and preferences make the world go round. For something that is an integral part of the human experience, I was even more fascinated that very few students coming into college knew much about sexuality.

During my sophomore year, I worked with Dr. Struckman-Johnson on a research team that gathered data on student’s sex education before college as well as a quiz to test their current knowledge. The story painted by the data revealed something very similar to what I had already observed in my own life and my short time at college. Only around half of the students had sex education in high school, and the sex education that they did have was dismal at best.

It was at this point that I knew something had to change. How could something with which our society is so obsessed be nonchalantly passed over in education decade after decade? One of my favorite sex educators, Al Vernacchio, says it best, “We are so sexually obsessed that
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we are sexually repressed.” The lack of sex education continues the story of repression while simultaneously increasing obsession.

When I started this project, I had some grand plans to survey teachers, parents, and make a curriculum. However, it turns out that being a full-time student, having a few jobs, and a social life can make it difficult to accomplish a massive three-part, dissertation sized, thesis. So I settled on exploring the history of sex education and the current sex education practices in South Dakota. In looking back at history an interesting, but negative, a pattern emerges, and to end the pattern we must first acknowledge that it exists. That was my teaser to encourage you to read the first section of this thesis which is essentially a long story about sex education. The second section shows the data of current sex education in South Dakota and explores explanations on why it currently is this way. Also, this section has lots of colorful pictures (also known as graphs) that help to explain the information, so you should read that section too.

Sex education is really important. I think everyone knows this (whether they want to admit it or not). We do our students a grave disservice by not teaching them about their bodies and sexuality. I hope to do something more to change that in the future, but in the meantime, this is a good start.
ACKNOWLEDGMENTS

The path to the completion of this thesis has been quite the journey. Shockingly, enough a year-long writing assignment may be the actual worst project for a procrastinator. Nevertheless, I will be eternally grateful for the individuals that supported, challenged, engaged, listened, and celebrated with me over the last year as I worked on this. I am honored that Dr. Birkeland agreed to chair this project even though it is not her first field of interest. Though I’m sure that if we thought about it long enough, we could come up with a way to combine economics and sexuality. Perhaps a demand graph illustrating the relationship between the price of birth control and demand for diapers? There are not enough words, Dr. Birkeland, to express my thanks and the impact that you have had on me over the last year. I appreciate your vision that helped me to focus on the topics and narrow down the writing process. I still have the homemade note cards by the way. I am also thankful that I had you to keep me on track during this whole process. I looked forward to our weekly meetings, even if three-fourths of time was spent talking about anything but the thesis. You are a kind, passionate, and brilliant mentor and professor. From the bottom of my heart, thank you.

Dr. Struckman-Johnson you had my attention from the first day of Psychology of Sexuality. I knew after that first class period that you would become one of my favorite and most respected professors from my time at USD. Your knowledge and passion for sexuality education are unparalleled and evident in everything you do. You put so much effort into your lesson plans and your research. You are shaping the culture of future generations one student at a time. In
addition to your academic work, you are truly one of the most thoughtful professors I have ever encountered. Your care for your students is so evident and I will miss our weekly research meetings and talk sessions. You are a protector of your students and a champion of their rights. I am so grateful to have been your student for the past three years. You have taught me more than you could ever know. Thank you for being someone I can aspire to be like one day.

Of course, I can not forget Sarah Wittmuss. While you were not on my committee you also played a large role in this work, mostly because I probably would not have made it through college without you. Thank you for always having an open door and telling it to me straight. You were the supportive shoulder that I needed to lean on during the last three years. You showed me that hard work and passion do pay off (and also that candy and ice breakers make for a good Supplemental Instruction session). The impact you make on students' lives with your charm and wit is irreplaceable. Thank you for being you.

To my other committee members and the countless professors and staff I have worked with during my time at USD, thank you for providing me with an education that challenged and inspired me. I am grateful to have met so many passionate and knowledgeable individuals over the years that never hesitated to take time out of their day to invest in me and all their other students.

To my parents, family, and friends I am grateful for love and support during this process. From the endless brainstorming to proofreading and bringing me several Diet Cokes and other snacks I could not have done this without you. This has been a humbling yet exciting experience that I hope will carry into the future.
DEDICATION

For the future students of South Dakota- may we do better.
Beginning with an in depth view of the path sex education has taken in America, this paper winds through the ups and downs of sexuality over the past the centuries. In order to understand the present, one must first look to the past. The history shows the periods of progress and eras of stagnation, allowing the readers a basis for comparison. As the US progressed forward, even though it was slowly

Research on sex education has a long-standing history. Sex education roots can be traced back before the 1900s in the Victorian Era. Stifled by old Victorian morals, society controlled every aspect of an individual's life, including sexuality. As formal education increased, so did the need for sexual education (Rury, 1987). By the early 1900s, WWI had begun and with it came a crisis of venereal disease. Venereal disease prompted urgency in sexual education in order to save lives and prevent the spread of illness (Burnham, 1973). The sex education that was prompted by the venereal disease crisis was harsh, focused on strict sexual morality and hygiene (Strong, 1972). To stop the spread of disease, the government had to take hold of sex education (Huber & Firmin, 2014).

Ironically, when the government entered the sex education scene to create change, progress seemed to halt. The next few decades of sex education history were dormant besides a few notable exceptions. Thanks to Margaret Sanger’s work on women’s reproductive rights and Alfred Kinsey’s pioneering sex research, progress in sex education was not completely stalled (Chesler, 1992 & Morantz, 1977). This was the calm before the storm. The Sexual Revolution took the US by storm in the 1960s and 70s. Through progressive changes such as explicit media, birth control pills, pro-sex organizations, and increases in women’s rights, the morality of society
started to shift as people shed their strict Victorian ways and sex education had a path forward (Huber & Firmin, 2014).

Once again, a crisis struck in the sexual health scene catapulting sex education forward. The AIDS crisis illustrated the important role sex education had in society. During this time, sex education had the power to save lives and stop the spread of a disease (Haffner, 1989). In the wake of the AIDS crisis, the narrative around sex became increasingly negative. Sex was immoral and dirty, or so the abstinence only educators said. Abstinence Only Education (AOE) marked a dramatic shift in the way sexual education was taught in schools. With a flurry of published curricula and large amounts of government funding, the lessons of AOE programs flooded the schools, and schools today are still trying to recover (Herdt & Howe, 2007).

The results of AOE were two-fold: misinformation and guilt. Numerous school curricula and extracurricular organizations, such as the Silver Ring Thing, were created to deploy the message of abstinence. However, these programs used misinformation and guilt to create their results which had no positive long term impacts on the students (Calterone Williams, 2011). These programs created barriers to sex education that are still an issue today. Lack of training, fear of community response, and structural barriers have prevented students from receiving the sex education that they need (Eisenberg et al., 2013). When students can not receive accurate information from school, they go to other sources for information. Today some of the student's top sources of information include peers and media. While these sources may provide some beneficial information, they may not paint a full and realistic picture for adolescents (Bleakley et al., 2009).
Enter Comprehensive Sex Education (CSE). CSE covers a wide range of topics that include traditional sex education components such as anatomy and STIs while also exploring the emotional and social aspects of sexuality. CSE is a holistic student approach that empowers students and allows them to develop their own values based on accurate information (Panchaud & Anderson, 2014). In addition, CSE is effective at deterring risky sexual behavior (Kirby, 2008). Even though CSE has been shown to be the best option for students, there are still many states that have not implemented these programs due to barriers.

Moving forward from the history of sex education and further into the current climate, this paper examines barriers to sex education in the US including lack of training, outdated curriculums, and the narrow view of sex education today (Scales, 1989 & Eisenberg et al., 2013). These barriers prevent students from getting the information that they need so they begin to look for sexual health knowledge from sources outside of school. An examination of current literature on sources of knowledge shows that friends and media are some of the top sources of information (Kaiser Family Foundation et al., 2003).

Understanding the history and current state of sex education in the US, allows for a greater understanding of how to help South Dakota today. South Dakota currently has no laws that specifically mention sexual education. Without any laws to standardize sex education content across the state, is likely that content varies widely. The lack of government intervention and concern for sex education seen by school authorities make the current state of sex education in South Dakota similar to eras long ago. While the rest of the US has moved forward with sex education, South Dakota has remained in the past with few mandates and little governmental
support. This paper summarizes the little research available on sex education in South Dakota.

Finally, this study examines current topics included in sex education programs in South Dakota compared to topics that should be included in an ideal program according to teachers. In addition, a survey on the effectiveness of current programs, barriers to sex education, and sources of student and teacher knowledge are included. Results show that many South Dakota sex education classes do not include the topics teachers report to be ideal. Barriers to achieving the ideal education included out of date materials, lack of training, and lack of government support. This study provides novel information about the sex education topics teachers believe need to be taught and why a disparity occurs between reality and ideal in sex education classes.

It is important that when assessing the value of an education program that the broad picture is made is clear. In this case, that begins with a history of sex education back before the 1900s. While this may seem like an unnecessary starting point, the look back at the history of sex education allows readers to see the pattern that emerges. A pattern that illustrates the necessity of change from the status quo in South Dakota. The pattern in sex education history goes something like this: society imposes a strict expectation of sexuality that halts the progression of sex education, and then a crisis arises that pushes sex education forward in a moment of need.

Since before the 1900s, society has repeatedly tried to dictate the role that sex has in individuals lives. Usually, the role is strict like in the Victorian Era, or it focuses on the unhygienic nature of sex like during the time of WWI, or maybe the ideals of proper womanhood and innocence such as during the 1950s, or most recently, the importance of blind abstinence. Society attempts to exert control over natural desires and, as a result, it thwarts the progress of
learning and advancement of the understanding of sexuality. By continuing to make these topics taboo, sex education stalls for decades at a time until something propels it forward. The second part of the pattern occurs when an inevitable crisis ensues, forcing society’s hand to stop the repression of sexuality and educate the generation. Examples include the venereal disease crisis that followed WWI, the Sexual Revolution, and the AIDS epidemic. These times of trouble demonstrated the importance of sex education and relied on its power to fix the mess. However, as soon as the crisis passed, people forgot and returned to allowing society to have authority on the importance of sexuality. If the cycle continues to repeat, sex education will only progress when a crisis warrants its help. Meanwhile, in between epidemics countless individuals miss out on vital information that could keep them safe, healthy, and allow them to be the best version of themselves.

But what if we did not wait for an epidemic to appear to force us into seeing the value of sex education again? What if instead of allowing society to dictate the role of sexuality and sex education, we students and educators determine its value? Today, we are at a crossroads. We can continue to let the pattern repeat and slowly inch sex education forward or we can learn from the past. Today, we can take a stand to push past the barriers to create an ideal sex education program that addresses the needs of our students.

Review of Literature

History of Sex Education

Victorian Era: Before 1900

Prior to the 1900s, the concept of sexuality, much less sex education, was limited. Consequently, research and writings on sex education are scarce for this early period. While
writings specific to sex education may not exist, many historians have commented on Victorian morals and the role of religion during the 1800s; an understanding of the perceived role of sex can be gathered from this.

**Victorian Morality.** The Victorian morality that governed the 1800s can be summed up in one word: control. The Victorian Era prized control over every aspect of a person's life from food consumption to work roles and even sexuality. The nineteenth-century saw drastic changes in almost every aspect of a person's life. The Industrial Revolution, which took place between 1820 and 1840, fueled the large scale movement of people from rural farming communities to urbanized cities. As cities began to populate, formal education increased and with it the intellectual ability of the working population. Women began to see an increase in freedom as girls began to attend school and enter the workforce. This resulted in a slight shift in the role of women in society from being solely mothers and caretakers to allow for a simple education or a chance at specific work roles (Rury, 1987).

While most would argue that the advancements made in the 1800s were largely good for the human race, urbanization and growing female independence brought about new perceived "problems." Formal education resulted in faster social development in children that attended school which led to earlier knowledge of sexuality and began earlier onset of puberty. Coeducation was blamed for rising rates of promiscuity among adolescents in school. Urbanization also led to an increase in prostitution and a noticeable decrease in sexual morals. In addition, newly educated women were starting to explore their role outside of the home and question whether their purpose was solely to bear children and maintain a home life (Rury, 1987).
Many aspects of life were changing in ways that leaders and conservative society members found uncomfortable. In an attempt to resist the unwanted change, the Victorian era emerged with an iron fist to control citizens' everyday lives. With respect to sexuality, the nineteenth century was characterized by repression that spread regarding adolescent and middle-class American sexuality (Huber & Firmin, 2014). Sexual activity was discouraged and sexual expression was repressed, especially among women. In fact, an early sex education manual said: "we teach the girl repression, the boy expression, not simply by word and book, but the lesson are graven in tho their very being by all traditions, prejudices, and customs of society" (quoted in D'Emilio & Freedman, 1988). The strict moral values of the Victorian Era that discouraged sexual expression became an attempt to repress women and halt the change that was overtaking the country.

**Social Purity Movement.** The Victorian Era inspired a general attitude of control among most American citizens, but some individuals viewed their responsibility to uphold the sex values of the Victorian Era more seriously. The strict values of the 1800s led to the Social Purity Movement. The Social Purity Movement served as the first effort to create sex training for individuals. This movement was a combination of the available public health information and Christian morals. Medical professionals and devout Christians teamed up to promote the idea that physical health, spiritual health, and sexual health were all intertwined. To create the best society, all parts of a person must be virtuous. Religion played a large role in the purity movement, but members also sought to investigate sexuality with a dispassionate approach that would allow them to gather more scientific data. This practice opened up the movement to embrace progressive ideas that allowed for female pleasure and independence. This movement
came to embody an important mix of both conservative and progressive agendas. Social purists advocated for the abolition of prostitution and pornography and the return to conservative ideas. Yet, they also championed feminist movements such as increasing the age of consent and other progressive ideas. The social purists did work to support public agendas, but in the later decades of the 1800s, they realized that the real impact of their work would be seen in homes. During this time, the movement shifted its focus to helping train mothers in proper child-rearing tactics that would lead to children with increased knowledge of security and freedom from sexual vices. After all, knowledge is power (Egan & Hawkes, 2008). While the Social Purity Movement may sound repressive in nature, it served as a progressive step forward for both women and sex education. Hall notes that the movement gave women a language to use to speak out about sexual repression in the decades to come. The Social Purity Movement served as a stepping stone for sex education during the 1800s (Hall, 2004).

**Religious Pamphlets.** The Victorian Era yielded benefits for the beginnings of sex education, but its strict moral values also led to campaigns filled with scare tactics and untrue information. Religious beliefs, predominantly Christian, were the foundation for the control that the Victorian Era tried to impress on society. Seeing that religion played a large role in society, it is no surprise that many religious leaders had opinions on the emerging sexual problems of the nineteenth century. Reverend John Todd's, “A Student Manual,” which was a detailed narrative of how to stay chaste and uphold moral character, sold over 100,000 copies in the mid-1800s (Millstein, 2015). This served as sex education for many adolescents but was filled with fear tactics. The book warned men that any sort of sexual activity would deplete their overall strength.
and ability to earn money. Therefore, remaining chaste was the best option for their longevity (Todd, 1840).

Another pamphlet that was widely circulated was the McGuffey Reader. These readers were Biblically based, focused on maintaining healthy relationships, and promoted character-based decision-making skills. These pamphlets served as one of the only methods of sex education available for homeschooled adolescents as well as students receiving formal education. Unfortunately, these pamphlets contained little factual information to help adolescents learn more about their sexuality (Huber & Firmin, 2014).

**Sex Education at Home.** Even though urbanization was occurring throughout America, the movement of people from the country into growing cities was only in the early stages. As a result, homeschooling was still the predominant method of educating children which left mothers in charge of sex education for their children. As one might imagine, the sex education provided by parents in the 1800s was minimal given that most people knew little about reproduction or sexuality. The students who did attend public schools did not receive any better sex education as the topic of sexuality was not thought to be appropriate public discourse during this era. Also, it was early in the organization of public schools, and there was little consistency between schools which made standardized sex education hard to promote (Huber & Firmin, 2014).

