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Public Sex Education and the State's Potential to Cultivate Sexually Healthy Adolescents through Evaluation

by

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"…the parents who have the courage, intelligence, and tact to explain the sex organs and functions to their children are so rare that its needs must fall on the school system to convey this info."

Dr. Ella Flagg Young, the first woman president of the National Education Association and the first woman to head a big city school system[1]

The sex education infrastructure of today's U.S. public schools was developed on themes and ideologies that are exclusive, filled with health and wellness inaccuracies, and reliant on discrete limited outcomes of pregnancy and sexually transmitted diseases and infections. Abstinence-Only-Until-Marriage Education (AOUME) uses fears of pregnancy and disease to teach "healthy practices". This paper is written in favor of turning school systems toward practices that incorporate a social justice component paired with healthy discourse on a wider range of topics and well-established medically-accurate truths. Systemic collaborative change must aim to uproot the nation's entrenched history in AOUME to address the present gap in policy attentiveness toward important sexual health and wellness outcomes associated with sex education in U.S. public schools. Monitoring and evaluation practices must also reflect progressive holistic sex education practices and expand past one-dimensional indicators.

[1] Jensen, 52.

I. INTRODUCTION

When a public good has the potential to prevent harm and risk, public school systems are a clear vehicle for educating not only youth, but communities as well. However, the mere mention of sexual health and wellness is accompanied by an overwhelming stigma and public avoidance. Thus, public health messages are lost in politics and individual moralities. While the reproductive justice movement in sexuality education, or sex education for short, has made clear strides in favor of holistic programs and practices, the U.S.' policy entrenchment in Abstinence-Only-Until-Marriage Education (AOUME) remains a barrier. This project seeks to examine the current nature and needs of sex education in U.S. public schools while asking why there is a gap in the dissemination of information even when good policy is in place. Following a study on the current status and consequences of present mandates, this project questions if standardized mandates at the state or federal level can overcome the variation in sex education today; and, what are the current oppositions to holistic sex education? Through a cross-sectional analysis, these guiding questions will provide a framework to understand the current variation in sex education policy stories present in the U.S. and contribute to associated works seeking a solution to harmful deep-rooted public-school policy.

These questions arise because much of the literature following the onset of federal AOUME revolved around pregnancy as the main sexual health consequence and outcome. Because school curriculum design is a responsibility of the state and its localities, intervention from the federal government is rare. However, federal regulation has occurred with the Family Educational Rights and Privacy Act (FERPA), the Elementary and Secondary Education Act of 1965 (ESEA), and the Individuals with Disabilities Education Act (IDEA), among other acts. Consequently, the framework for sex education is still left to state or local decision makers and

as such there are large gaps in ways school education systems address many pressing consequences of failing sex education. Comprehensive sex education is a direct policy solution to youth sexual violence and risky sexual behavior. Truly comprehensive, or holistic, sex education is defined by the Federal Center for Health Education and the International Planned Parenthood Federation European Network to mean, "

> "learning about the cognitive emotional, social, interactive, and physical aspects of sexuality. Sex education starts early in childhood and progresses through adolescence and adulthood. It aims at supporting and protecting sexual development. It gradually equips and empowers children and young people with information, skills and positive values to understand and enjoy their sexuality, have safe and fulfilling relationships, and take responsibility for their own and other people's sexual health and well-being."[2]

Because a variety of sexual health professionals and educators have dedicated their resources to developing exactly what holistic sex education programs require, the purpose of this project is not to define the preferred pedagogical choices and messaging. While the prevalence of adult sexual violence has approached the forefront of media attention, very little coverage has paid mind to the ways policy can actually provide systemic change.

Laura Lindberg, a Principal Research Scientist at the Guttmacher Institute, posed the question, "Is it time to close the books on sex education in the United States?" with a follow-up mentioning that federal policy is not up to par and there are even gaps in the dissemination of education in states with holistic sex education mandates. Lindberg asks if policy is enough to make an impactful presence in public school sex education, or do non-governmental educators need to take a leading role. This thesis aims to demonstrate current policy may not be meeting the standards of holistic sex education, but genuine policy change must be the goal. Organizational efforts are empowered by numbers and funding, but these resources would be for

[2] Everett Ketting and Olena Ivanova, *Sexuality Education in Europe and Central Asia: State of the Art and Recent Developments,* International Planned Parenthood Federation European Network/Federal Center for Health Education, (Cologne, Germany, December 2017).

naught, if not targeting systemic legislative change. While sex education policy has the added obstruction of religion, tabooed subjects, and societal discomfort, local efforts can mount to nation-wide realizations. This type of bottom-up change may be the greatest advantage in providing the greatest of resources to a future of sexually healthy and informed youth.