Even though the responsibility of sex education during this time fell on mothers, they were not left completely in the dark on how to educate their children. Elizabeth Blackwell, the first woman to receive a medical degree in the U.S., wrote a book on how to morally instruct children about sexuality (Egan & Hawkes, 2008). In her viewpoint, a viewpoint far ahead of her time, she believed that careful instruction on sexuality was needed to ensure healthy and happy
adults for future generations. She recognized how essential sex education is for both boys and girls (Blackwell, 1884). Her ideas about equal and thorough sex education in the late 1800s began conversations about how to best address the need for sex education in America both in schools and at home that moved with society into the new decade (Egan & Hawkes, 2008).

Unfortunately, keeping with the ideals of the Victorian Era, many mothers feared that educating their children on sexual matters would only serve to destroy their innocence. Innocence, especially in females, was a cherished virtue during the 1800s. While this virtue may have been an asset earlier in the century as society began to evolve, innocence quickly turned into ignorance (Egan & Hawkes, 2008). David Arthur Welsh joined with Blackwell and assured mothers that their responsibility in educating their children on sexuality was nothing but beneficial. They also informed them that innocence had been confused with ignorance. Innocence and ignorance were not to be confused with each other since they were competing conditions. He encouraged mothers that it was possible to instruct their children without destroying their innocence, and, in fact, the best way to preserve their innocence was to teach them about sexuality with a foundation of strong moral beliefs as outlined by Blackwell (Welsh, 1917). While it is clear that the sex education that did occur in the 1800s happened at home, it is unclear what parents taught their child. With little knowledge or public discourse about sex, it can be assumed that the sex education before the 1900s was minimal and inaccurate.

**Separation of Sex and Reproduction.** Another important development that occurred before the 1900s was the separation of sexuality and reproduction. While society did not truly acknowledge this separation until the 20th century, it is clear that the beginning of this movement began in the 1800s. As women recognized that they could have an existence outside
the home, the desire to have many children decreased. The birth rate in American declined steadily over the entirety of the century. New information about birth control and its increasing availability coupled with the desire of women to work contributed to the declining birth rate. While many viewed this as an acceptable direction for society, religious conservatives took issue with the changing attitudes toward sex and the invention of birth control devices (D’emilio et al., 1988).

Throughout most of the 1800s, the government kept its hands out of the sexuality of American citizens. The Victorian morals seemed to be enough to keep the population in check. With the rise of technological advancements, new ideas in sexuality continued to appear, making it harder for the government to turn a blind eye. Enter in the Comstock Act of 1873. The Comstock Act, proposed by Anthony Comstock, made both the dissemination of information about birth control and the sale of contraceptives illegal. He claimed that contraceptives were obscene devices; their existence alone promoted lewdness. During this time, contraceptives were not widely available or used. Therefore, the public did not pay much attention to this new law when it was passed (Public Broadcasting Service, 2019). The impact of the Comstock Act would be felt decades later, but its creation signaled that the Government saw a need to begin to control the sexuality of American citizens through more than just the morals of the era. The Comstock Act was the turning point at which the U.S. government abandoned its laissez-faire attitude regarding sexuality and began to initiate programs that would provide reform and educate American citizens (Huber & Firmin, 2014).
Progressive Era: 1900-1920

As the 19th century came to a close, it became clear that the outdated ways of educating children on sexuality at home would no longer be sufficient for raising generations of children into healthy adults. The Progressive Era, named appropriately for its progression from no formal sexuality training through hygiene education to the first school-based sex education, resulted from the venereal disease crisis that surfaced at the beginning of the 20th century. In order to combat this national health crisis, the government stepped in with public campaigns and funding in an unprecedented way, paving the way for formal sex education in the future decades.

Venereal Disease. While venereal disease had been a problem for a few decades prior to the turn of the century, the early 1900s marked a dramatic increase in both the occurrence and severity of sexually transmitted diseases. Physicians across the country published and presented their findings on these new diseases that proved particularly difficult to treat. In the beginning, the chaos surrounding venereal disease stayed confined to the medical realm, but as the disease started to run rampant in society, more people started to take notice. The American Medical Association advised that the public should be educated on the disease and its prevention, and routine medical inspection of known prostitutes should be conducted (Burnham, 1973).

The momentum continued to build around venereal disease as it spread to women and children. Men, who were having affairs with prostitutes or other infected women, were bringing home disease to their wives and passing it on to their children. As more cases of “innocent” infection arose, so did the public's outrage at these new uncontrollable diseases. The situation was only worsened by World War I as soldiers stationed abroad brought venereal disease home with them after being discharged (Bulkeley, 1895). Estimates during this period reported that
50%-90% of men over the age of 18 had been infected with venereal disease. However, it has been noted that fear tactics were a large part of venereal disease campaigns, so these numbers could be inflated (Bigelow, 1916).

**Social Hygiene Movement.** The epidemic-like spread of venereal disease in the early 1900s garnered the attention of many, but due to the cultural morals, few took action. Prince Morrow was one of the first to set the stage for reform. Morrow began what is now known as the social hygiene movement. Morrow believed that the only way venereal disease could be prevented was through education (Huber & Firmin, 2014). The social hygiene movement had two goals, to teach about sexual morality and social hygiene. The hygiene education provided to students, mostly through pamphlets and some in-school training, emphasized cleanliness, making good moral decisions, and information on prevention of sexually transmitted diseases (Strong, 1972). The committee, The American Federation for Sex Hygiene, was created to oversee the dissemination of information as well as provide guidelines for the hygiene education provided. The official recommendation of education content mandated that the material should have “no study of external human anatomy and very limited study of internal anatomy” (Imber, 1982). While this hygiene education was not comprehensive and was often laden with fear tactics, it was a tangible step in the right direction. Hygiene education paved the way for a discussion on sexual education and allowed a gateway for schools to play a role in educating adolescents.

Hygiene education was important information for society, but it neglected sexuality as a whole and left out glaringly important information about reproduction and reproductive organs. It is important to understand the role the Progressive Era played in creating formal school sex...
education that was seen in later decades. Hygiene education was an essential beginning of the sex education movement. During the Progressive Era, three crucial components allowed for the evolution of hygiene education into sex education.

**Government Intervention.** For there to be widespread social change, it was clear that the government needed to be involved; it was the primary catalyst for change. Government intervention began with public campaigns to educate WWI soldiers on the dangers of sexually transmitted diseases. The government promoted information to soldiers through presentations and pamphlets saying that STDs made them more vulnerable to the enemy and could cause a lifetime of illness. The soldiers were also shown the impact that STDs could have on their wife and future children should they bring this disease home with them. The War Department also set up free clinics for STD testing and praised soldiers whose test came back clean. These campaigns in the military were successful at lowering the rate of STDs to the lowest rate reported in decades (Huber & Firmin, 2014). The War Department knew that the battle against venereal disease did not end with the war. They instructed soldiers upon discharge to go home and share this information with their families, sons, or younger brothers. The battle against venereal disease had moved to the homefront (War Department, 1918).

The government did not stop its public campaigns once their war was over. In addition to encouraging soldiers to be an advocate against venereal disease. The Chamberlain-Kahn was passed to mandate STD education to soldiers and to set aside government money to educate more of the population. Many states used this new money to open up free testing and treatment clinics and to increase the education available in their state. Forty-eight out of 50 states worked with the Public Health Service to control the problem of STD in America during the Progressive
Era. This high rate of state participation is evidence of the menace that venereal disease had
turned into. However, the education provided by states was hygiene education and was usually
specifically limited to STD information. Yet it marked an important step in the development of
sex education as it was the first government initiative to disseminate information for this sort
(Huber & Firmin, 2014).

In addition to public health campaigns that brought new funding and increased awareness
of sexual health, the government also began investing in research. The first sex education
research survey was created by the US Public Health Service and the US Bureau of Education
(Faraguna, 2019). The questionnaire sought information in three areas: the number of high
schools teaching sex education, the content of sex education instruction, and the attitudes of s on
sex education. This was a pioneering study as the subject of sexuality was still largely taboo. Out
of almost 6,500 responses, only two-fifths of the schools had any sort of sex education
curriculum. This number was surprisingly high for 1920 as there were no formal education
requirements regarding sexuality. The study also found that 85% of principals believed there
needed to be sex education in schools regardless of whether their school offered it at the time.
This landmark study by the government highlighted the general support from school
administrators in providing sex education beyond hygiene education and served as evidence that
many schools had begun the conversation about sexual health in the classroom (Edson, 1921).

**Ella Young In Chicago.** The final change during the Progressive Era that allowed for the
transition from hygiene education to sex education was the changing attitudes regarding sex.
Prior to the 1900s, sex was generally viewed as only useful for procreation. It was not until the
turn of the century that the idea of sex for recreation started to take hold. A few activists, such as
Maurice Parmelee, were advocates for the pleasures of sex outside of procreation as well as sex education including all aspects of sexuality (Huber & Firmin, 2014). This sexual frankness seeped into the general population, especially adolescents. The outward signs of the shifting purpose of sex were the changes in female clothing and new dance styles over these decades. As adolescents became more outspoken about their desires, the culture began to shift. It was this shift in culture that pushed the need for sex education. While hygiene education was beneficial at preventing the spread of disease, it did not provide the sexuality information that adolescents needed (Faraguna, 2019).

One woman, Ella Young, noticed the shift that was occurring in the Progressive Era. Ms Young was the superintendent of the Chicago Public Schools, and she believed that students in Chicago needed to have formal sex education. She proposed a series of three one-hour lectures on the topics of biology, venereal disease, and abstinence until marriage (Moran, 1996). Despite many of her peers across the country outwardly disparaging her idea, she believed it was moral to provide students access to scientifically accurate sexual health information. She recruited males and females with high moral standards to present the information to the gender-separated students on three separate occasions. Over the course of the 1913-1914 school year, 20,000 Chicago students received the first formal sex education in America. While Superintendent Young was confident in her work, the sex education upset many (Imber, 1982). The backlash against the program was too strong and, consequently, it only ran for one school year. Shortly thereafter, Young stepped down from her position due to pressure from outside forces. What might have looked like a “failure” at the time was a momentous step in the progress of sex education. A large scale sex education curriculum was still ahead of its time, but the hygiene
education of the past was certainly outdated. Young’s attempt to provide a moral, scientifically accurate sex education was used as a model for schools across the country for the next few decades as schools quietly incorporated the information into extant classes to avoid backlash from parents and leadership (Huber & Firmin, 2014). Through public campaigns, government research and fundings, and change in attitudes, the Progressive Era showed a new promise of formal sex education for adolescents.

**Intermediate Era: 1920-1950**

Unfortunately, many of the advancements in sex education that were made during the progressive era seemed to stall for several decades after the resolution of WWI. As the severity of venereal disease decreased, so did the hysteria that came with it. The “failure” of sex education in Chicago made other schools hesitant to implement something similar. During the intermediate era, sex education remained mostly dormant except for a few notable exceptions that managed to make some progress despite the stalling of interest in sex education among most American citizens.

**Margaret Sanger.** Margaret Sanger, a name that has become synonymous with birth control history, was a pioneer for birth control and women's reproductive rights. She believed it was each women's right to have access to clinics that could offer healthcare services to serve all the needs of women (Chesler, 1992). In trying to achieve this goal, Sanger opened up her illegal health clinic in New York which was shut down due to the Comstock laws and resulted in jail time. She challenged the court's ruling to close her clinic. In doing so, a precedent was established that allowed doctors to give family planning services for medical reasons (Centers for Disease Control and Prevention, 1999). Despite constant adversity from the conservative
government, she did not give up but went underground with her clinic work while also publishing journal articles, writing pamphlets, and hosting lectures in the public eye. Her passion for women’s rights and sexuality did not go unnoticed (Chesler, 1992). Due largely to Sanger’s efforts, a court ruling in 1936 overturned the Comstock law. Under this new law, birth control information and devices were no longer considered obscene (Tuhus-Dubrow, 2007). The work that Sanger did over her lifetime impacted not only the women to whom she provided access to information and birth control, but also the millions of women that have access to all reproductive health options today. Her relentless work to change the status quo stemmed from the liberty that she knew all women should have: access to health services and birth control. While Sanger may have been ahead of her time in the 1930s, her work set the stage for women’s clinics, increased access to birth control, oral contraception, and continued sex education.

Alfred Kinsey. Another pioneer paving the way during the intermediate era was Alfred Kinsey. Kinsey, a former biologist studying the gall wasp turned pioneering sex researcher, started conducting his research after he began to teach a marriage course at Indiana University. He saw firsthand the lack of research that was available, especially any research documenting the sex lives of everyday Americans. Concerned with this notable gap in research, Kinsey began collecting sex histories of students that came through his class. After collecting nearly 2000 histories, he received a small grant to continue the work outside of the classroom. His work continued, and in 1947 he received a $40,000 grant and began the Institute for Sex Research, now known as the Kinsey Institute at Indiana University. Kinsey was then able to hire assistants, receive more funding, and have access to better sample populations (Kinsey Institute, n.d.).
In 1948, soon after beginning the Institute for Sex Research, Kinsey published one of the most influential pieces of literature in American sex history, Sexual Behavior of the Human Male. Five years later, in 1953, he published Sexual Behavior of the Human Female. The books contained controversial information for the time as they detailed topics such as homosexuality, premarital sex, and even bestiality (Morantz, 1977). Yet, this “illicit” information intrigued the public, and the books quickly rose to the top of the New York Times bestseller list (Kinsey Institute). The most notably controversial information presented was the occurrence of homosexuality in America. At this point, homosexual acts were illegal. Yet Kinsey’s reports detailed many people having homosexual encounters. He estimated that 10% of the population was homosexual (Huber & Firmin, 2014). This statistic, now known to be higher than the actual percentage of 4.5%, was shocking to American citizens (Newport, 2018). The books also contained innovative new measures for sex research. The Kinsey Scale, still used in sex research today, is a graduated scale from 0-6 that measures the level of homosexual orientation in an individual, with zero being entirely heterosexual and 6 being entirely homosexual. This scale was an important finding in research as it provided the basis for homosexual research and a reliable way to measure homosexuality going forward (Mestel, 2004).

Most historians agree that Kinsey’s greatest contribution was not the advancements he made in sex research but rather the effect his writings had on American citizens. Kinsey’s systematic investigation of American sexuality was free from judgment or cultural norms. His reports documented that the norms that were expected were far from rational. Instead of producing another report with misguided figures about what sexuality in America should be, Kinsey reported what was occurring. He separated sexuality from morality for the first time in
history. As a result, people realized what they were experiencing was normal. There was a liberation from the rules and expectations that society had on them. The shame that surrounded sexuality at this time was not lost overnight, but Kinsey set into motion the dissipation of humiliation and began a liberation of sexuality that carried into the sex education movement (Morantz, 1977).

**Sex Education Classes During the Intermediate Era.** The implementation of sex education within schools continued in this era, but with much less fanfare and excitement. The example of Chicago forced many schools to integrate sex education into routinely offered classes. During this era, sex information was broken down and offered in appropriate classes. For example, sexual anatomy was presented in biology, and the emotional side of sexuality was taught in a social science of physical education class. When the sex education material was presented via other curriculums, it was less offensive to the public. This method proved useful to schools, and in 1927 45% of schools offered sex ed this way (Carter, 2001).

As the 1940s and 1950s approached, classes that focused on the psychological implications of sexual development started to appear. Many of these classes appeared as family life classes such as home economics. These classes did not truly present any more sex education than the biology classes of two decades prior, but they did bring about the conversation of many other topics that had been previously addressed. Marriage, money management, work-life balance, and cooking were all topics covered in family life classes. These classes changed the setting of sex education and placed it in a safe environment in which it was discussed in the context of marriage and family life. The public responded well to this new direction of sex education (Huber & Firmin, 2014). The Intermediate Era made some progress forward thanks to
the efforts of people like Margaret Sanger and Alfred Kinsey. Sex education was growing in schools but it was under the guise of other classes, leaving it pushed to the side and forgotten. The Intermediate Era was a calm period of slow growth. It was the calm before the storm of the Sexual Revolution.