The argument of this project is driven by a two-sided approach using both an overarching state-based study and state case studies to illustrate what programs encompass. The cross-sectional report hypothesized an association between public school mandates and associated youth health and wellness outcomes. The analyses did not conclusively find youth violence—dating, sexual, and physical— and risky behaviors, such as absence of contraception usage and use of drugs or alcohol prior to intercourse, avoidable through comprehensive sex education mandates. The nation-wide models of state mandates and associated concerns examined health systems and education funding as possible confounders. Additionally, Texas, Virginia, Colorado, and California state policy frameworks are studied to provide a localized picture of how communities and policy makers maneuver the institutions in place. While some states choose to further cement AOUME or "just say NO" programs in public schools, other states have angled toward healthy systemic changes. This multi-faceted method exemplifies the difficulty addressing school program disparities and reveals why overarching systemic policy can be the only solution to undo the harmful—and discriminatory—tradition of many sex education programs of the present.

This paper begins by explaining how sex education has been framed and implemented in formal school systems through a history of the Progressive era, the Intermediate era, the Sexual Revolution, and the Modern era of sex education programs. This timeline spans the late 19th century to President Barack Obama's aim to eliminate AOUME funding in the 2010 Federal

Budget. Second, the cases of Texas, Virginia, Colorado, and California present the patchwork variation in sexuality education across the United States and have each introduced largely disputed policies across the spectrum of progress and regress. The disparities present in each story explain the obstacles of state-wide initiatives, but they are instrumental in demonstrating that nation-wide advancement is possible. Following the state-based policy stories cases, the project turns to an empirical analysis of state mandates and outcomes. The cross-sectional study will introduce a series of models relating current state sex education mandates and outcomes of youth risky behavior and sexual violence. Much of the literature relating sex education to associated risks fail to address youth sexual violence as a valid consequence of inadequate programming. The study of these specific outcomes will proceed in the hopes of highlighting the severity and prevalence of this youth-oriented issue. The final section will conclude this project with anticipation for a collaborative solution. This project will conclude with a call for standardization alongside an understanding that uprooting entire belief systems is the greatest challenge to U.S. political acceptance comprehensive holistic sex education.

II. DERIVING THE NEED FOR HOLISTIC SEXUALITY EDUCATION

Before 1880, young students were expected to learn about reproduction through the home and observation in nature. As much of the American population resided in agrarian environments, breeding the family's livestock might have served as the only demonstrations of sexuality for adolescents. Many children were taught from home, and virtually all schooling materials incorporated Christian morality and theology. While McGuffey Readers[3] were a

[3] McGuffey Readers, formally titled *McGuffey's Eclectic Readers*, were the closest resource the U.S. could consider a nationally standardized textbook for elementary-aged schoolchildren. The Readers reflected the morality of the early 1800s but also molded communities the teaching of the English language.

starting point for standardization in American literacy learning, little else in teacher pedagogy carried over from classroom to classroom across states.[4] Students experienced large variations in the quality of education due to differing learning environments and class sizes. Wide-spread stigmas restricted any sort of dialogue on sex education in public institutions, but the introduction of the Comstock Laws and social movements in tandem introduced sexuality education as a possibility. The following sections introduce the social contexts in which sex education movements emerged which are invaluable to the discussion on future policy decision-making.

i. Introducing Public Sex Ed in the Progressive Era (1880-1919)

The decades leading into the 20th century signaled a shift in how all subjects of education were delivered to students. Progressive era philosophies of childhood development intersected with the new learning environments in a variety of disciplines. The building of public discourse on sex education beginning over a century ago shares commonalities with today's contention in that partisan framing, application of language, lack of consideration to those most vulnerable, morality, and conflict between health science and sexuality are apparent. Because principles of morality were widely applied within this era, much of the contention between groups is ironic, according to Robin E. Jensen.[5] This section outlines three movements within the Progressive Era crucial to understanding how public sex education has emerged in today's political educational scheme and underlines how ambiguous language, censorship, ideologues of purity, and emphasis of abstinence participated. Social-hygienists, social-purists, and early justice reformers, alike led

[4] Valerie J. Huber and Michael W. Firman, "A History of Sex Education in the United States since 1900," *International Journal of Educational Reform* 23, no. 1 (2014).
[5] Robin E. Jensen. *Dirty Words: The Rhetoric of Public Sex Education, 1870-1924*, (Urbana, IL: University of Illinois Press, 2010).

diverging movements during the Progressive Era, with punctuated interaction and inflamed dialogue.

It is often the case that popular activists of the past are venerated for their contributions regardless of whether or not their interests conflict with social progressive movements of the day. As in the circumstance of Dr. Prince A. Morrow, who coined the term "social-hygiene" as a more digestible name for sexual health, social hygienists during the Progressive Era advanced chastity as a method for cleansing society. Morrow framed public sex education under this movement to appeal to eugenics politics, and his collective often worked under the guise of 'social purists'. He centered his vision sharing that sexual-hygiene would demystify sex and enforce chastity outside of marriage—recognizing extra-marital affairs as moral flaws. Although Morrow was not the first to advance concepts of reproductive biology, germ theory, and human physiology, he is identified as the founder of the Social-Hygiene movement and acknowledged for stimulating a wave of public school sex education.[6] Proponents of morality politics joined Morrow and other physicians in a newly perceived knowledge-based support network and entered the discussions on school-based sex education. Morrow's intervention rhetoric included the social and ethical aspects to sex education programs along with the physical aspect. With the common education materials simply outlining STD and venereal disease prevention, Morrow was adamant that the public's ignorance caused heightened prevalence. His programs depicted prostitution as a social ill and a moral evil and called for a social cleansing of sorts.[7] The medical framing of healing "moral evils"[8] of ignorance and sexual prowess allowed the social hygiene

[6] Jensen, 1-3.
[7] Huber and Firman, *International Journal of Educational Reform*.
[8] Huber and Firman, *International Journal of Educational Reform*.

movement to participate in governmental interventions in disseminating or restricting sex education.