**Sexual Revolution: 1960s-1970s**

The calmness of the Intermediate Era made the eccentric roar of the Sexual Revolution that much louder. The Sexual Revolution refers to a period of time during the 1960’s and 1970’s when there was a great shift in attitudes regarding sexuality. The traditional Victorian morality that was still prevalent in sexuality was uprooted through new ideas and inventions that became popular during this era. This shift in morality was evident in society as the disapproval for premarital sex began to decrease and the explicit imagery, such as x-rated movies, began to increase. The Sexual Revolution was also aided by the concurrent hippie and free love movement which emphasized love and good feelings over long-held societal standards and rules. This entire era was extremely important for the development of sex education, but there are a few notable events, such as mass distribution of The Pill and Roe v. Wade, that fueled the development of sexuality and sex education (Smith, 1990).

**Sex and the Single Girl.** In 1962, the start of the Sexual Revolution began as “Sex and the Single Girl,” by Helen Gurley Brown hit the shelves. The book, part autobiographical and part self-help, detailed the sexual escapades of an unmarried young woman along with less offensive information such as recipes and makeup tips. Before this book, it was unheard of for anyone to so much as whisper about premarital sex, so when Gurley Brown wrote a book about her own experience for everyone to read, it shocked the public. This book was controversial, as
details about virginity and contraception were far from appropriate book topics, but it was only controversial enough to make it a complete sensation. “Sex and the Single Girl” quickly rose to the top of the bestseller list and sold 150,000 copies during the first year. The book was no literary masterpiece, but it's frank description and breezy nature enticed women across the country to continue turning the pages (Allyn, 2001).

Helen Gurley Brown did not intend to begin a revolt, but her book was the first step toward an emancipation of women from the Victorian ideals that remained. The tight grip of the 1950s held men and women to a double standard. Men were applauded for their sex drives while women were told to serve quietly inside the home and wait for a wedding ring. Many women believed that they would be punished for expressing their sexuality. Media reinforced these ideas through movies and books, but Gurley Brown changed that with her publication. Gurley Brown’s book set into motion the idea of sexual independence for women across the country; this was well received in the free love movement of the 1960s and 1970s. Gone were the days of “single women with double standards” (Allyn, 2001).

**The Pill.** If “Sex and the Single Girl” was a spark in the fire of women’s rights, then the mass distribution of the Pill was the gasoline to the flames of freedom. The Pill was first introduced in America in 1957 when it was cleared by the FDA as a method of menstrual cycle regulation. Dr. John Rock and Dr. Gregory Pincus, ironically both devout Catholics, were the driving forces behind the clinic research of the pill. They began their research in 1954 claiming that the pill was an extension of a natural form of family planning called the rhythm method (Liao & Dollin, 2012). Through a small US trial and a larger trial in Puerto Rico where laws regarding participant safety were less strict, the two men gathered enough evidence to show the
FDA that it would be a useful medication in America. Even though the knowledge of the Pill’s contraceptive power was well known, the initial release of the Pill was not be used for contraceptive purposes (Dexter Mccormick, 2015)

The first Pill was a revolutionary combination of progestin and estrogen that came in a simple package. The Pill was easy to use and effective which made it preferable to other methods that were available at the time. However, the Pill released in the 1950s and 1960s contained a significantly higher dose of hormones than the average pill today. Enovid, the first Pill, contained 66 times the amount of progestin and five times the amount of estrogen needed to prevent contraception and regulate menstrual cycles. As one can imagine, many side effects accompanied the large dosage of hormones. Despite the side effects, many women still choose the Pill. By 1959, 500,000 women were taking the Pill to “regulate their menstrual cycle,” contraception was just a bonus (Dexter Mccormick, 2015).

After lobbying and protests, the Pill was finally approved by the FDA for use as a contraceptive in 1960. Within seven years, nearly thirteen million women were using the Pill. Today, over 100 million women worldwide use oral contraceptives (Dexter Mccormick, 2015). For the first time in history, women could take control of their reproductive cycles. The Pill separated intercourse from procreation and unwanted pregnancy, and the impact of this separation was unlike that of previous contraceptives. Women could engage in sexual activity without the fear of pregnancy and the shame that accompanied it since they were in control of the protection. Also, the Pill was taken at the same time each day regardless of whether sexual activity was going to occur, and it worked chemically without any noticeable outside mechanism. This separated birth control from the act of sex which made many believe that this
was a “cleaner” form of birth control (Allyn, 2001). The Pill allowed women to control their fertility which resulted in dramatically fewer maternal and infant mortalities. It also allowed for better family planning which created more ideal spacing between children. The Pill has granted women the freedom to pursue a variety of roles in education and the workforce that were previously out of reach (Dexter McCormick, 2015). A philosopher, Ashley Montagu, likened the invention of the Pill to the discovery of fire. The Pill appealed to the progressive nature of America during the Sexual Revolution. Much like the discovery of fire led to a whole host of changes and new developments, the Pill emancipated women and gave them the power to find their sexuality. Thanks to the Pill, men and women became equally responsible for the creation of the future generations and women found independence in expressing their sexuality. The mass distribution of the Pill was easily one of the most influential acts of the 20th century (Allyn, 2001).

Masters & Johnson. While the introduction of the Pill and “Sex and the Single Girl” certainly made strides to change the climate of public discourse surrounding sexuality in America, Dr. William Masters, and Virginia Johnson were changing the way researchers and scientists thought about sexuality in the 1960s. Masters and Johnson began their research together at Washington University in 1957. It was not long after that they rose to national fame. Their research was scientific in nature; they gathered data and statistics, which was a sharp contrast to the survey-based research Alfred Kinsey had done in the 1950s (Banner, 2013). Masters and Johnson knew that to make progress in the field of sexuality research in America, data on the anatomical and physiological responses to sex must be gathered through direct observation. In order to do this type of research, the team invented new machines and research
techniques that are still used today. Throughout the years, their research spanned many topics on sexuality including sexual response cycle, sexual disorders, and dysfunction (Kinsey Institute, 2013).

Their seminal work, “Human Sexual Response,” was published in 1966. The book documented in great detail the sexual response cycle (SRC). The book described the physiological changes that occurred during the excitement, plateau, orgasm, and resolution phases of the SRC (Banner, 2013). The book also normalized behaviors such as masturbation, elderly sex, and sex as a relational partnership. This work was essential in moving the topic of sex from a taboo idea to an important part of the health and well being of humans. In using scientific methods and clinical observations to study sexuality, Masters and Johnsons illustrated that sex was not any different from other studied human behaviors.

Masters and Johnson’s legacy expanded beyond their publication of “Human Sexual Response.” Not only did the team conduct pioneering research, but they also made it their mission to provide training to educators and therapists. At a time when sexual medicine and sex education were still largely absent, Masters and Johnson provided a scientific approach that made the topics more palatable to society. By normalizing sexual behaviors and creating a vocabulary to talk about these behaviors scientifically, they paved the way for educators and doctors alike to educate students and patients using facts and scientific evidence. Their research allowed for the diagnosis and treatment of sexual disorders, undoubtedly improving the lives of many Americans. It also provided a path for sexual educators in the future to use scientific data while teaching students and prompted open discussion (Banner, 2013).
Sexual Information and Education Council for the United States (SIECUS). The birth of pro-sex organizations during the Sexual Revolution was also instrumental in the development of sex education classes in the US. In 1964, the former medical director of Planned Parenthood, Mary Calderone, formed the Sexual Information and Education Council of the United States (SIECUS) (Sexual Information and Education Council for the United States, 2019). What Margaret Sanger was for birth control, Mary Calderone was for modern sex education. Calderone was frustrated with the inaccuracy and lack of sex education information presented to students. SIECUS was established as a values-neutral guide to comprehensive sex education through publishing books, journal articles, curriculums, and training workshops. SIECUS programs encouraged students to decide sexual morals for themselves after being presented with accurate information. SIECUS was also instrumental in certification programs for sex education and sex therapists. The American Association for Sex Educators and Counselors and Therapists created training standards, and by 1973 more than 450 people had received their professional sex education certification. Pro-sex organizations such as SIECUS advanced a standard and comprehensive sex education curriculum forward so that sex could be viewed as a normal and healthy part of everyday life (Huber & Firmin, 2014).

Roe v. Wade. The final impactful event on the track of sex education in the Sexual Revolution was the decision of Roe v. Wade. In this landmark case in 1972, the Supreme Court ruled that a woman has a right to make decisions regarding the status of her pregnancy. It also stipulated that states have the right to limit abortions as they see fit based on the viability of the fetus (Roe v. Wade, 1973). Before this, 17% of deaths related to pregnancy were caused by unsafe abortion practices (National Center for Health Statistics, 1967). This case was viewed as
another triumph for women’s reproductive rights and equality. With this ruling, women could now control their education and work lives due to the increased control over their reproductive lives (Planned Parenthood of Southeastern Pennsylvania v. Casey, 1992). Roe v. Wade moved the cultural narrative of equal gender forward, increased accessibility of contraception, and promoted medically accurate sexual health information which aided the development of sex education through increased dialogue on these topics (Cahn & Goldstein, 2004).

The Sexual Revolution was a time of upheaval in the views of sexuality in society. The creation of new sexual norms, the Pill, and the outcome of Roe v. Wade each had a significant impact on the trajectory of sex education. As the topic of sexuality become more status quo in society so did the ability to talk about sex in a school setting. This openness coupled with increased scientific research on sexuality meant that more comprehensive curricula could be formed (Huber & Firmin, 2014).

**Modern Era: 1980s-2000s**

The final era in history before present-day sex education is the Modern Era. During the Modern Era, two notable movements took place that are still present in sex education today: the AIDS epidemic and abstinence only education. The AIDS crisis in America instilled fear in the public and reverted sex education to its controlling roots of the 1920s. As a result, the detrimental abstinence before marriage crusade swept the nation and remains part of sex education today.

**AIDS Crisis.** The AIDS crisis began in the 1980s with the observation that a deadly disease was affecting gay men in the San Francisco area. Originally thought to be a “gay cancer,” it was not until 1982 that the term “AIDS” was coined and society began to understand that it
was a sexually transmitted infection. Unfortunately, little was known about the disease, so it continued to spread across the U.S. in the 1980s (HIV.gov, 2019). By the mid-1980s, there were 150,000 infectious cases reported. The majority of people with those early cases died due to the lack of medical understanding and treatment of this new disease (Centers for Disease Control, 2001).

The panic that the AIDS crisis created had a significant impact on sex education. Before the epidemic, the topic of what should versus should not be included in sex education could have continued indefinitely. Government officials and school leaders were content leaving questions such as who is best suited to teach adolescents about sex and at what time on the back burner. The matter did not seem urgent, but AIDS changed the field quickly. In 1980 only three states mandated that sex education be taught in school. By 1993 47 states recommended AIDS education (Rothman, 2014). The topics that parents, teachers, school leaders, and the government had ignored for decades became essential to the stop of a nationwide crisis. Sex education became a matter of life and death (Haffner, 1989).

The importance of sex education in fighting the battle against AIDS became even more apparent when the Surgeon General, C. Everett Koop, declared that sex education in the U.S. needed to become a top priority in schools. In a press conference in 1987, Koop said,

“Education concerning AIDS must start at the lowest grade possible as part of any health and hygiene program-- there is now no doubt that we need Sex Education in schools and that it must include information on heterosexual and homosexual relationships. The threat of AIDS should be sufficient to permit a Sex Education curriculum with a heavy
emphasis on the prevention of AIDS and other sexually transmitted diseases (Legislature of the State of California, 1987/1988)."

The call to put off indecision and take action for sex education in America drove school leaders forward in pursuing class time and curricula for these topics.

While schools did begin to teach about AIDS, limited sexuality information, and safer sex practices, sex education across the country regressed to early teaching practices. Sex education in the 1980s and early 1990s mirrored that of the 1920s hygiene era in which sex was depicted as dirty and immoral (Haffner, 1989). While some leaders tried to adopt a value-neutral curriculum that just presented facts about sex and AIDS, the predominant narrative around sex in the 1980s was fear. Scare tactics were used to discourage sex in adolescents, encouraging teens to abstain from sex to avoid dying from AIDS or being associated with homosexuality. The regression in teaching style due to the AIDS crisis was detrimental to the overall development of sex education and may have negated the benefits of increased sex education across the country (Rothman, 2014).

**Abstinence Only Education Movement.** Abstinence only sex education was another important movement to come from the Modern Era in sex education. Abstinence only education (AOE) refers to sex education that promotes remaining abstinent until marriage for both psychological and physical well being. This movement became popular during the AIDS crisis as a way to stop the spread. In 1989 only one in 50 teachers had an AOE curriculum, but by 1999 one in four teachers were using an AOE program. AOE programs became the fastest growing sex education curricula (Calterone Williams, 2011). Also, religious organizations got involved in
turning the AOE movement into a religious crusade. The religious crusade was an attempt to take back the youth from being immersed in an over-sexualized society (Calterone Williams, 2011).

As it was made clear during the AIDS epidemic, it was time for the government to step in and support sex education in schools. The first funding for AOE came in 1981 by way of the Adolescent Family Life Act or AFLA. AFLA offered over ten million dollars to sex education programs across the country, but the money came with stipulations. In order to receive AFLA funds, the program had to promote chastity for adolescents and adoption if an unwanted pregnancy should arise. The program also needed to be affiliated with a religious organization. These stipulations made using the money for comprehensive sex education impossible, so a majority of the money went to religious groups and their pregnancy crisis centers (Kantor, 2008).

In 1996, the Temporary Assistance for Needy Families (TANF), commonly referred to as ‘welfare reform,’ was established. TANF designated $50 million to the states every year for AOE. The AOE entitlement outlined that every four government dollars had to be matched with three state government dollars to receive the funds. All the money needed to go toward approved AOE programs or community events (Herdt & Howe, 2007).

The final string of funds made available for sex education came in 2000 as the Community-Based Abstinence Education (CBAE). This program resulted from lobbying by social conservatives who believed that programs receiving funds from the aforementioned entitlements were not strictly adhering to the abstinence only education requirements. CBAE funds were allocated directly from the U.S. Department of Health and Human Services to the programs which bypassed state health departments because those departments had become too
forgiving in their standards (Kantor, 2008). These funds were considered the strictest as the program had to demonstrate that it met every requirement of AOE (Herdt & Howe, 2007).

As a result of these federally funded programs, abstinence only education needed to be defined to determine whether a program could qualify for government money. The federal eight-point definition of abstinence education is in Section 510 of Title V of the Social Security Act. The eight-point definition mandates that it should be communicated that abstinence is the expected standard in America, abstinence is the only way to prevent unwanted pregnancy and STIs, any sex outside of marriage is harmful both physically and mentally, raising a child out of wedlock is harmful for both the baby and the parent. In addition, training on how to reject sexual advances was required to be included (Ott & Santelli, 2007). These programs could not endorse the use of contraception and could only include information on contraception in the context of its potential failure. They also promoted heteronormative gender stereotypes and heterosexual couples (Harris, 2004). Within schools, these definitions led to restrictive programs that included medically inaccurate information, misinformation on the effectiveness of condoms and risk of abortion, and potentially withheld lifesaving information on HIV (Ott & Santelli, 2007). In 2004, a review of the most common abstinence only curricula found that eleven out of thirteen contained misinformation (U.S. House of Representatives Committee on Government Reform - Minority Staff, 2014).

In addition to school programs, a few external programs developed to target teens and promote abstinence. Programs such as The Silver Ring Thing and Abstinators programs served more as entertainment than an actual presentation of information. Through websites, weekend rallies, after school programs, and church groups, teens were pledging their virginity across
America. These programs included a heavy emphasis on faith, yet adolescents from all backgrounds came to the rallies. These external programs promoted the idea of abstinence well beyond school walls (Calterone Williams, 2011).

What started as a response to the HIV crisis of the 1980s soon spiraled into a religious crusade in an attempt to protect teens. Unfortunately, the AOE curriculums far from protected teens as they were filled with misinformation and lacked the thoroughness necessary in sex education. Because the funding for AOE programs from the government remains, these curricula persist in schools today (Herdt & Howe, 2007).

**Sex Education In the United States Today**

Thirty-nine states and the District of Columbia (DC) require formal sex or HIV education today (Guttmacher Institute, 2019). Formal education is defined as instruction that takes place in a structured setting such as a school or community program (Lindberg et al., 2016). Twenty-seven of these states mandate both HIV and sex education, two require only sex education, and ten states require only HIV education. While it seems that a good portion of states mandate sex education, the number of schools with specific health practices that carry out state policy has decreased. Since 2000 about 20% fewer schools require instruction on topics such as HPV, human sexuality, and STD prevention (National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, 2015). Out of the 39 states that require sex education, 26 states and DC mandate that the instruction provided be appropriate for the grade level, and only seventeen states require the information taught to be medically accurate. If a parent does not want his/her child to receive sex education at school, 36 states provide parents with an option to remove the child (Guttmacher Institute, 2019).
The content of sex education is also mandated by the states. All 39 and DC that require sex education also require information on abstinence to be presented. State policy can mandate whether abstinence be ‘covered’ or ‘stressed.’ Twenty-nine states require that abstinence be stressed while the other 10 require that abstinence only be covered. Twenty states mandate information on contraception. However, between 2006 and 2013 there was a reported 10% decline in females who received information about birth control and a 6% decline in males. More alarmingly, only around half of the adolescents received necessary information on contraception before their first sexual debut, and only 40% reported having information on how to obtain birth control (Lindberg et al., 2016). Nineteen states and DC also require that the negative effect of adolescent sex and pregnancy be discussed. Seventeen states and DC have policies on how sexual orientation should be covered with ten states and DC requiring the material to be inclusive of all sexual orientations. Unfortunately, the other seven states mandate that instruction includes negative information regarding some sexual orientations and/or positive views of heterosexuality (Guttmacher Institute, 2019). Very few high schools offer specific instruction on sexual health topics as they relate to the LGBTQ community, with a low of only 11% in South Dakota high schools (Demissie et al., 2015). As a result, less than 17% of LGBTQ students reported positive views of LGBTQ subjects (Kosciw et al., 2014).

Some states also require life skills to be taught in sex education classes. Thirty-five states and DC mandate information on healthy sexual relationships and 26 states plus DC include information on the importance of self-control in sexual decision making. An additional life skill required by many programs is the recognition of teen dating violence. Thirty-seven states require instruction on recognizing and responding to sexual violence, but only eight states require a
discussion on the importance of consent (Guttmacher Institute, 2019). While states may mandate a variety of topics, many states are not fulfilling the requirements. Current sex education has decreased substantially since the AOE revolution. Students today are receiving less exposure to important sexual information than they were in 2006 (Lindberg et al., 2016).

**Nationwide Funding**

Many state programs are funded by federal government dollars. Between the years of 1996 and 2018, over $2.2 billion in government dollars has been spent on AOE. Federal funding for sex education began in 1981 with the American Family Life Act (AFLA), continued in 1996 with Temporary Assistance for Needy Families Title V program, and in 2000 Community-Based Abstinence Education (CBAE) was born. These programs supported AOE education for decades, but by 2010 Congress had eliminated both AFLA and CBAE funding. The expiration of this funding was precipitated by numerous states continuing to decline funding that required abstinence only education. In 2009, almost half of the states in America were declining funding due to the reported ineffectiveness of AOE programs. The only program that was funded in 2010 was Title V. This program received a five year (2010-2014) $250 million extension as part of the Affordable Care Act. This program still required states to match every four federal dollars with three state dollars. In 2010 only 30 states applied for money from the Title V program (SIECUS, 2019).

In 2012 Congress created a grant program in addition to Title V. This grant program, Competitive Abstinence Education (CAE), operated on $5 million per year and supported more comprehensive sexual education approaches. This program ended in 2015. In 2016 Congress debuted a new program termed Sexual Risk Avoidance Education (SRAE). The SRAE program
was an attempt to rebrand AOE programs, however, the main goal of curricula that receive funding from this program is still voluntary abstinence. This program still operates today. In 2019 the grant program distributed $35 million which is triple what it began with in 2016 (SIECUS, 2019).

**Types of Sex Education**

**Abstinence Only Education**

Funding for sex education programs through the US government is only available for Abstinence Only Education (AOE) curriculums. AOE is the most popular and widely used type of sex education program in the U.S. today due to the requirements set by federal funds. At the most basic level, abstinence means refraining from sexual intercourse, but various programs include additional behaviors (such as oral sex) in this definition as well. Someone who is abstinent is referred to as a virgin. Many programs frame abstinence as making a commitment in the name of faith as faith is tied to many AOE programs. Many curricula also promote the idea that abstinence is the only method of contraception that is 100% effective. However, contraception is typically measured in two ways: perfect use and typical use. If a contraceptive method is used perfectly, all the time, the perfect use statistics illustrate its effectiveness. The typical use statistic models the use of ordinary people who make mistakes (Santelli et al., 2006). While perfect use of abstinence may be 100% effective, typical use is far from 100%. A study from 2005 found that 88% of those who pledged abstinence did not remain abstinent until marriage, and their rates of STIs did not differ from their non-pledge peers. Typical use paints a different story of the practicality of AOE (Brückner & Bearman, 2005).
Even though AOE education is common in schools, research shows that AOE is the least preferred program among parents with only 36% strongly or somewhat supporting it. Also, AOE has the highest level of opposition at 50% (Bleakley et al., 2006). AOE programs often contain misinformation. A congressional review found that 11 out of 13 programs contained medically inaccurate information. For this reason and more, AOE programs are ineffective in delaying sexual intercourse or preventing STI transmission (J. S. Santelli et al., 2017), (Kirby, 2001), and (Stanger-Hall & Hall, 2011). However, some behavioral impacts can be seen due to AOE. One year after an AOE program, there are increased intentions of abstinence as well as slightly more positive views of abstinence (Trenholm et al., 2007). While the philosophy behind AOE education is stable, the application of it in the U.S. has led to both the lack of information and misinformation that could potentially harm students (Santelli et al., 2006).

**Abstinence-Plus Education**

Abstinence-plus education programs include information about all forms of contraception while still promoting strong messages of abstinence (Alford, 2009). This type of program was created in response to the gaps that AOE had left for many students, but it maintains the pure ideals of abstinence. While abstinence-plus programs provide contraceptive information like comprehensive sex education, the two should not be confused. Abstinence-plus programs present contraceptive information as a hierarchy, with abstinence being at the top. The best method of contraception is abstinence. However, not everyone will adhere to that method which is why other forms of contraception are also presented to teach students about safer sex.

Research has shown abstinence-plus programs to be more beneficial for students. Abstinence-plus education has been linked to increases in HIV knowledge, reduction in
unplanned pregnancy, and a reduction in unprotected sex (Underhill et al., 2008). Other research has illustrated the benefit of abstinence-plus programs on increased condom use and delay of sexual initiation. Overall, when these programs are contrasted with typically AOE programs, the benefits of presenting additional contraceptive information become clear (Dworkin & Santelli, 2007).

**Comprehensive Sex Education**

Comprehensive Sex Education (CSE) is a new wave of sex education that views the student’s sexuality holistically. Sex education is an integral part of the development of both the social and emotional aspects of a student. CSE attempts to do more than just prevent pregnancy and disease. It should promote essential life skills and encourage students to develop values. While CSE does still cover the physical and biological components of sexuality, it also covers social and emotional aspects at a level appropriate to the student's age (Panchaud & Anderson, 2014). The Guttmacher Institute identifies three goals that every CSE program should help the student to accomplish “1) Acquire accurate information on sexual and reproductive rights, information to dispel myths, and references to resources and services, 2) Develop life skills including critical thinking, communication and negotiation, self-development and decision-making; sense of self; confidence; assertiveness; ability to take responsibility; ability to ask questions and seek help; and empathy, 3) Nurture positive attitudes and values, including open-mindedness, respect for self and others, positive self-worth/esteem, comfort, nonjudgmental attitude, sense of responsibility, and positive attitude toward their sexual and reproductive health” (Panchaud & Anderson, 2014). CSE is much more than just “sex ed.”
As the public has begun to realize the importance of CSE for students, public support for these programs has increased. In 2001, only 51% of the population sampled agreed with CSE in schools (Herrman et al., 2013). Today, the majority of adults support CSE or CSE topics across the nation including 86% in Delaware, 72% in North Carolina, 90% in South Carolina, 80% in Texas, and 64% in Utah. Overall, 98% of adults believe that students should have some type of sexual education in high school (Sexual Information and Education Council of the United States, 2018a).

Some dissenters still believe that sex education in schools may increase sexual activity. However, a growing body of research shows the CSE reduces the likelihood of teen pregnancy, delays sexual initiation, increases contraceptive use, and reduces the likelihood of sexual assault (Kirby, 2001). In 2008, Kirby assessed 48 studies that evaluated the impact of CSE on student behaviors. There were several criteria that both the sex education curriculum being evaluated and the method of research had to meet to be included in Kirby’s analysis. The analysis represented a variety of CSE programs implemented across the U.S. The results showed no program hastened sexual initiation; rather, 47% of the programs delayed sexual initiation. No program increased the frequency of sex, but 29% reduced the frequency. In addition, 46% of programs decreased the number of sexual partners. One program did increase the number of partners. Forty-four percent of programs increased contraceptive use, and 47% of programs increased condom use specifically. Contraception use was negatively impacted in one program. Overall, 62% of programs reduced sexual risk in students (Kirby, 2008).

Other research has yielded the same results. Research from Kohler and colleagues found that there was a significant reduction in reported teen pregnancy for individuals that were
enrolled in CSE versus no sexual education (Kohler et al., 2008). Stanger-Hall & Hall found that the level of emphasis on abstinence impacted teen pregnancy rates. In states where abstinence is stressed, females were more likely to become pregnant than the average adolescent females.

Lower rates of teen pregnancy were found in states that did not emphasize abstinence (Stanger-Hall & Hall, 2011). The effects of CSE are not short-lived. Kirby and colleagues followed students for 31 months after a CSE program and found that the program, Safer Choices, reduced one or more sexual risk taking behaviors in students for almost three years, especially in males (Kirby et al., 2004). Additionally, research published in 2018 suggests that CSE that includes refusal skills can provide a protective effect for students by reducing the likelihood of sexual assault during college (J. S. Santelli et al., 2018).

CSE also benefits populations other than American high school students. Grossman and colleagues found that CSE has a beneficial impact on students in middle school. The study followed middle school students over three years to see if CSE during middle school could delay early sexual initiation compared to schools with no sex education. Results showed a 15% reduction in early sexual initiation in females and 16% in males. Thus, CSE seems to have a protective effect for middle school students as well (Grossman et al., 2014). CSE has also been effective for Mexican students. In populations where knowledge about contraceptives is low and access to contraception even lower, CSE can help students identify effective methods and obtain them. Research shows that when CSE is used, students are more likely to recognize at least three out of five effective methods of contraception (de Castro et al., 2018). Mexico is not the only country trying to implement CSE programs, China has begun to use them as well. A study done in China analyzed the effects of CSE on attitudes toward sexual minorities. The 2013 study
found there was a significant increase in positive attitudes toward sexual minorities, but it was noted that these changes may require further reinforcement in order to be maintained. Using CSE to increase knowledge can help to protect adolescents against unsafe sex practices in other countries (Chi et al., 2013).

This growing body of evidence suggests that CSE is an effective choice for educating students on sexuality. By delaying the age of initiation, increasing use of contraception, reducing teen pregnancy rates, decreasing rates of infection, decreasing the likelihood of sexual assault, and increasing positive attitudes towards sexual minorities, CSE has proven that it is an effective means of presenting sexual health information to students. This finding coupled with public support for CSE programs suggests that CSE should be made an essential part of American students' education (Panchaud & Anderson, 2014).

**Barriers**

Despite the proven effectiveness and majority public support, sex education, let alone CSE, is still not consistently taught in high schools. Barriers posed to sex education range from structural barriers (number of students in class), to insufficient instructor knowledge, to legislative barriers. Unfortunately, little research has been done on barriers to sex education since the 1990s, but the ideas presented in those studies are still relevant today. The barriers from decades ago are the same barriers that teachers are face today as the world of sex education seems to progress at a painfully slow rate. Scales was the first researcher to document barriers to sex education in 1989. He proposed five barriers in his study. Three of the barriers are still relevant today including taking a narrow view of sex education, lack of understanding of the importance of self-efficacy, and inadequate political skills. Many schools and states take a
narrow view of sex education today by restricting sex education content to anatomy, STIs, and only topics that revolve around sexual intercourse. While this information is important, sex education should do more for a student. It should challenge their ideas and help them to create values, negotiate points of view, evaluate information, communicate effectively, and analyze the world around them. Sex education should involve a holistic student approach that goes beyond the narrowness of anatomy and disease. This concept also illustrates another subtle barrier: measurement. While sex education does have measurable positive effects such as reducing teen pregnancy and increasing contraception, it would be narrow to justify its necessity through those measurements alone. As stated previously, sex education is more than just basic information; it should be a transformational process that may have little measurable external effect on students. However, that does not make the internal effects any less important (Scales, 1989).

Scales notes that another barrier is the failure to understand the importance of self efficacy in sex education programs. Self efficacy, one’s perception of their ability to do what is required of them, is essential to positive behavior change, which is one of the main goals of sex education. Programs must incorporate social and emotional aspects, such as self efficacy and personal confidence, into the curriculum to make a lasting impact on students (Scales, 1989).

The final barrier that Scales reports is the inadequate political skills of those passionate about changing sex education. As many aspects of sex education are mandated by local, state, and federal authorities, it is immensely important that those seeking to change the status quo of sex education be familiar with how the political system works. Understanding how to create budgets, set agendas, and communicate the needs of a program to officials is essential to overcoming barriers that government funding and rules pose to sex education. If sex educators
can learn how to represent their beliefs and address their needs in political settings, this barrier can be overcome (Scales, 1989).

Research published in 1994 surveyed sex education teachers to assess their perspectives on barriers to their classes. Teachers were given a list of 25 common problems for sex education teachers and instructed to rate each item on a five point scale of applicability. The overwhelming common response from teachers was insufficient knowledge, unclear procedure, and insufficient training and experience. Many also noted the lack of materials and curricula. This study illustrated the importance of equipping teachers with the knowledge and materials to effectively teach sex education (Csincsak et al., 1994).

The final and more recent study on barriers to sex education surveyed topics taught in Minnesota as well as barriers those teachers faced. A majority of the teachers surveyed reported facing some barriers while teaching sex education. Most commonly, teachers reported structural barriers. Forty-eight percent of teachers cited not having enough time as the structural barrier. Forty-five percent of respondents said they worried about community response to their teaching (from parents and administrators). Additionally, 25% reported that school or district policy was a barrier to sex education at their school. Barriers reported did not differ between grade levels. This research illustrates the ongoing structural barriers as well as concern for community backlash that sex educators face today (Eisenberg et al., 2013).

Sources of Student Knowledge

The barriers to sex education prevent students from receiving the information they need from school. With an obvious lack of information, students turn to other sources to fill their knowledge gap about sexual health concepts. The top two sources of information for sexuality
are friends and the media (Kaiser Family Foundation et al., 2003). These sources of information play a vital role in the development of an adolescent’s perspective on sexuality. Some sources such as friends or parents may have more weight and, thus, more impact. However, the constant flow of sexual topics from the media can be hard to ignore. Sources such as friends, family, and the media typically have widely varying views on sexual health topics that can make it confusing for an adolescent to decipher fact from fiction. While access to these sources can increase knowledge, adolescents must be weary of inaccurate information or ideas that are not consistent with reality (Bleakley et al., 2006).

Sex Education in South Dakota Today

Looking back across the history of sex education and the complexity of it in the US today, it is not difficult to see the dramatic changes that have occurred from before the 1900s to 2020. While dramatic change, albeit with plenty of room for growth, has occurred for the majority of the US, one can infer that South Dakota has remained largely stagnant in its development of sex education from the current state of it today. The avoidance of “unsavory” topics lingers from the Victorian Era, the lack of laws and governmental guidance resembles troubles from the Progressive Era, and the general lack of progress (or arguable movement backward) indicates that South Dakota is still stuck in the 1950s Intermediate Era. Referring back to the cycle that was seen throughout the history of sex education, change does not come to this field until a crisis arises. This will stand true for South Dakota as well. Unless an outside force pushes sex education in South Dakota forward, the training and curriculums will continue as relics of the past depriving students of the education that they need and forcing them to look elsewhere for their sources of knowledge. If South Dakota does not begin to actively address
students' sex education needs, they are setting themselves up for a crisis to occur. A crisis that only sex education can resolve.