Anthony Comstock, a noted vice reformer promoting the uncontaminated purity and innocence of children, built a following by employing social powers within racialized hierarchies.[9] Comstock and his company of social purists aimed to 1) eliminate the sexual double standard, stating that women were just as vulnerable as men in succumbing to sexual desire, 2) provide purity education, and 3) abolish prostitution. The social purist movement associated sexual indulgence with immigrant populations and the working class and gained substantial traction through the Women's Christian Temperance Union (WCTU) and more generally white, upper-class, women.[10] Comstock convinced local, state, and federal governments that public discourse on sex corrupted children, and in 1874 the federal Comstock Law was passed—formally named the Act for the Suppression of Trade in, and Circulation of, Obscene Literature and Articles of Immoral Use. Comstock Law prohibited the distribution of pornographic or sexually informative materials from mailing. Birth control information and devices also fell into this category of materials too lewd and/or obscene to be mailed.[11] Meanwhile, 24 states passed variant versions of Comstock Laws. Comstock utilized a pronounced double standard, as Nicola Beisel stated[12], and preserved social institutions of white power through convictions over 3,800 individuals who broke censorship boundaries. For those doctors who served the most elite of society, Comstock refrained from reporting family planning or contraceptive referrals while targeting those doctors who provided the same services to lower income individuals. Elusive

[9] Jensen, 5.
[10] Jensen, 13.
[11] Huber and Firman, *International Journal of Educational Reform*.
[12] Timothy J. Gilfoyle, "Nicola Beisel. Imperiled Innocents: Anthony Comstock and Family Reproduction in Victorian America, *The American Historical Review* 103, no. 2 (April 1, 1998): 610-611.

language supported his systemic arrests of immigrants, the poor, midwives, and "alternative doctors".[13]

Sanger supporters and Comstock Law

Margaret Sanger, a main protagonist in the birth control movement and health justice reformer, was forcibly arrested due to Comstock's interjection. With deep sympathy for working-class women who couldn't control their fertility status, Sanger pursued a solution for women stuck in a cycle of pregnancy under constrained resources. She worked to include working-class women in conversations of sex-education where Comstock aimed to discount the experiences of those outside the elite class. Sanger established the first birth control clinic and widely advocated for contraceptive devices. Identified as the founder of the modern birth control movement, Sanger wrote sexual abuse and venereal diseases will "exist until women rise in one big sisterhood to fight this capitalist society which compels a woman to serve as a sex implement for a man's use. Education is necessary—education is the need of the people."[14] in her book *What a Girl Should Know.*[15] Comstock became aggressive in his censorship tactics angled at Sanger, and she responded with "plain sexual talk" where she used specific, concise rhetoric in her teaching. Sanger was dissatisfied with the status quo where well-financed women could publicly seek sexual instruction and contraception, while lower-income women would be forced into illegal abortions if no other option existed. In an outrage, Sanger once exclaimed: "

> Comstockery must die! Education on the means to prevent conception and the publicity of Comstock's actions is the surest weapon to strike the blow. When people have the knowledge to prevent conceptions then the law becomes useless and falls away like the dead skins of a snake."[16]

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[13] Jensen, 6.
[14] Margaret Sanger, *What Every Girl Should Know*, 67th ed. (New York: Max N. Maisel, 1916), 91.
[15] Sanger even included, "To the working girls of the world this little book is lovingly dedicated," in *What Every Girl Should Know.*
[16] Jensen, 31.

Sanger and birth control proponents criticized Comstock's approach of maintaining elitist control over sex education discussions by exempting regular doctors and elite clients from legal censure while punishing the working class.

Sanger and Maurice Parmalee, a noted author, sociologist, and soon-to-be member of Franklin D. Roosevelt's administration, argued for disbanding the view that sexual activity should not be for enjoyment. While Sanger promoted reproductive and sexual freedoms for women, both sought to eliminate the double standard of sex before marriage as an illicit activity for both men and women. Parmelee was an advocate for children learning all facets of sex and for sexual decision-making to be the responsibility of both adult partners in marital affairs.[17] The public neared complacency with granting sexual freedoms to men. But, Sanger and Parmalee demanded a similar allowance to women; men could express and satisfy their "needs," whereas a woman would become blacklisted—or even sick or pregnant—if she were to do the same. Altogether, the majority of challengers disapproved of premarital sex altogether. As the contention between equality and justice groups supported contraceptives, the opposition founded in traditional moralities looked to chastity. The traditional view held contraception as immoral and asserted restraints in desire to control behavior but also protect women in their communities from social consequences and all-too-physical ills. Comstock challenged Sanger and Parmalee as incompetent and unfounded while both the social-purist and social-hygiene movements capitalized on ambiguous language to persuade.[18]