There is little documentation of the history of sex education or the current state of sex education in South Dakota aside from South Dakota law, the SEICUS state profiles, and CDC school health profiles. South Dakota is one of three states (Alaska & Arkansas) in the US that are silent on sexual education matters (Alemansour et al., 2019). Currently, South Dakota law does not have any standards for sexual education. In fact, the education codes for health do not even mention sexual education. South Dakota codified law does, however, mandate “character development instruction.” Character development is designed to “impress upon the minds of the students the importance of citizenship, patriotism, honesty, self discipline, self respect, sexual abstinence, respect for the contributions of minority and ethnic groups to the heritage of South Dakota, regard for the elderly, and respect for authority” (§13-33-6.1). Since the state government provides no standards for sex education, the decision and implementation is left to the school boards and other district leaders (Alemansour et al., 2019).

In the past, there have been potential bills that could have impacted sex education in South Dakota. In 2019, the South Dakota legislature voted on three bills that addressed the rights of transgender students. House Bill 1108 prohibited the instruction of gender dysphoria between kindergarten and 7th grade (An Act to prohibit certain gender dysphoria instruction in public schools, 2019). The other two bills worked in tandem to ensure that the sexual identity noted on a student’s birth certificate is the sole determinant of gender for athletic participation (An Act to establish a determinant in identifying a student’s sexual identity for participation in high school athletics, 2019) and (An Act to declare void the transgender procedure adopted by the South
Dakota High School Activities Association and to establish a determinant in identifying a student’s sexual identity for participation in high school athletics, 2019). All three of these bills were struck down.

However, in 2020 a new House Bill was introduced. House Bill 1162 not only mandates sex education but also details what is required and prohibited in the curriculum. The first section of the act includes an opt-in policy. This policy would require that parents provide written permission for their child to participate in any sexual education. Notices of planned instruction would be sent out two weeks before the class with a description of the content that is to be presented in class. Any students whose parents do not sign the opt-in policy would be given a study period during the class time (An Act to provide certain provisions regarding sex education in public schools, 2020). Only four other states have opt-in policies as they pose a substantial hurdle to providing sex education to students (SIECUS, 2018a).

The other section of the bill detailed what abstinence education programs in South Dakota should look like. The section lists 14 points that programs should adhere to including: “stress the importance and benefits of abstinence from all sexual activity before marriage,” “communicate that sexual abstinence is the only effective method of eliminating the risk of unplanned or out-of-wedlock pregnancy and sexually-transmitted diseases,” “inform students of the benefits of ceasing sexual activity if a student is sexually active,” and “sexual abstinence programs may not include models of instruction, based on risk reduction, encourage or promote or provide instruction on the use of contraceptives products or methods. Materials and instruction may not be excessively graphic or explicit and may not include explicit descriptions of sexual activity that encourage erotic, lewd, or obscene behavior.” (An Act to provide certain provisions
regarding sex education in public schools, 2020). Under this new bill, teachers would only be allowed to promote abstinence and not be allowed to discuss contraception.

South Dakota receives funding from various sources. In 2017, South Dakota received over $1.8 million to help fund sexual education efforts across the state. Funding sources include the Division of Adolescent and School Health (DASH), Teen Pregnancy Prevention Program (TPPP), Personal Responsibility Program (PREP), and Title V Abstinence-Only-Until-Marriage (Title V AUOM). However, $1.3 million went to efforts in tribal organizations to benefit the Native American community (SIECUS, 2018b). Programs in the Native American community such as Rural America Initiatives and Tribal PREP serve students by helping them “develop and maintain a positive lifestyle, especially through practicing positive cultural values, including regular exercise, healthy eating and avoiding risky behaviors” (RAI, n.d.). These programs are designed to follow materials similar to what is presented in public schools on sexual health matters but with special emphasis on tribal needs and traditions (FYSB, 2015).

Each year the CDC publishes a collection of state health profiles that document the type of information included in each state's health classes. The report serves as a way to celebrate successes and positive trends over the years but also to address gaps across the country. Individual states may also find the data useful to determine how they compare to other states. Data is collected through surveys administered to principals and lead health educators at schools in the state (n=169). The CDC does note that the results may reflect more positive results than is reality since the results are self-reported by the principals and lead health educators. The results show that South Dakota is severely lacking in teaching sex education to students in 6th-8th grades according to the CDC data when compared to nationwide counterparts. South Dakota is
also well below the median on every topic in 9th-12th grade courses (Centers for Disease Control and Prevention, 2019).

Table 1

<table>
<thead>
<tr>
<th>Topic</th>
<th>Grades 6, 7, or 8 in SD</th>
<th>Grades 6, 7, or 8 in US (median)</th>
<th>Grades 9, 10, 11, or 12 in SD</th>
<th>Grades 9, 10, 11, or 12 in US (median)</th>
</tr>
</thead>
<tbody>
<tr>
<td>All 20 critical sexual health education topics in a required course</td>
<td>3.7%</td>
<td>17.6%</td>
<td>19.9%</td>
<td>42.8%</td>
</tr>
<tr>
<td>Benefits of being sexually abstinent</td>
<td>28.9%</td>
<td>73.3%</td>
<td>77.3%</td>
<td>93.0%</td>
</tr>
<tr>
<td>How to access valid and reliable information, products, and services related to HIV, other STDs, and pregnancy</td>
<td>28.9%</td>
<td>63.5%</td>
<td>68.9%</td>
<td>91.2%</td>
</tr>
<tr>
<td>Importance of using condoms consistently and correctly</td>
<td>13.4%</td>
<td>44.0%</td>
<td>47.3%</td>
<td>79.7%</td>
</tr>
<tr>
<td>How to create and sustain healthy and respectful relationships</td>
<td>36.6%</td>
<td>75.9%</td>
<td>79.0%</td>
<td>92.5%</td>
</tr>
<tr>
<td>How HIV and other STDs are transmitted</td>
<td>31.8%</td>
<td>70.7%</td>
<td>74.8%</td>
<td>94.2%</td>
</tr>
<tr>
<td>Health consequences of HIV, other STDs, and pregnancy</td>
<td>32.2%</td>
<td>70.9%</td>
<td>76.2%</td>
<td>93.2%</td>
</tr>
<tr>
<td>How to correctly use a condom</td>
<td>7.4%</td>
<td>27.6%</td>
<td>27.3%</td>
<td>62.1%</td>
</tr>
<tr>
<td>Methods of contraception other than condoms</td>
<td>15.7%</td>
<td>47.9%</td>
<td>55.2%</td>
<td>81.6%</td>
</tr>
<tr>
<td>Topic</td>
<td>6-8th Grade</td>
<td>9th-12th Grade</td>
<td>Note</td>
<td></td>
</tr>
<tr>
<td>------------------------------------------------------</td>
<td>-------------</td>
<td>----------------</td>
<td>------</td>
<td></td>
</tr>
<tr>
<td>Sexual orientation</td>
<td>9.7%</td>
<td>36.2%</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>39.6%</td>
<td>61.0%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gender roles, gender identity, or gender expression</td>
<td>8.4%</td>
<td>38.5%</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>38.4%</td>
<td>61.7%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>


South Dakota also faces some unique challenges concerning sex education. Nearly 75% of South Dakota’s population is classified as rural (United States Department of Agriculture, 2000). Rural communities need sex education more than ever as rural females are significantly more likely to have had sex by age 19 than urban females (55% vs. 40%), less likely to use contraception the first time they have sex than urban females (71%-81%), and the teen birthrate is 33% higher in rural communities (Finley & Stewart, 2013). These data become more urgent when paired with recent data that show a significant trend of decreasing sex education in rural communities. This trend has occurred across a variety of topics and for both genders (Lindberg et al., 2016). The decrease in sex education in rural areas puts already at-risk youth in more danger.

In addition, South Dakota is home to a large Native American population with nine reservations and 71,000 Native Americans. Research has shown that the Native American individuals are subject to increased violence over their lifetimes, specifically females. Native American women are two times more likely to be a victim of rape or sexual assault than any other race. One in three Native American women will be raped, and 39% of Native American women have been a victim of intimate partner violence compared to 27% of white women (NCAI Policy Research Center, 2013). This illustrates the need for sex education programs in
both rural and reservation areas. These programs need to be culturally relevant and address the
distinctive needs of these unique populations in South Dakota.

To address the gaps in research regarding sex education content, effectiveness, barriers, and perceived information sources in South Dakota, this study will use a survey to gain the perspective of teachers. Teachers of sex education have first-hand experience in understanding the importance that sexual education can have on students and have unique insight into the particular needs within a school. This information can help make progress in changing the sex education available to students in South Dakota to best meet their needs in order to increase their well being both physically and mentally.

**Method**

To gather data, this study used a survey to collect information from sex education teachers from the state of South Dakota. The survey was sent via email and hosted through Psychdata. The survey contained 115 questions on current sex education content, ideal content, and a sexual knowledge quiz. The survey was sent to over 500 principals and educators. However, only twelve participants provided usable data.

**Survey**

The survey used in this study was adapted from research by Cindy Struckman-Johnson and her research assistants, one of which was me, from 2019. A report of that study is yet to be published. After working on this project The original survey reviewed students' experiences and perspectives on their sexual education experiences. The survey used in this study was modified for use in evaluating sexual education from the perspective of the educators. This survey includes ideas about optimal coverage of sexual health topics, barriers to sex education,
implementation suggestions, and an analysis on sources of sexual health knowledge. The entire survey can be found in the Appendix.

**Demographics and Background**

The brief demographic portion of the survey contained six questions to collect relevant data on personal participant characteristics such as years teaching, years teaching sexual education, race, gender, education level, educational background, and location of secondary education. The second demographic section collected information on the participants' school. This information included school size, sexual education class size, public or private classification, rural or urban classification, type of school and configuration (elementary, middle, or high school), and if sex ed was taught at the school. The final background section gathered information about the teacher’s sexual education teaching within the school. This section gathered information on when sexual education was provided in the school, classes taught that include sexual education, additional classes taught, and number of sex educators in the school.

**Sexual Education Taught by Participants**

The next three sections collected data on the sexual education provided by the participants. This part of the survey was broken down into three sections (1st-5th, 6th-8th, and 9th-12th) to isolate the differences in information presented to the different age groups. The sections included a wide variety of information regarding the sexual education presented by that teacher and consisted of sixteen questions. As basic background info questions were asked on the grades the teacher taught sexual education for, how the class was separated in regards to gender, what curriculum, if any, was used, and how many hours were spent on sexual education in the class. The next set of questions were formatted as “check all that apply” for topics that were
discussed in the class including: basics of sexual education, negative consequences of sex, abstinence, contraception, and pregnancy prevention, healthy and unhealthy relationships, sexual behaviors, and sexual identity. The section concluded with a question to assess the methods used to present the material in class.

**Program Reflection**

This section surveyed participants’ views on their sexual education curriculum. It included questions on the best and worst aspects of their sexual education programs and the perceived effectiveness of the program.

**Barriers**

The barriers section focused on perceived barriers to sexual education in South Dakota. It also collected data on the value of current curricula.

**Ideal Program**

In the next section, participants were asked to create their ideal sex ed curriculum by checking all topics that they believe should be covered in the best program. This section was a replica of the section about what is currently taught. The main topics of basics of sexual education, negative consequences of sex, abstinence, contraception, and pregnancy prevention, healthy and unhealthy relationships, sexual behaviors, and sexual identity were broken down into more specific items within the category. There were also questions about who would teach an ideal class, how the material would be presented, and how much time would be spent on sexual education in class.
Your Students’ Knowledge of Sexuality

This section aimed to understand where teachers perceive that students get the majority of their sexual education. The participants were asked to check the top three from the following choices: personal experience, parents, siblings, same-age relatives, peers, social media, internet, mainstream media--television, magazines, school sex ed program 1st-12th grade, information obtained in a medical setting, college level courses that covered sexuality, or pornography. The participants were then asked to identify from the previous list of options where they think students should get their sexual health information.

Your Own Knowledge of Sexuality

This section repeated the questions from the previous section but asked about the participant’s own sexual knowledge. The participants were asked to check the top three ways they received sexual health information from the following choices: personal experience, parents, siblings, same-age relatives, peers, social media, internet, mainstream media--television, magazines, school sex ed program 1st-12th grade, information obtained in a medical setting, college level courses that covered sexuality, or pornography. The participants were then asked to identify from the previous list of options where they do get their sexual health information. The final question assessed the number of college level classes on sexuality the participants have had.

Knowledge of Sexuality

The final section of the survey was designed to assess the participant’s knowledge of sexuality and sexual health related topics. The fifteen item questionnaire was designed to be difficult as the questions were taken from upper level undergraduate courses on sexuality. The participants were asked to not look up any of the answers so that an accurate conclusion could be
drawn about their present knowledge. The questions covered a wide variety of topics including: STIs, medications for STIs, how contraception functions, male and female reproductive organs, stages of sexual response, hormones, and sexual orientation.

**Participants**

**Teachers**

Twenty four sexual health educators from South Dakota, recruited via email, agreed to participate in the study. Twelve participants were removed from the study for spending less than two minutes responding or for incomplete data. Of the 24 participants, twelve provided complete data via an internet survey. Participants consisted of ten female and two male respondents (female= 83.33%, male= 16.67%). At the time of response, the final sample of participants had taught in general for 11.25 years (SD<sub>years</sub> = 10.16; range<sub>years</sub> = 3-34) and sexual education specifically for 6.75 years (SD<sub>years</sub> = 9.15; range<sub>years</sub> = 0-34). Seven participants (58.33%) reported that their highest level of education was a bachelor's degree and the five remaining participants (41.67%) had additional training beyond undergraduate education in the form of a specialization certificate or masters degree. The respondents had a wide variety of majors including physical education and health, biology, and education (Figure 1). The participants also taught in a variety of school configurations, as such their teaching responsibilities spanned a variety of grade levels.
Figure 1

Undergraduate Majors of Participants

![Pie chart showing the distribution of undergraduate majors with percentages]

Note: The figure displays all majors represented in the sample population with the percentage occurrence of each major.

Figure 2

Configuration of Schools Represented

![Pie chart showing the distribution of school configurations with percentages]

Note. This figure displays the five different configurations of schools represented in this sample along with the percentage occurrence of each configuration.

Schools
Demographic information about the schools was also surveyed. The average school had 335 student participants. School sizes ranged from 60 students to more than 600. Individual school breakdown is pictured in Figure 3. All twelve schools were reported as public. Eleven out of the twelve schools were categorized as rural with the remaining one categorized as urban. However, no diagnostic criteria was given to make the distinction between urban and rural. The average class size for sexual education classes within the schools is 17.33. The largest class size reported was 38 and the smallest class size was one-on-one counseling as needed. Out of the twelve participants, only 10 (83.33%) reported that the school they teach at provides sexual education.

Figure 3

Size of Schools Represented

![Pie chart showing the distribution of school sizes.]

**Procedure**

All methods received prior approval from the Institutional Review Board at the University of South Dakota. Initial contact with potential participants was made through an email sent to all principals of elementary, middle, or high schools in the State of South Dakota. Email
addresses were obtained through the South Dakota Department of Education website and through access to a high school principal mailing list. The principals were sent an email with a cover letter containing information about the survey as well as the request to forward the email to any teacher at their school who provides any sort of sexual health education. The sexuality educator portion of the email included the informed consent, a cover letter explaining the study, and the link to the survey. The survey was hosted through PsychData and was to be completed online. All participants remained anonymous as no identifying information was given. After providing informed consent, the participants were instructed to complete the survey described above to the best of their ability. The participants were not compensated for completing the survey.

Results

Section Background

1st-5th Grade Class Background

All participants who reported teaching a sexual education class in 1st-5th grade reported teaching in 5th grade only. The classes in 5th grade were separated into male and female sections. All participants reported that instruction was provided in a sexual education only class or as one-on-one instruction as needed. Time spent in class ranged from one to four hours.

6th-8th Grade Class Background

Participants reported that sexual education occurred in all three grades. The distribution among grades is shown in Figure 4. The majority of classes (75%) were co-ed and 25% of the classes were separated by gender. Sexual education instruction occurred in health classes, sex ed
specific classes, and science classes (Figure 5). Time spent on topics of sexual education ranged from one to more than 20 hours (Figure 6).