The Young Men's Christian Association (YMCA), who began funding Comstock's censorship efforts in 1873, eventually began sponsoring sex education presentations under the supervision of the American Social Hygiene Association (ASHA). John D. Rockefeller

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[17] Huber and Firman, *International Journal of Educational Reform*.
[18] Jensen, 16.

established a partnership of social-hygienists and social-purists under the ASHA, who then began endorsing blood-testing before marriage, compulsory venereal disease reporting by physicians, and mandatory courses in schools, churches and organizations. Through the early 1900s, the newly instated ASHA took advantage of drastically increasing public school enrollment to organize and implement chastity education. Almost simultaneously, Dr. Ella Flagg Young observed the need for inclusive sex education programming incorporated into health education in public school systems and pursued a path toward growing self-sufficient youth.

Introducing Sex Ed in Public Schools

20,000 high school students in Chicago Public Schools (CPS) completed the first public-school sponsored sex education program in 1913. Dr. Ella Flagg Young, the first female CPS superintendent, elected president of the Illinois State Teacher's Association, and then-President of the National Education Association, used her platforms to advance public sex education through three prominent conversations: 1) a philosophy of education interlacing learning and citizenship ideals, 2) integrity of scientific discovery, and 3) importance of physical fitness and relationship to educational growth. Additional advantage came with Flagg Young's use of framing and appeals to parents and her CPS Board of Education. Initially parents were wary of inexperienced teachers who often rotated and weren't able to develop relationships with their students. But, Flagg Young alleviated this concern by checking in with students and delivering some of the lectures herself.[19] In granting parents an improved understanding of the health topics and delivery their students would receive, Flagg Young brought the CPS Board to appreciate the demand that she perceived.

[19] Smith, Joan Karen, "Ella Flagg Young: portrait of a leader," *Iowa State University Digital Repository: Retrospective Theses and Dissertations,* (Ames, IA, 1976), 29-34.

The 'Chicago Experiment' was approved under the monikers of "purity lessons," and although her actions were not unopposed, the dire need for public health interventions on many levels laid a conducive environment for the program. Chicago local governments—in a large urban-planning phase—recognized that rising migrant and immigrant populations were left the most vulnerable. Amidst other health crises such as waste disposal issues causing cholera, typhoid fever, dysentery, and tuberculosis, prevalence of venereal increased. Flagg Young argued for scientific-based curricula facing the Catholic Church when stating that evidence-based education was incapable of harm or corruption. Leading the Chicagoan opposition to Flagg Young's new programs, parents voiced dire concerns that hygienists entered schools in order to replace the parental control of sex education. Parents brought three main rationales to the CPS Board:

> 1) Children wouldn't receive information about sexuality out in the public, so there was no purpose in dedicating school hours to "'correct such misinformation;"
> 2) Experimentation was natural, so any effort to quell these behaviors would be a waste; and
> 3) It was only natural for boys to follow their sexual urges and desires while young girls were to remain chaste, so gender neutral messaging would be contradictory to the parental expectation.[20]

Although, Flagg Young's curriculum was integrated into the fabric of health education, CPS' Board of Education disbanded the public-school programs of the Chicago Experiment because Comstock Law ruled the lessons unmailable.[21]

Young resigned from her posts in CPS and the NEA in response to a widespread loss of confidence in her sex education sessions. And although Young's perceived aggressive advocacy tactics were often blamed in the implementation phases, other schools observed and incorporated similar programs in years following.

Approaching wider public implementation

[20] Huber and Firman, *International Journal of Educational Reform*.
[21] Jensen, 65.

Many school boards did not accept cross-district sex education programs in a formal manner, but individual schools started to incorporate principles of sexual and social hygiene in biology and home economics curricula.[22] In cooperation with the U.S. PHS, the Bureau of Education distributed surveys on the topics of structure, content and methodology, and principal acceptance of sex education instruction to 12,025 accredited and partially-accredited high schools in 1920. Of the 6,488 schools who responded, 40.6 percent fell into the category of providing "sex instruction of some sort"—including *emergency instruction* through pamphlets, occasional lectures, or school-based exhibitions, or *integrated sex instruction* through existing classroom curricula.[23] The Bureau of Education concluded that there was a marked advanced integration of sex education in Western states compared to Eastern states, although there is not a uniform ratio of schools that have sex education to those who do not in any form for any state. If the 1920 survey respondents were a representative sample, the Bureau also concluded that those states following integrated sex instruction had rather overarching principal approval with biological sciences hosting much of the conversations on sex and reproduction. And finally, the survey's conclusions introduced sociology, physiology, physical education, and hygiene curricula—subjects all directly referencing *human* behavior—as potential environments for standardized implementation, although few teachers noted sex instruction in these subjects.

Schools experimenting with new sex education materials in a variety of classroom subjects confronted the challenge of controlling and containing sexual desire and propagating the real fears of venereal disease to protect the family unit. Irving Steinhardt released *Ten Sex Talks to Girls* and *Ten Sex Talks to Boys*, in 1913 and 1914 respectively, to contribute to the sex

[22] Huber and Firman, *International Journal of Educational Reform*.
[23] United States, Department of the Interior, Bureau of Education, Status of Sex Education in High Schools, by Newell W. Edson (Washington, D.C.: United States Public Health Service, 1922).

educator pedagogy. Julian Carter writes of the particularly graphic visualizations included in the manuals—notably one of the first times repellent photographs of venereal disease were systemically incorporated in public sex education:

> In the manual for girls, the photograph appeared in the middle of a long passage addressing and sympathizing with the infant depicted there: "Poor little syphilitic baby! No one loves you nor wants to hug and kiss you except, perhaps, the poor mother who had the misfortune to bring you into the world." The photograph makes the reason plain. The infant's skin is badly discolored, cracked, and apparently sloughing off; its mouth gapes and is crusted with diseased tissue, and, just at the limit of the camera's focus, its eyes wear the fixed and unnerving stare of death. The image is the more disturbing in that at first glance the baby seems terribly distorted, its feet almost as large as its head and too close to it. A second look reveals that the picture is actually two photographs, one of the head and one of the feet, juxtaposed on the page in a way that heightens the horror of the composite image while it discreetly avoids showing the infant's genitals. The image of the syphilitic baby represents disease with excessive clarity, while it crops all other obvious information about sex out of the picture."[24]

Lessons of sex were typically repeated at the elementary, junior high school, and high school levels. Typically called "nature study" in the literature on sex education, students read about sex through the fertilization processes of fish, frogs, and of course, the birds and the bees. Various pamphlets, textbooks, and even hands-on instruction demonstrated human reproduction through visual representations expecting core takeaways: 1) babies came from eggs and 2) babies always had two parents—represented by the fertilizing agent and the fertilized. Many allusions brought about the codependency of the pollinator and the flower, and some pictures featured characterizations of animals expressing idealization of the mother and father in the sex education storylines: "

> Perhaps you have seen the birds chasing each other in the spring and have supposed that they were fighting. Not at all! The male birds frequently fight each other when they are courting the female, but the two mates do not fight. They build the nest together; they help one another; the male carries food to the female when she is on the nest; he protects her from harm; and if we may judge by his actions he loves her in very much the same way that your own father loves your mother. Of course then he would not wish to fight her! He is merely giving her the substance from his own body which she can then put into the eggs so that the baby birds will be part his and part her children."[25]

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[24] Julian B. Carter, "Birds, Bees, and Venereal Disease: Toward an Intellectual History of Sex Education," *Journal of the History of Sexuality* 10, no. 2 (2001), 230.
[25] Carter, 245.

Carter reminds that nature study underlined specific representations of marriage and the model family. Regardless of if the animals truly pair-bond in nature, educators used animals to demonstrate the value in mating for life. Even at the level of high school instruction, mammalian reproduction was rarely discussed—even in biology classrooms. In 1915, the head of biology department at a large New York City high school James Peabody, decreed that topics of sexual intercourse "did not in any way concern them at their time of life." Peabody then further explained that the proper "time of life" to discuss sex was after engagement.[26] Ambivalence in sexuality instruction was evident through varied levels of education, but the overarching framing of sexuality emphasized the familial unit and excluded direct representation of human sexuality. Carter wrote that that schools in the first half of the 20th century were "...caught between the desire to shape sexual activity and the fear of stimulating it,"[27] and the true pedagogy of the time could be absorbed through the distributed materials. Once again, as morality lead sex educators in to their messaging in the classroom, scientific accuracy took a secondary priority during the Progressive era leading into the Intermediate era. With an emphasis on nature, neglecting human nature, schools maintained a visible strength in molding their students for sound citizenship and adulthood while neglecting many of the true implications of their instruction and methodology.

Influences of World War I on the Discussion

Five days into entering World War I, Congress enacted the Committee on Training Camp Activities (CTCA) which initiated sex education programs to protect soldiers against the threat of syphilis and gonorrhea.[28] Much of the CTCA literature idolized soldiers purposeful latent desire as a means for protecting the nation. Pamphlets posed prostitutes as the unequivocal

[26] Carter, 246.
[27] Carter, 216.
[28] Jensen, 84.

source of venereal disease and called venereal disease "a most sinister intruder." American schools began to derive their own sex education programming from the CTCA's framework and directed boys and young men to observe abstinence as the true testament to manliness. Educators followed in stride with the military instruction and instructed that only "a weakling, a cad, or a fool" would fall in to the trap of prostitutes. School instruction led boys to verbally choose between being a man with abstaining from premarital sex or lesser by submitting to sexual desire.[29]

Under the system of 'separate, but not equal' African American soldiers were systemically left out of the social-hygiene courses.[30] With racist references to 'African American promiscuity and sexual looseness,' the CTCA's programs effectively reflected no progress in the ways of institutional advancement ever came about in correcting these flaws. Dr. Rachelle Slobodinsky Yarros reintroduced inclusion in information and accessibility for birth control toward the close of WWI. Speaking as a part of the US Public Health Service and ASHA, she imparted sentiments of the social hygiene movements while arguing that sex education is needed for fitness and citizenship. While the ASHA mainly participated in men's health measures, Slobodinsky Yarros expanded their models in social hygiene propaganda for women and girls. While her appeals for these programs used broad representations of the rhetoric she used in her seminars, her quite directional instructions often included matters of desire and sexual social implications for women.[31]