**Figure 4**

*Percent of Participants Who Teach 6th-8th Grade*

![Percent of Participants Who Teach 6th-8th Grade](Image)

**Figure 5**

*6th-8th Grade Classes in which Sexual Education is Taught*
Eight-five percent of participants who taught in the 9th-12th Grade category reported teaching sexual education in 9th grade (Figure 7). All participants’ classes were co-ed. The majority of sex education provided in this age group is presented in health class (71.4%) (Figure 8). There was a fairly even distribution of time spent on sexual education topics ranging from two hours to more than 20 (Figure 9).
Figure 7

*Percent of Participants Who Teach 9th-12th Grade*

![Bar chart showing the percentage of participants teaching 9th, 10th, 11th, and 12th grade. 9th grade has the highest percentage, followed by 10th, 11th, and 12th grade with the lowest.]

Figure 8

*9th-12th Grade Classes in which Sexual Education is Taught*

![Pie chart showing the distribution of classes in which sexual education is taught. Health class accounts for 71.4% and anatomy class for 28.6%.]

Figure 9

*Amount of Time Spent on Sexual Education in 9th-12th Grade*

![Pie chart showing the distribution of time spent on sexual education. 2 hours accounts for 28.6% and 20+ hours also accounts for 28.6%.]
Topic Analysis

The survey had six sections that grouped topics included in sexual education programs. The sections were separated into age groups to differentiate what topics were included based on grade level. The three sections were 1st-5th grade, 6th-8th grade, and 9th-12th grade. If a participant did not teach any class in a particular age group, he/she did not answer any of the questions for that age group. The participants were asked to mark which topics were included in the sexual education classes that they taught. The participants were also asked which topics they would include in an ideal curriculum. The ideal results are included as a demonstration of the separation between ideal goals and the reality of what is currently being taught.

Basics

Participants reported teaching basic sexual education in all grade levels. Good touch and bad touch were under-taught in comparison to what participants say would be ideal. All of the 1st-5th participants reported teaching about male and female anatomy. Sex and pregnancy were only covered in the upper age ranges. Pregnancy was included more often than participants suggested would be ideal.

Figure 10

Comparison of Basic Content
Negative Consequences

No negative consequences are included in the 1st-5th grade sexual education classes. The data show that 100% of classes teach about sexually transmitted infections, which is consistent with what participants suggest would be ideal. Participants report that all classes should include information on the danger of contraceptives and the difficulties of raising a child. In general, ideal topic inclusion was higher or in some cases similar, to what is currently being taught in South Dakota.

Figure 11

Comparison of Negative Consequences Content

Abstinence

Abstinence was not included as a topic in any 1st-5th grade classes. General information on abstinence was provided in 100% of 9th-12th grade classes and 75% of 6th-8th grade classes,
which is consistent with the suggested ideal class. The importance of abstinence and pledging abstinence was not taught in any 9th-12th grade classes despite some participants suggesting that it should be included in an ideal class.

**Figure 12**

*Comparison of Abstinence Content*

![Comparison of Abstinence Content](image)

**Contraception and Pregnancy Prevention**

The topics in contraception and pregnancy prevention were not discussed in any 1st-5th grade class. Overall, these topics were more consistently included in 6th-8th grade classes in comparison to 9th-12th grade classes. Condom demonstrations, how to obtain contraception, and information on options available if one becomes pregnant were included at a higher rate in 6th-8th grade classes. Only 85.7% of 9-12th grade classes included instruction on contraception
and how it works in contrast to 100% of participants that reported it should be included in an ideal class. In general, ideal topic inclusion was higher than actual topic inclusion in this section.

Figure 13

Comparison of Contraception and Pregnancy Prevention Content

Healthy and Unhealthy Relationships

The topics of healthy and unhealthy relationships were not included in any 1st-5th grade classes. These topics had similar levels of inclusion between 6th-8th grade and 9th-12th grade. However, these levels were considerably lower than what participants suggested would be ideal. Participants reported that topics of sexual harassment and assault should be discussed in 100% of classes, yet sexual harassment was only included in 50% of 6th-8th grade classes and 57.12% of
9th-12th grade classes. Sexual assault was included in 50% of 6th-8th grade classes and only 42.86% of 9th-12th grade classes.

**Figure 14**

Comparison of Unhealthy and Healthy Relationship Content

![Bar chart showing comparison of unhealthy and healthy relationship content](image)

**Sexual Behaviors**

The topics included in sexual behaviors were not covered in any 1st-5th grade class. Reported ideal rates of inclusion were higher than what was currently taught on every topic. These topics, for example, masturbation and benefits of sex, can be controversial classroom topics so ideal rates of inclusion on these topics were lower than ideal rates on most other topic
categories. The ideal inclusion rate for the topic of masturbation was only 20% and the ideal rate for benefits of sex was 30%. The topics of masturbation and benefits of sex were never covered in 6th-8th grade classes but were covered in some 9th-12th grade classes.

Figure 15

Comparison of Sexual Behavior Content

Sexual Identity

The topics of sexual identity, including sexual orientation and LGBTQ tolerance or rejection, were not covered in any 1st-5th grade classes or 6-8th grade classes. A small portion, 14.28%, of 9th-12th grade classes covered sexual orientation and tolerance of LGBTQ individuals. Ideal rates of inclusion of this topic in sexual education classes were also low with
40% of participants reporting the sexual identity should be covered. Only 20% of participants suggested that tolerance of LGBTQ individuals be included in an ideal program.

**Figure 16**  
*Comparison of Sexual Identity Content*

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**Method of Instruction**

There are many methods of instruction which instructors can employ when teaching sexual education. All participants reported using a variety of methods to teach sexual education, however, a few methods were utilized less frequently such as online computer games or self-guided online programs. Types of pictures of genitals differed based on age group as 1st-5th grade participants reported using no realistic pictures of genitals and using more cartoon pictures
than their 6th-8th grade and 9th-12th grade counterparts. No participants reported that having no pictures of genitals should be included in an ideal program. Indirect terms, such as nicknames for body parts, were also used more frequently in 1st-5th grade programs.

In addition to these topics, participants were also asked the ideal instructor for sexual education and age that it should occur. Ideal age responses formed a bell curve shape of responses with younger and older students being less ideal age groups for sexual education. 100% of participants agreed that sexual education should occur in 9th grade.

**Figure 17**

*Comparison of Method of Instruction*
Effectiveness

Participants were asked to evaluate their current program for effectiveness, good aspects, and negative aspects. Eighty percent of participants reported that they thought their current program was effective, and 20% did not believe their program was effective. The reasons that participants did not believe their program was effective included: lack of information on how to avoid dangerous situations (sexual abuse/harassment), no information on good touch or bad touch past 5th grade, and teachers that skip information that they are responsible for teaching especially in high school. Eighty percent of participants did not believe that the current curricula being used were the best options for the students.

Participants reported a variety of good aspects in each of their programs that make them effective. Common themes include: age-appropriate instruction, up-to-date information, open and honest classroom environment, thorough information on contraceptives and abstinence, information on various sexually transmitted infections, and whole-person approaches to sexual education that include emotional and social changes. Some of the worst aspects reported about participants' sexual education programs include outdated curriculums, lack of diversity within curricula, lack of access to new curricula, lack of information on contraceptive options, and immaturity of students. Some participants also noted the lack of an actual sexual education class is a hindrance in their school as one-on-one sexual education from a school nurse or the reproductive organ unit in anatomy class do not replace a legitimate sexual education experience.

Barriers

Participants were asked to report whether they believed barriers to sexual education existed in South Dakota. Seventy percent of participants believe there are significant barriers to
sexual education in South Dakota while 30% do not. Participants were asked to explain what they saw as barriers in South Dakota. These barriers include lack of statewide agreement on whether sexual education should be taught in schools, lack of appropriate materials, curricula, and training, absence of clear statewide standards and support from the state government, and conservative values that push abstinence rather than student safety.

**Sources of Knowledge**

Participants were asked to identify where they believed students received their information about sexual health and where they got their information on sexual health as well as from where they wanted this information to come. Participants believed that students' main forms of sexual health information came from peers and social media but reported wanting the information to come from parents, school programs, or clinics. The participants said that their sexual health information came from personal experience, personal research, and health clinics, but they would have preferred their information to come from sexual education-specific training for teachers.

**Figure 18**

*Where Participants Believe Students Get Sexual Health Information*
Figure 19

*Where Participants Want Students to Get Sexual Health Information*

![Bar chart showing where participants want students to get sexual health information.](chart1.png)

Figure 20

*Where Participants Get Sexual Health Information*

![Bar chart showing where participants get sexual health information.](chart2.png)
Sex Knowledge Quiz

The survey ended with a sex knowledge quiz to assess educators’ understanding of sexual health related topics. This quiz used questions pulled from college level human sexuality class material. The test was meant to be difficult, however, the average participant score was only barely above passing with an average of 64% (range $score: 42$%-85%). Questions that were most commonly answered accurately included STIs and hormones. Frequently missed questions included topics about how birth control works and the stages of sexual response.
Discussion

Findings indicate that sex education teachers believe that sex education classes should include a wide variety of topics related to sexual health. Unfortunately, findings also show that many classes do not cover the topics that teachers say would be ideal. While many teachers indicate that controversial topics should be taught in classes, it is these topics, such as sexual orientation and sexuality as a natural part of human behavior, that are under-taught in South Dakota. Teachers use various methods of instruction to teach sexual education and refrain from using nicknames or cartoon drawings of genitalia. The majority of teachers did report that their programs were effective, but the curricula are outdated and need to be updated. This study also provides novel findings regarding 1st-5th grade sexual education and barriers specific to South Dakota which has been studied in previous research.

Sexual education topics were more widely covered in 9th-12th grade than in 1st-5th or 6th-8th. More time is spent on sexual education as age increases. This was consistent with previous research that sex education topics are more commonly required for high school students (Centers for Disease Control and Prevention, 2019). Programs begin separated by gender in 1st-5th grade but as age increases, classes move to co-ed. The data on 1st-5th grade classes mimicked a typical “development night” that often occurs one time in 4th or 5th grade. These programs often only cover the basics of puberty including anatomy, menstruation, good and bad touch, and other health-related concepts (P&G School Programs, n.d.). While the data is consistent with typical nationwide puberty talk programs, the data also suggests that it may be necessary to begin the conversation on some ideal topics such as sexual intercourse and pregnancy earlier on to make sure that all students get to hear the information before they need it.
Ideal topic inclusion was higher than what is currently being presented in classes across South Dakota on almost every topic. Previous research was done on topic inclusion by the CDC for all states including South Dakota. Not all topics from the CDC study perfectly matched up with topics in this study, but broader topic content could be matched between the studies to make a comparison (Centers for Disease Control and Prevention, 2019).

Overall, the pattern of topic inclusion shows that more 6th-8th grade classes in SD in this study include a wider range of topics than the sample population of the CDC study. Sixth through 8th grade classes reported on in this study had higher rates of topic inclusion in seven out of eight comparable CDC categories. Ninth through 12th grade, on the other hand, only had higher rates of inclusion in three out of eight comparable CDC categories. This could be due to the limited sample size (n=12) in this study compared to the large sample size (n= 169) in the CDC study. Also, this study was completed only by teachers and could have been perceived as “lower stakes” since it was not administered from a well-known government organization. The CDC study surveyed both principals and teachers. Principals may be less likely to know what is being taught in a sex education class and may be more inclined to answer in a way that portrays the school favorably. This could explain some of the differences in results between the two studies. The ideal topic inclusion from this study was also higher than the current topic inclusion from the CDC study, indicating that the current state of sex education in South Dakota is lacking the quality and content that teachers believe is necessary for the health and safety of students (Centers for Disease Control and Prevention, 2019).

Table 2
### Comparison of Percentage of Classes that Taught Specific Sex Education Topics in any Required Course

<table>
<thead>
<tr>
<th>Topic</th>
<th>CDC Grades 6, 7, or 8 in SD</th>
<th>Study Grades 6, 7, or 8 in SD</th>
<th>CDC Grades 9, 10, 11, or 12 in SD</th>
<th>Study Grades 9, 10, 11, or 12 in SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benefits of being sexually abstinence</td>
<td>28.9%</td>
<td>75%</td>
<td>77.3%</td>
<td>100%</td>
</tr>
<tr>
<td>How to access valid and reliable information, products, and services related to HIV, other STDs, and pregnancy</td>
<td>28.9%</td>
<td>50%</td>
<td>68.9%</td>
<td>28.6%</td>
</tr>
<tr>
<td>How to correctly use a condom</td>
<td>7.4%</td>
<td>25%</td>
<td>27.3%</td>
<td>0%</td>
</tr>
<tr>
<td>Methods of contraception other than condoms</td>
<td>15.7%</td>
<td>50%</td>
<td>55.2%</td>
<td>85.7%</td>
</tr>
<tr>
<td>How HIV and other STDs are transmitted</td>
<td>31.8%</td>
<td>100%</td>
<td>74.8%</td>
<td>100%</td>
</tr>
<tr>
<td>Health consequences of HIV, other STDs, and pregnancy</td>
<td>32.2%</td>
<td>75%</td>
<td>76.2%</td>
<td>57.1%</td>
</tr>
<tr>
<td>How to create and sustain healthy and respectful relationships</td>
<td>36.6%</td>
<td>50%</td>
<td>79.0%</td>
<td>57.1%</td>
</tr>
<tr>
<td>Sexual orientation</td>
<td>9.7%</td>
<td>0%</td>
<td>39.6%</td>
<td>14.2%</td>
</tr>
</tbody>
</table>

**Note.** This table compares the rate of topic inclusion between a previous CDC study and the current study in both 6th-8th grades and 9th-12th grades. Topic content was matched between the studies in order to make comparisons.


While overall topic inclusion is significantly lower than median topic inclusion in the US, South Dakota classes do cover particular topics in a majority of classes. The following topics...
were reported by teachers as being covered in more than 75% of classes: dangers of contraceptives (9th-12th), consequences of pregnancy (6th-8th), difficulties of being a parent (6th-8th), and contraception (9th-12th). These topics were included in 100% of classes: female sexual body parts (1st-5th), male sexual body parts (1st-5th), how male and female bodies differ (1st-5th), pregnancy and birth (6th-8th and 9th-12th), STIs and their consequences (6th-8th and 9th-12th), and abstinence (9th-12th). These topics constitute the basics of sex education, so it is promising that students are receiving the basic sex education knowledge. It is also interesting to note that the six topics that are taught in 100% of classes have little overlap with what was reported as an ideal topic to include in 100% of classes. Ideal topics that should be included in 100% of the class are STIs and their consequences, dangers of contraception, difficulties of raising a baby, abstinence, and contraception, sexual harassment, and sexual assault. The only topic that was reported to be taught in 100% of classes and should be taught in 100% of classes according to participants was STIs and their consequences. This suggests that class content and curricula in South Dakota should be altered so that educators can teach what they believe is necessary knowledge for students.

Some topics were rarely covered in classes. The following topics were included in 25% or less of classes: good touch and bad touch (6th-8th), loss of opportunity due to pregnancy (6th-8th), failure to follow religious values (6th-8th), dangers of abortion (6th-8th), pledging abstinence until marriage (6th-8th and 9th-12th), the importance of abstinence to religion (9th-12th), demonstration of contraception (6th-8th and 9th-12th), masturbation as normal behavior (6th-8th and 9th-12th), nocturnal emissions (6th-8th), stages of sexual response (6th-8th), sexual difficulties (6th-8th and 9th-12th), benefits of sex (6th-8th), sex is natural
(6th-8th and 9th-12th), sexual orientation (6th-8th and 9th-12th), tolerance of LGBTQA (6th-8th and 9th-12th), rejection of LGBTQA (6th-8th and 9th-12th). These results follow with the idea that less information is presented in 6th-8th grade sex education. However, this shows that there are a number of topics that are often left out of classroom content, but some of these topics, such as rejection of LGBTQA, are left out for the best.