Initiated in 1919, the Chamberlain-Kahn Act directed federal funding toward venereal disease prevention because of the growing visibility. As STD prevention became an apparent

[29] Carter, 221-223.
[30] Jensen, 84-85.
[31] Jensen, 109-110.

threat to the social good, the PHS collaborated with more localized governments to open clinics who provided treatment and disseminated information about the common diseases prevalent in each community. Within three years the federal government's attention fueled 47 of 48 state governments to buy into public STD control, marking the first time the federal government initiated a universal sex education project.[32] A 1919 Public Health Report by the Assistant Surgeon General and Chief of the Section on Public Health Education in the PHS stated more than 17,000 letters to the PHS and federal offices stimulated the federal funding of the "War on Venereal Diseases to Continue". The two officials named venereal diseases as a handicap of the U.S. military and called for the American Red Cross and all additional health care providers to take on venereal disease prevention as an effort to support the War.[33] WWI has been celebrated for advancing sex education in a public setting, but in the manner of Sanger-like critique, the new recognition of public sex education excluded much of the U.S. populace—African Americans, women, the poor, etc.[34]

With the 18th Amendment enacted in 1919, an initiative fronted by the WCTU, the morality of certain vices such as drugs, alcohol, and sexuality remained a hot topic in the public agenda. Women engaged in anti-alcoholism actions as the consequences of the widespread addiction left families destitute, often abused, and neglected. With men wielding a control of familial savings, excessive spending on the listed vices would escalate financial burdens. As federal government presence in civil society and social activity was already increasing through the years of World War I, national agendas in controlling moral activity and education gained traction alongside peacetime years as well.

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[32] Huber and Firman, *International Journal of Educational Reform*.
[33] Benjamin S. Warren and Charles F. Bolduan, "War Activities of the United States Public Health Service," *Public Health Reports (1896-1970)* 34, no. 23 (1919).
[34] Jensen, 72-73.

'Selective Reproduction' Enters the Discussion

As arguments in favor of purifying the American population advanced, states passed laws allowing marriage restrictions and sterilization laws by the 1920s. Alongside the increased spread of eugenics rhetoric, individual agency in reproductive rights shrunk while opposition to public sexuality conversation and materials grew.[35] Even President Theodore Roosevelt had used the "New Woman," "the good, average woman," and "American motherhood" to idealize chastity as a supreme characteristic.[36] As the eugenics movement, peaking between 1905 and 1930, steered public schools toward sex education implementation, theories of selective breeding emerged.

Following the peak popularity of the eugenics movement in the 1920s—as Nazi German rhetoric often touted eugenics theories in mental, physical, and social matters—the general American following dissipated in dissociation amidst WWII. The eugenics movement became socially tabooed, which caused the American Eugenics Society to reach for collaboration with other social progress of the time. The emergence of birth control and related advocacy fueled the president of the American Eugenics Society to pinpoint commonalities in the "two great movements," calling support for birth control a new method for selective reproduction.[37] Although what was once thought to be a prominent progressive argument turned into a fringe social movement, the timeline of the eugenics movement intersected many landmark moments for birth control advocates.

With eugenics rhetoric closely tying human reproduction with an emphasis on social choice, public sex education programs often encouraged "selective breeding" or "discriminatory

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[35] Jensen, 20.
[36] Jensen, 19.
[37] Huber and Firman, *International Journal of Educational Reform*.

reproduction".[38] These references to Darwinian terminology embraced the theory that future generations would benefit from appropriate choices in sexual activity in the present. This common belief created space for individualism in public health programming to thrive where the individual would be blamed for their own negative health outcomes.

ii. Sex Education in the Intermediate Era (1920-1959)

In 1936, Margaret Sanger was victorious in the case of the *United States v. One Package* which overturned an important mandate of the Comstock laws.[39] Sexuality information could now be sent through the mail, and doctors were granted the right to disseminate contraceptives to married women. While Comstock Laws were officially abolished, the silencing rhetoric made way for framing of today's discourse.[40] Moreover, institutions and civil society who embarked on campaigns using similar phrasing continued on in the same path although transfer of related materials was no longer banned. During the period of peacetime between the wars, "Keeping Fit" continued the initiatives for male protection against venereal diseases and other "harms" of sexual activity. The PHS and ASHA endorsed ideas of celibacy before marriage and literature which reflected similar ideologies to promote healthy behavior for men. "Youth and Life" campaigns from the PHS closely flowed and targeted young, specifically white, women. Posters and promotional materials emphasized characteristics of femininity to regenerate a sense of responsibility in motherhood and household upbringing. Additionally, the postwar related propaganda created a "Keeping Fit for Negro Boys and Young Men" campaign to reach young black men who were left out of the targeted marketing of WWI CTCA efforts.[41] Even role models portrayed in posters and pamphlets portrayed ideals of "separate but equal" approaches

[38] Huber and Firman, *International Journal of Educational Reform*.
[39] Huber and Firman, *International Journal of Educational Reform*.
[40] Jensen, 6.
[41] Jensen, 118-122.

in civil society. While "Keeping Fit" pictured Presidents Abraham Lincoln and Theodore Roosevelt, the "Keeping Fit for Negro Boys and Young Men" materials featured Booker T. Washington and Frederick Douglas as models promoting healthy decision-making.[42]

Yarros had used the ideals of American individualism and healthy decision-making to promote her programs, but the ASHA and the PHS used assumptions of health as a choice and accomplishment which vastly ignores highly racialized environments and accessibility of resources at the time. The "Keeping Fit" and "Youth and Life" campaigns idealized marriage as a principle of health and happiness, and paved the way for institutions to comment and make recommendations for the virtues of individuals. Following a severe syphilis outbreak, the PHS renewed their boys' and girls' education campaigning which had been discontinued due to post-WWI depression and federal budget restraints. And, as the U.S. began switching gears into preparing soldiers for going into war leading into WWII, the AHSA incorporated "Fit to Fight" and "Fit for Life" slogans in their repertoire to combat STD transmission. With the perceived imminent threat of venereal disease, the federal government drove efforts to open more treatment clinics and promoted the widespread use of penicillin as treatment once it's benefit as a cure was discovered.[43]

Margaret Sanger and the creation of 'The Pill'

In 1921, Sanger and her fellow advocates in favor of equal access to contraceptive products and services founded the American Birth Control League, renamed Planned Parenthood in 1942. The organization aimed at equalizing the female experience in sexuality offering counseling in family planning and contraceptive service. The male condom was the most popular, and most effective, contraceptive at the time, but Sanger aimed to find a family planning

[42] Jensen, 128.
[43] Huber and Firman, *International Journal of Educational Reform*.

solution for women who may or may not have the consent of their sexual partners. Sanger sought out Gregory Pincus under the guise that his expertise in zoology and mammalian reproduction would contribute to greater science and society.[44] Pincus made large strides in his early profession studying endocrinology and biology but was looking for an opportunity to restore his tarnished reputation after his application for tenure was rejected by Harvard University.[45] Sanger commissioned Pincus and his colleague Min Chueh Chang who began their research by experimenting with the effects of progesterone on reproduction in rabbits. Jonathan Eig wrote, "The science of reproduction might have advanced more swiftly if a few of the researchers involved had been women." As very few women were able to achieve high levels of agency in conducting research, and sexuality and reproduction were rarely studied in a laboratory or medical/clinical settings, few were actually motivating the efforts in regulating women's abilities to control pregnancy. Sanger posed the challenge to Pincus as an endeavor in controlling overpopulation which he accepted as a claim to achieving the public recognition he desired.[46]

Gynecologist John Rock had begun experimenting with oral doses of progesterone and estrogen as infertility treatments, admitting to the 80 women brought into his clinical cohort that he did not know if the treatment would work. As the 'treatment' stopped menstruation and had side effects which replicated pregnancy, many of the women did believe they were pregnant for a time. But, Rock had to eventually publish that the progesterone and estrogen treatments did not address his intended cause. Pincus had been experimenting with the ovulation cycles in rabbits for years, but had no reference as to if the treatments would harm human females. He learned of

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[44] Marc A. Shampo and Robert A. Kyle, "Gregory Pincus-Codeveloper of "the Pill"," *Mayo Clinic Proceedings* 88, no. 2 (Feb, 2013): e15.
[45] Jonathan Eig, *The Birth of the Pill: How Four Crusaders Reinvented Sex and Launched a Revolution*, New York: W.W. Norton & Company, 2014.
[46] Eig, (2014).

Rock's research on healthy women and requested a partnership. The two would go on to test their Pill in Puerto Rico and Haiti on patients in asylum or destitute in slums, but were pleased to have the continued support of the Planned Parenthood Federation of America.[47][48] After testing hundreds of individuals and submitting consistent reports back to Planned Parenthood, Pincus and Rock gained full traction in posing the Pill for Food and Drug Administration (FDA) approval. Finally, in 1960, the FDA finally licensed the first oral contraceptive in 1960.[49]

This first birth control pill made way for further options in family planning and contraception.[50] As, Sanger had followed the project from conception, she already had a widespread platform to advertise the new drug providing women—and herself, in particular—an outlet in equalizing sexuality. Sanger was quite successful in bringing men onto her side to advocate for women's rights to control pregnancy and found that Pincus and Jordan's participation could be used to achieve support from men, as well. Sanger then began on a path to introducing this newfound information to women within all segments of society who, once educated, could control their own pregnancy regardless of spousal approval, predict ovulation patterns, and be better equipped to consult with their doctors.

A New Morality

A new subculture mainly vocalized by young adult populations in the early 1920s denounced expectations of celibacy before marriage. This "new morality" as put forth by Huber and Firman challenged traditional conceptions of decency and individual values placed on young women and men. The work of Alfred Kinsey sent a shock into the discussion on sexual behavior.

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[47] Eig, *(2014)*.
[48] Jonathan Eig, *The Birth of the Pill: How Four Crusaders Reinvented Sex and Launched a Revolution*, (New York: W. W. Norton & Company, 2014), quoted in "The Team That Invented the Birth-Control Pill." *The Atlantic*. (October 9, 2014).
[49] Shampo Kyle, *Mayo Clinic Proceedings*.
[50] Huber and Firman, *International Journal of Educational Reform*.