Despite variety in ways to teach sex education, 80% of participants did report that they believe their sex education class to be effective. Of those who did not believe their programs are effective, common reasons include lack of information on dangerous situations, no information on good and bad touch past 5th grade, and schools skip the sex education part of the curriculum. These answers coincide with data from the survey as only half of the classes taught information on sexual harassment and assault and less than half of classes taught about good and bad touch past 5th grade. These topics should be considered for improvement as they are imperative to student safety. Also, 80% also reported that better curricula could be used. Suggestions for a better curriculum include up-to-date information with comprehensive information on contraceptive options and increased diversity. In addition, a majority of participants did report barriers to sexual education. These barriers included lack of training, governmental policies, and fear of community response which has also been reported in previous literature (Csincsak et al., 1994 and Eisenberg et al., 2013).

It is also worth noting that participants were accurate in identifying where students get their sexual health information. Participants listed peers, internet/social media, parents, and personal experience as the top sources of information. Other studies have listed parents, friends, and media as the main source of sexual health information for adolescents (Bleckley et al.,
Participants, however, indicated that they wanted their students to get their sex health knowledge from school sex education programs. With up-to-date curricula that covered all ideal topics, students may be less likely to look for other places for information.

Overall, the findings did show that participants performed poorly in the sex knowledge quiz at the end of the survey. While the questions were hard, teachers of sexual education should do better than a 64% average. The questions most commonly answered correctly were about STIs and hormones. This is in line with what educators report teaching as STIs and anatomy are commonly included topics. Despite contraception being frequently included in reported sex education classes, participants did not know how various types of birth control work to prevent pregnancy in the body. This may indicate that there is an emphasis on abstinence and that information presented about contraception is limited. The low average score points to the lack of preparation teachers receive before having to teach sex education. With a good portion of the teachers being physical education (or simply a different background not related to sexuality), it is improbable for them to have in-depth knowledge on human sexuality, let alone teach it. For many sex education teachers, human sexuality is not in their background. Some participants indicated that this lack of training was a barrier to teaching sex education. Lack of training has also been documented as a barrier in two research studies (Eisenberg et al., 2013 and Csincsak et al., 1994). A little over 25% of participants reported having specific sex education training, but more than 75% said they would want to have training, and 50% said they would like to participate in a college-level human sexuality course. Creating sex education training workshops or allowing sex educators to participate in college-level human sexuality courses would not only
better the education students receive but also make teachers more confident in the classroom and
decrease one of the main barriers to sex education in South Dakota.

Limitations

This study does have limitations. First and most importantly, this study had a small
sample size. With only twelve participants, these results can not be readily generalized to the
State of South Dakota. A possible solution to this problem could include sending the recruitment
email directly to health educators rather than relying on a principal to forward the email. By
removing the intermediary, the survey may have a better chance of ending up in a sex educator’s
inbox. The study could have also been incentivized to increase participation. A drawing for a gift
card or small reimbursement to each participant could increase the number of responses.
However, this may not increase the number of quality responses that could add its own set of
issues. It is also important to note that the survey was sent out at an inopportune time for most.
The survey was sent just before the COVID-19 pandemic began in the US. It is reasonable to
assume that educators were more focused on students' needs and shifting their classes online than
answering an online survey.

However, the small sample size could also illustrate a larger story. Over 500 emails were
sent out to principals across the state, yet only 24 participants responded and only twelve of these
responses contained usable data. That is a 2.4% response rate. While it may just be difficult to
reach the sample group, this could also indicate the lack of concern for sex education in South
Dakota in general.

Another explanation for the small sample size could be that teachers who actively teach
sex education in the classroom are more likely to fill out a survey about it than teachers who are
supposed to teach sex in and do not. If a teacher is proud of the work that they in their school they will want to report this information in a survey, however, teachers that do not fulfill this responsibility or teach at school that does not enable them to teach sex education would be less likely to respond. This may contribute to the higher rates of response from teachers who report teaching comprehensive sex education in South Dakota.

With any self-report measure, there is always a chance for self-report bias. In this study, the occurrence of self-report bias may be higher than normal due to the controversial nature of many of the topics. Also, participants may want to protect themselves or their schools and represent them in the best, albeit sometimes inaccurate, light possible. In an attempt to eliminate this bias, the participants were assured that they would remain completely anonymous.

**Recommendations for Further Research**

Future research will be necessary to validate the kind of conclusions that can be drawn from this study. A number of gaps remain in understanding the state of sex education in South Dakota. These topics would benefit from further research and extend the findings that have developed here:

1. A future study should aim for a larger sample size that is representative of all South Dakota schools. Special attention should be paid to rural versus urban schools as research indicates that sex education looks very different between these two places.

2. Exploration of sex education specifically on Native American Reservations is crucial to obtain a full picture of sex education in South Dakota. Knowing that there is an increased rate of assault on reservations and toward Native American women, it is important to
understand what sex education looks like there now. This could pave the way for changes to be made to better protect students on the reservations.

3. There should be a comparison between reports of students sex education experiences in South Dakota and what teachers reported in this study. Due to self-report bias, the participant's responses may not be entirely accurate, but comparing them to what students report occurred in their sex education classes would allow for a better look into what goes on in a typical classroom in South Dakota.

4. This study could also be replicated with parent perspectives. By surveying what parents of students in South Dakota believe should be included in a sex education program, we could gain a better understanding of what parents expect their children to learn in the classroom. If this research was implemented into curricula, we could reduce parent resistance to sex education programs and reduce the barriers that teachers feel from fear of community backlash.

5. It would also be helpful to identify what programs or workshops could be created to help teachers feel prepared to teach sex education. Workshops could be a way to promote excitement and confidence in sex educators as well as keep them updated on changes within the field. Increasing teachers' comfort with this material would not only benefit them but would also be passed directly to the students as well.

6. Finally, this research creates a base for a more in-depth look into how sex education classes are formatted in South Dakota. While data on the length of sex education classes, separation of gender within classes, a general type of class sex education is taught in was reported in this study, it did not provide an in-depth view into how these classes are
conducted. The demographics collected of sex education classes in South Dakota were largely surface level and would benefit from further investigation in additional research. In order to understand how best to change the status quo for the betterment of student experience, there needs to be an understanding of how the classes work now and what modifications can be made in the future. This study allowed us to see the content presented in class, further research should show how the class is taught and how the content is presented.

Conclusion

The results of this study show a large disparity between what is currently being taught in sex education classes in South Dakota and what educators believe should be taught. Barriers such as lack of training and clear direction prevent students from getting the education they need. This study presented novel information on barriers to sex education and a look into 1st-5th sex education in South Dakota. Understanding what an ideal program could look like and how to eliminate barriers is a crucial step forward in stopping the pattern of stagnation followed by crisis-prompted progress and improving the emotional and physical health of students in South Dakota.
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the United States.


Appendix

Section A: Demographics

Please answer these questions to the best of your ability. By definition, Sexual Education (Sex Ed) can include discussions about good touch-bad touch, puberty, sexual behaviors, pregnancy, contraception, STIs, and LGBTQ.

1. How many years have you been teaching in total (fill in your answer below)?
2. How many years have you been teaching sexual education (fill in your answer below)?
3. Race/ethnicity: Which of the following below pertain to you (check all that apply)?
   ___ White
   ___ Black or African-American
   ___ American Indian or Alaskan Native
   ___ Asian
   ___ Native Hawaiian or other Pacific Islander
   ___ From multiple races
   ___ Other (please specify)
4. What is your gender (check your answer)?
   ___ Female
   ___ Male
   ___ Nonbinary/Other
5. What is your education level (check your answer)?
   ___ Highschool/GED
   ___ Associates
   ___ Bachelors
   ___ Masters
   ___ Doctorate
6. What is your educational background in ie. college major or post secondary degrees (fill in your answer below)?
7. What state did you attend secondary education (fill in your answer)?
8. What is the size of the school that you teach at (fill in your answer below)?
9. What is the average class size that you teach (fill in your answer below)?

10. Would you classify your school as urban or rural (check your answer)?
   ___ Rural
   ___ Urban
   ___ Other

11. Is your school classified as public or private (check your answer)?
   ___ Public
   ___ Private

12. If private, Does the private school have a religious affiliation (fill in your answer below)?
   ___ Yes
   ___ No

13. If so, what is the religious affiliation (fill in your answer below)?

14. What type of school do you teach at (select all that apply)?
   ___ Elementary school
   ___ Middle School
   ___ Highschool

**Section B: General Information on Your School**

*Answer these questions to the best of your ability regarding sexual education in general at your school. By definition, Sexual Education (Sex Ed) can include discussions about good touch-bad touch, puberty, sexual behaviors, pregnancy, contraception, STIs, and LGBTQA. (If unsure please provide your best estimate.)*

15. Does your school provide any form of sexual education?
   ___ Yes
   ___ No

16. In which grades is sexual education provided at your school (check all that apply)?
   ___ K
   ___ 1
   ___ 2
   ___ 3
17. What grades do you provide sexual education for (select all that apply)?

___ K
___ 1
___ 2
___ 3
___ 4
___ 5
___ 6
___ 7
___ 8
___ 9
___ 10
___ 11
___ 12

18. Are you the sole sexual educator at your school (select your answer)?

___ Yes
___ No

19. What classes do you teach that include any form of sex ed (fill in your answer)?

20. What additional classes and extracurricular activities do you teach or coach (fill in your answer)?
Section C: Sexual Education in 1st-5th grade

Answer the following questions to the best of your ability regarding any sexual education classes you teach between 1st-5th grade. By definition, Sexual Education (Sex Ed) can include discussions about good touch-bad touch, puberty, sexual behaviors, pregnancy, contraception, STIs, and LGBTQA. (If unsure please provide your best estimate.)

21. Do you teach any sexual education or human development instruction during 1st grade through 5th grade (check your answer)?
   ___ Yes
   ___ No

22. What grades do you instruct in 1st grade through 5th grade (check all that apply)?
   ___ 1
   ___ 2
   ___ 3
   ___ 4
   ___ 5

23. How is your 1st - 5th grade Sex Ed program separated in regards to gender? (Check all that apply if you had several classes)
   ___ Boys and girls separately
   ___ Co-ed (girls and boys together)

24. Is the current sexual education curriculum that you use presented in a health education class?
   ___ Yes
   ___ No

25. If yes, what is the curriculum used(fill in your answer)?

26. Is the current sexual education curriculum that you use presented in a sexual education only class?
   ___ Yes
   ___ No

27. If yes, what is the curriculum used(fill in your answer)?
28. Is the current sexual education information presented in another class or program not previously mentioned?
   ___ Yes
   ___ No

29. If yes, which class and what curriculum or program do you use (fill in your answer)?

30. On average, how many total hours of sex ed instruction do your students receive per year? (Check one answer)
   ___ 1 hr or less
   ___ 2 hrs
   ___ 3 hrs
   ___ 4 hrs
   ___ 5-10 hrs
   ___ 10-20 hrs
   ___ 20 or more hours

31. Basics: (Check all that are taught)
   ___ Good touch, bad touch (stranger danger)
   ___ Female sexual body parts, puberty, menstruation
   ___ Male sexual body parts, puberty
   ___ How male and female bodies differ
   ___ Pregnancy, giving birth, how to care for a baby
   ___ What is sex, how babies are made, basic steps of sexual intercourse

32. Negative Consequences of Sex: (Check all that are discussed)
   ___ STI’s (sexually transmitted infections) and health consequences
   ___ Dangers, harm, and ineffectiveness of using condoms & contraceptives
   ___ Bad consequences of pregnancy, difficulties of childbirth
   ___ Difficulties of raising a baby, being a parent, costs of raising a child
   ___ Loss of reputation, being a bad person, loss of friends, parental disappointment
   ___ Loss of life opportunities, not going to school, not getting a good job
___ Failure to follow religious values
___ The dangers and immorality of abortion

33. Abstinence: (Check all that are taught)
___ Abstinence, reasons to abstain, how to abstain
___ Pledging abstinence until marriage
___ The importance of abstinence to religion

34. Contraception & Pregnancy prevention: (Check all that are taught)
___ Discussion of condoms/contraceptives and how they work
___ Actual demonstration of condoms, birth control devices
___ How to obtain and use contraceptives and condoms
___ Options if one gets pregnant (e.g., adoption, abortion)

35. Healthy and Unhealthy Relationships: (Check all that are taught)
___ Partner communication (how to talk about sex)
___ What is sexual consent and how to obtain it
___ What is sexual harassment
___ What is sexual assault
___ How to avoid being a victim of a sexual crime
___ How to avoid being the perpetrator of a sexual crime

36. Sexual Behaviors: (Check all that are taught)
___ Masturbation as normal behavior
___ Nocturnal emissions (wet dreams)
___ Stages of sexual response (e.g., orgasm)
___ Types of sex (oral, vaginal, anal)
___ Sexual difficulties such as premature ejaculation, inability to have orgasm
___ Benefits of sex for having a close relationship, as a part of growing up
___ That sex is natural, pleasurable behavior

37. Sexual Identity: (Check all that are taught)
___ Sexual orientation, gender identity (e.g., heterosexuality, LGBTQA, transsexuals)
38. Does your 1st - 5th grad Sex Ed program include any of the following? (Check all that happen)

___ Verbal presentation from speaker
___ Video or slide show
___ Realistic pictures of human genitals
___ Cartoons or drawings of human genitals
___ No pictures of human genitals
___ Use of correct medical terms for genitals and sexual behaviors
___ Use of indirect terms (e.g., nick names, slang, euphemisms) for genitals
___ In class interaction (icebreakers or games)
___ Role playing (taking care of a fake baby, acting out a skit)
___ Computer video games
___ Self guided Online education program
___ Other-- Please explain:

Section D: Sexual Education in 6th-8th grade

Answer the following questions to the best of your ability regarding any sexual education classes you teach between 1st-5th grade. By definition, Sexual Education (Sex Ed) can include discussions about good touch-bad touch, puberty, sexual behaviors, pregnancy, contraception, STIs, and LGBTQA. (If unsure please provide your best estimate.)

39. Do you provide any sexual education or human development instruction during 6th grade through 8th grade (check your answer)?

___ Yes
___ No

40. What grades do you instruct in 6th grade through 8th grade (check all that apply)?

___ 6th grade
___ 7th grade
41. How is your 6th - 8th grade Sex Ed program separated in regards to gender? (Check all that apply if you had several classes)
   ___ Boys and girls separately
   ___ Co-ed (girls and boys together)

42. Is the current sexual education curriculum that you use presented in a health education class?
   ___ Yes
   ___ No

43. If yes, what is the curriculum used (fill in your answer)?

44. Is the current sexual education curriculum that you use presented in a sexual education only class?
   ___ Yes
   ___ No

45. If yes, what is the curriculum used (fill in your answer)?

46. Is the current sexual education information presented in another class or program not previously mentioned?
   ___ Yes
   ___ No

47. If yes, which class and what curriculum or program do you use (fill in your answer)?

48. On average, how many total hours of sex ed instruction do your students receive per year? (Check one answer)
   ___ 1 hr or less
   ___ 2 hrs
   ___ 3 hrs
   ___ 4 hrs
   ___ 5-10 hrs
   ___ 10-20 hrs
   ___ 20 or more hours
49. Basics: (Check all that are taught)

___ Good touch, bad touch (stranger danger)
___ Female sexual body parts, puberty, menstruation
___ Male sexual body parts, puberty
___ How male and female bodies differ
___ Pregnancy, giving birth, how to care for a baby
___ What is sex, how babies are made, basic steps of sexual intercourse

50. Negative Consequences of Sex: (Check all that are discussed)

___ STI’s (sexually transmitted infections) and health consequences
___ Dangers, harm, and ineffectiveness of using condoms & contraceptives
___ Bad consequences of pregnancy, difficulties of childbirth
___ Difficulties of raising a baby, being a parent, costs of raising a child
___ Loss of reputation, being a bad person, loss of friends, parental disappointment
___ Loss of life opportunities, not going to school, not getting a good job
___ Failure to follow religious values
___ The dangers and immorality of abortion

51. Abstinence: (Check all that are taught)

___ Abstinence, reasons to abstain, how to abstain
___ Pledging abstinence until marriage
___ The importance of abstinence to religion

52. Contraception & Pregnancy prevention: (Check all that are taught)

___ Discussion of condoms/contraceptives and how they work
___ Actual demonstration of condoms, birth control devices
___ How to obtain and use contraceptives and condoms
___ Options if one gets pregnant (e.g., adoption, abortion)

53. Healthy and Unhealthy Relationships: (Check all that are taught)

___ Partner communication (how to talk about sex)
___ What is sexual consent and how to obtain it
___ What is sexual harassment
___ What is sexual assault
___ How to avoid being a victim of a sexual crime
___ How to avoid being the perpetrator of a sexual crime

54. Sexual Behaviors: (Check all that are taught)
___ Masturbation as normal behavior
___ Nocturnal emissions (wet dreams)
___ Stages of sexual response (e.g., orgasm)
___ Types of sex (oral, vaginal, anal)
___ Sexual difficulties such as premature ejaculation, inability to have orgasm
___ Benefits of sex for having a close relationship, as a part of growing up
___ That sex is natural, pleasurable behavior

55. Sexual Identity: (Check all that are taught)
___ Sexual orientation, gender identity (e.g., heterosexuality, LGBTQA, transsexuals)
___ Tolerance of LGBTQA emphasized
___ Rejection of LGBTQA emphasized

56. Does your 6th - 8th grade Sex Ed program include any of the following? (Check all that happen)
___ Verbal presentation from speaker
___ Video or slide show
___ Realistic pictures of human genitals
___ Cartoons or drawings of human genitals
___ No pictures of human genitals
___ Use of correct medical terms for genitals and sexual behaviors
___ Use of indirect terms (e.g., nicknames, slang, euphemisms) for genitals & sexual behaviors
___ In class interaction (icebreakers or games)
___ Role playing (taking care of a fake baby, acting out a skit)
Section E: Sex Education in 9th-12th Grade Section

Answer the following questions to the best of your ability regarding any sexual education classes you teach between 1st-5th grade. By definition, Sexual Education (Sex Ed) can include discussions about good touch-bad touch, puberty, sexual behaviors, pregnancy, contraception, STIs, and LGBTQ. (If unsure please provide your best estimate.)

57. Do you provide any sexual education or human development instruction during 9th grade through 12th grade (check your answer)?

___ Yes
___ No

58. What grades do you instruct in 9th grade through 12th grade (check all that apply)?

___ 9th grade
___ 10th grade
___ 11th grade
___ 12th grade

59. How is your 9th-12th grade Sex Ed program separated in regards to gender? (Check all that apply if you had several classes)

___ Boys and girls separately
___ Co-ed (girls and boys together)

60. Is the current sexual education curriculum that you use presented in a health education class?

___ Yes
___ No

61. If yes, what is the curriculum used (fill in your answer)?

62. Is the current sexual education curriculum that you use presented in a sexual education only class?

___ Yes
63. If yes, what is the curriculum used (fill in your answer)?

64. Is the current sexual education information presented in another class or program not previously mentioned?

   ___ Yes
   ___ No

65. If yes, which class and what curriculum or program do you use (fill in your answer)?

66. On average, how many total hours of sex ed instruction do your students receive per year? (Check one answer)

   ___ 1 hr or less
   ___ 2 hrs
   ___ 3 hrs
   ___ 4 hrs
   ___ 5-10 hrs
   ___ 10-20 hrs
   ___ 20 or more hours

67. Basics: (Check all that are taught)

   ___ Good touch, bad touch (stranger danger)
   ___ Female sexual body parts, puberty, menstruation
   ___ Male sexual body parts, puberty
   ___ How male and female bodies differ
   ___ Pregnancy, giving birth, how to care for a baby
   ___ What is sex, how babies are made, basic steps of sexual intercourse

68. Negative Consequences of Sex: (Check all that are discussed)

   ___ STI’s (sexually transmitted infections) and health consequences
   ___ Dangers, harm, and ineffectiveness of using condoms & contraceptives
   ___ Bad consequences of pregnancy, difficulties of childbirth
   ___ Difficulties of raising a baby, being a parent, costs of raising a child)
___ Loss of reputation, being a bad person, loss of friends, parental disappointment
___ Loss of life opportunities, not going to school, not getting a good job
___ Failure to follow religious values
___ The dangers and immorality of abortion

69. Abstinence: (Check all that are taught)
___ Abstinence, reasons to abstain, how to abstain
___ Pledging abstinence until marriage
___ The importance of abstinence to religion

70. Contraception & Pregnancy prevention: (Check all that are taught)
___ Discussion of condoms/contraceptives and how they work
___ Actual demonstration of condoms, birth control devices
___ How to obtain and use contraceptives and condoms
___ Options if one gets pregnant (e.g., adoption, abortion)

71. Healthy and Unhealthy Relationships: (Check all that are taught)
___ Partner communication (how to talk about sex)
___ What is sexual consent and how to obtain it
___ What is sexual harassment
___ What is sexual assault
___ How to avoid being a victim of a sexual crime
___ How to avoid being the perpetrator of a sexual crime

72. Sexual Behaviors: (Check all that are taught)
___ Masturbation as normal behavior
___ Nocturnal emissions (wet dreams)
___ Stages of sexual response (e.g., orgasm)
___ Types of sex (oral, vaginal, anal)
___ Sexual difficulties such as premature ejaculation, inability to have orgasm
___ Benefits of sex for having a close relationship, as a part of growing up
___ That sex is natural, pleasurable behavior
73. Sexual Identity: (Check all that are taught)

___ Sexual orientation, gender identity (e.g., heterosexuality, LGBTQ, transsexuals)

___ Tolerance of LGBTQA emphasized
___ Rejection of LGBTQA emphasized

74. Does your 9th-12th grade Sex Ed program include any of the following? (Check all that happen)

___ Verbal presentation from speaker
___ Video or slide show
___ Realistic pictures of human genitals
___ Cartoons or drawings of human genitals
___ No pictures of human genitals
___ Use of correct medical terms for genitals and sexual behaviors
___ Use of indirect terms (e.g., nick names, slang, euphemisms) for genitals & sexual behaviors
___ In class interaction (icebreakers or games)
___ Role playing (taking care of a fake baby, acting out a skit)
___ Computer video games
___ Self guided Online education program
___ Other-- Please explain:

Section F: Program Reflection

75. Overall, what is the best aspect about your sexual education course (fill in your answer below)?

76. Overall, what is the worst aspect about your sexual education course (fill in your answer below)?

77. Do you believe that your current sexual education program is effective?

___ Yes
___ No

78. If not, what would make it effective?
79. Do you think that there are barriers to sexual education in SD?
   ___Yes
   ___No
80. If yes, what are the barriers?
81. Do you think that current curriculums used are the best options for the students?
   ___Yes
   ___No
82. If no, do you think that there are current curriculums that would fulfill the needs of sexual education in South Dakota or should a new one be created?
   **Section G: Your Plan for the Ideal Sex Ed Program**
83. In your opinion, what would be the best year or years in school to teach Sex Ed? (Check all that apply)
   ___ K
   ___ 1
   ___ 2
   ___ 3
   ___ 4
   ___ 5
   ___ 6
   ___ 7
   ___ 8
   ___ 9
   ___ 10
   ___ 11
   ___ 12

*If you could plan an IDEAL School Sex Ed Program, what would be the most important topics to discuss?*
84. Basics: (Check all that are taught)
   ___ Good touch, bad touch (stranger danger)
___ Female sexual body parts, puberty, menstruation
___ Male sexual body parts, puberty
___ How male and female bodies differ
___ Pregnancy, giving birth, how to care for a baby
___ What is sex, how babies are made, basic steps of sexual intercourse

85. Negative Consequences of Sex: (Check all that are discussed)
___ STI’s (sexually transmitted infections) and health consequences
___ Dangers, harm, and ineffectiveness of using condoms & contraceptives
___ Bad consequences of pregnancy, difficulties of childbirth
___ Difficulties of raising a baby, being a parent, costs of raising a child
___ Loss of reputation, being a bad person, loss of friends, parental
disappointment
___ Loss of life opportunities, not going to school, not getting a good job
___ Failure to follow religious values
___ The dangers and immorality of abortion

86. Abstinence: (Check all that are taught)
___ Abstinence, reasons to abstain, how to abstain
___ Pledging abstinence until marriage
___ The importance of abstinence to religion

87. Contraception & Pregnancy prevention: (Check all that are taught)
___ Discussion of condoms/contraceptives and how they work
___ Actual demonstration of condoms, birth control devices
___ How to obtain and use contraceptives and condoms
___ Options if one gets pregnant (e.g., adoption, abortion)

88. Healthy and Unhealthy Relationships: (Check all that are taught)
___ Partner communication (how to talk about sex)
___ What is sexual consent and how to obtain it
___ What is sexual harassment
___ What is sexual assault
How to avoid being a victim of a sexual crime
How to avoid being the perpetrator of a sexual crime

89. Sexual Behaviors: (Check all that are taught)

- Masturbation as normal behavior
- Nocturnal emissions (wet dreams)
- Stages of sexual response (e.g., orgasm)
- Types of sex (oral, vaginal, anal)
- Sexual difficulties such as premature ejaculation, inability to have orgasm
- Benefits of sex for having a close relationship, as a part of growing up
- That sex is natural, pleasurable behavior

90. Sexual Identity: (Check all that are taught)

- Sexual orientation, gender identity (e.g., heterosexuality, LGBTQA, transsexuals)
- Tolerance of LGBTQA emphasized
- Rejection of LGBTQA emphasized

91. From the list below, check ONLY the topics you consider to be ESSENTIAL for your ideal Sex Ed course:

- Basics – (e.g., stranger danger, sexual body parts, puberty)
- Sexually Transmitted Infections (STIs)
- Negative consequences of unplanned pregnancy & raising a child & loss of opportunities
- Negative consequences of loss of reputation, parental disappointment, low morality
- Abstinence, religious views on sexuality
- Contraception – condoms and contraceptives
- Healthy and unhealthy sexual relationships (e.g., obtaining consent)
- Sexual behaviors (e.g., masturbation, oral, vaginal, anal sex, sexual response)
- Sexual identity (sexual orientation & gender identity - LGBTQA)

92. Who would teach your IDEAL School Sex Ed program? (Check all that apply)
___ Health teacher
___ Physical Education (P.E.) teacher, coach
___ General teacher
___ Guest Speaker
___ Guidance Counselor
___ Older students, College students
___ Medical expert
___ Religious leader
___ Parent
___ Other-- Please explain.

93. Which of the following would you include in your ideal Sex Ed program? (Check all that you would like to happen)

___ Verbal presentation from speaker
___ Video or slide show
___ Realistic pictures of human genitals
___ Cartoons or drawings of human genitals
___ No pictures of human genitals
___ Use of correct medical terms for genitals and sexual behaviors
___ Use of indirect terms (e.g., nick names, slang, euphemisms) for genitals &sexual behaviors
___ In class interaction (icebreakers or games)
___ Role playing (taking care of a fake baby, acting out a skit)
___ Computer video games
___ Self guided Online education program
___ Other-- Please explain:

94. How would you set up your Ideal Sex Ed program timewise? (Check all that apply).

___ Taught at least once a year in a class period or special program
___ Taught at least once a semester in a class or special program
___ Taught as part of a class (e.g., health) over several months each year
95. How many total hours would be involved in your ideal Sex Ed program? (Check all that apply)

___ 1 hr or less
___ 2 hrs
___ 3 hrs
___ 4 hrs
___ 5-10 hrs
___ 10-20 hrs
___ 20 or more hours

Section H: Your Students’ Knowledge about Sexuality

96. Check all of the following sources that you believe contribute SIGNIFICANTLY to your students knowledge of sexuality today:

___ Personal experience
___ Parents
___ Siblings, same-age relatives
___ Peers, friends
___ Social media, Internet
___ Mainstream media-- television, magazines
___ School sex ed program 1st – 12th grade
___ Information obtained in a clinic, pharmacy, or medical setting
___ College level courses that covered sexuality
___ Pornography

97. Of all of these sources, what are your TOP THREE CHOICES for where you would like your students to receive knowledge of sexuality? (Check ONLY THREE!)

___ Personal experience
___ Parents
___ Siblings, same-age relatives
___ Peers, friends
Section I: Your Own Knowledge about Sexuality

98. Check all of the following sources that have contributed SIGNIFICANTLY to your knowledge of sexuality that you hold today:

___ Personal experience
___ Parents
___ Siblings, same-age relatives
___ Peers, friends
___ Social media, Internet
___ Mainstream media-- television, magazines
___ School sex ed program 1st – 12th grade
___ Information obtained in a clinic, pharmacy, or medical setting
___ College level courses that covered sexuality
___ Pornography

99. Of all of these sources, what are your TOP THREE CHOICES for where you would like to receive your knowledge of sexuality? (Check ONLY THREE!)

___ Personal experience
___ Parents
___ Siblings, same-age relatives
___ Peers, friends
___ Social media, Internet
___ Mainstream media-- television, magazines
___ School sex ed program 1st – 12th grade
___ Information obtained in a clinic, pharmacy, or medical setting
College level courses that covered sexuality
Pornography

100. How many college-level courses have you had that have covered some substantial aspect of sexuality? Give a number from 0 - ?

Section J: KNOWLEDGE OF SEXUALITY

The following is a quiz on knowledge of various sexuality issues. The questions in this quiz are taken from an upper level college sexuality course. That being said, these questions are hard. We do not expect anyone to get them all right. The number that you get right does not reflect your quality of teaching and your answers can not be linked back to you. PLEASE DO NOT LOOK UP THE ANSWERS on-line as we need to assess how much typical sex educators know!

101. What Sexually Transmitted Infection (STI) is most common in the USD/Sioux Falls region area?
   a. Chlamydia
   b. Gonorrhea
   c. Syphilis
   d. Human Papillomavirus (HPV)

102. Adolescent girls and boys can be vaccinated to help prevent:
   a. Chlamydia
   b. Gonorrhea
   c. Syphilis
   d. Human Papillomavirus (HPV)

103. The medical treatment for Chlamydia is:
   a. Antibiotics
   b. Antiviral medication
   c. Cauterization or freezing of infected area
   d. There is no effective cure at this time.

104. What STI is most closely related to cancer of the cervix in females?
   a. Chlamydia
   b. Gonorrhea
c. Syphilis

d. Human Papillomavirus (HPV)

105. Herpes can be transmitted to a sexual partner even if the person who has Herpes is currently showing no signs of the infection.
   a. True
   b. False

106. What contraceptive is considered to be the MOST effective in preventing pregnancy?
   a. Variations of the Pill (pill, patch, nuvaring)
   b. IUD (intrauterine device)
   c. Condom
   d. Diaphragm

107. What contraceptive, if used quickly, can serve as Emergency Contraception if, for example, a condom breaks?
   a. Applying a spermicide
   b. Having Norplant inserted in the arm
   c. Having a certain kind of IUD inserted
   d. Quickly getting a Depo Provera injection

108. How does taking the Pill prevent pregnancy?
   a. It prevents implantation of a fertilized egg.
   b. Antiviral medication
   c. It prevents ovulation of an egg.
   d. It kills or inhibits sperm in the uterus.

109. How does using an IUD prevent pregnancy?
   a. It prevents implantation of a fertilized egg.
   b. Antiviral medication
   c. It prevents ovulation of an egg.
   d. It kills or inhibits sperm in the uterus.

110. Which one is NOT a natural family planning method?
   a. Basal body temperature
b. Cervical mucus method
c. Vaginal-Cervix ratio method
d. The calendar method

111. Which one is NOT a part of the female reproductive organs?
   a. Cowper’s gland
   b. Mons pubis
   c. Introitus
   d. Skene’s gland

112. Which one is NOT part of the male reproductive organs?
   a. Epididymis
   b. Vas deferens
   c. Seminal vesicle
   d. Iridium

113. Which one is NOT one of the stages of sexual response?
   a. Plateau
   b. Climax - orgasm
   c. Excitement
   d. Residual

114. Which hormone is associated with cuddling and bonding during sexual interactions?
   a. Progesterone
   b. Oxytocin
   c. Vasopressin
   d. Testosterone

115. Most experts agree that sexual orientation (being straight, gay, or lesbian) is strongly related to biological causes.
   a. True
   b. False

THE END. THANK YOU VERY MUCH!