Kinsey's books *Sexual Behavior in the Human Female* and *Sexual Behavior in the Human Male*, published in 1948, introduced topics of homosexuality, marital infidelity, infant sexual responses, and bestiality, which were often all equalized in a category of subjects not to be discussed.[51] As monogamy and premarital abstinence were defended social norms by civil society, the church, and the general public, when Kinsey drove conversations on exploring sexuality preference, the concept of open marriages, and orgasm and pleasure, schools became even more aware that literature and the media could be sources of this "counterculture".

Sex education of the intermediate era did progress from defining sex as a mere prerequisite of procreation. As sexually illicit behavior became more visible, some factions of society continued to work under the mandates of the social purity movement with newfound motivations. Catheryne Cooke Gilman and her supporters in the Minneapolis Women's Cooperative Alliance (WCA) pressed their local authorities to convict businessman and local philanthropist Joseph Bragdon, who had been found to be molesting young girls. After the WCA's role in Bragdon's persecution, the organization began on a survey campaign to learn of the other social sexual ills children in their community faced. Distraught by the growing presence of sexuality in films, burlesque, Vaudeville, the WCA became wary of the new forms of public amusement that might draw young girls and boys together—citing dance halls, amusement parks, automobiles, and movie theaters as potential threats to adolescent purity. Through a 1920 survey campaign, Gilman found through testimonies of mothers and their children that many had experienced sexual coercion or touching from peers, and many had experimented with intercourse with or without consent of a young partner. Gilman and her allies quickly mobilized to produce pamphlets and handbooks to battle the obscenities that children

[51] Huber and Firman, *International Journal of Educational Reform*.

would undeniably observe in the 'modern city.' Although, Gilman was strongly opposed to masturbation and her organization were undeniably supporters of abstinence until marriage, they sought to distribute information on 'proper relationships' to adolescents to target sexually ill activities of all natures like coercion, assault, or pedophilia.[52] The WCA believed that youth affected by environmental influences would become degenerate adults, so training and molding of 'sexual natures' should be compulsory.

American public-school sex education turned toward the promotion of celibacy in honor of one's future marital partner. As sex educated became more commonplace, the PHS published a manual in 1922 in the hopes of standardization. The manual called on the faults of the Chicago Public Schools experiment, naming biology, physical education, English, and social sciences courses as safe spaces to avoid opposition in implementation. The PHS called adolescent sex education a "phase of character formation," and with federal direction, 45% of schools offered some form of integrated sex education.[53] Eventually some public schools accepted contexts of sociology and psychology in curriculum and introduced family life education courses. This span of sex education in the 1940s and 1950s brought consideration of character building, relationships, personal finance, and marital responsibility into classroom curricula under this subject of family planning education. Sentiments entrenched in these courses underlined the importance of creating a 'healthy and safe' space for children, connecting abstinence prior to marriage to this concept of the ideal household.[54] As parent groups continued to front the opposition of district-wide implementation of integrated sex education, schools reverted to

[52] Leigh Ann Wheeler, "Rescuing Sex from Prudery and Prurience: American Women's Use of Sex Education as an Antidote to Obscenity, 1925-1932," *Journal of Women's History* 12, no. 3. (2000), 173-195.
[53] Huber and Firman, *International Journal of Educational Reform*.
[54] Huber and Firman, *International Journal of Educational Reform*.

entrenched curricula buried in relevant subjects.[55] This divergence from school acceptance of parental control in instructing student morality and virtue, marked an important role school systems embraced in the latter half of the Intermediate era. Up to this time period, advocacy groups and particularly visible spokespeople drove integration of sex education in public school curricula. But, as government intervention and public discourse placed importance on protection from venereal disease and the formula for upstanding citizenship, schools extended their intended virtues in advocating for the personal maturation of their students.

iii. Sex Education during the Sexual Revolution (1960-1979)

As the increasingly vocal subculture of young people purporting sexuality and desire as public expressions, schools found that their communities began to reflect this emergence of "free sexuality". Public displays included openings of bathhouses, safe nudist establishments, swing clubs, and the rising publicity of pornographic material in the post-Comstock era. New institutions of "free love" not restrained to marriage intervened in the public school common thought. The "free love" movement spurred Hugh Hefner's Playboy Foundation to create the Sexuality Information and Education Council of the United States (SIECUS) in 1964. SIECUS stood on the mandate that sex was a natural part of life and now stands as a premier resource for professionals seeking information on "values neutral" sex education. A previous director of Planned Parenthood, Mary Calderone, took the lead in the construction of the SIECUS model of research and education strategy, and she was one of the first to formalize the terms of "comprehensive sex education" in the manner of contemporary literature. SIECUS sought to educate individuals in how to make the correct decision to have sex, how to determine is abortion was a viable option in certain scenarios, and how to obtain easy access to birth control.

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[55] Huber and Firman, *International Journal of Educational Reform*.

SIEUCUS first spread sex education consultants across public school systems to train teachers and implement standards of sex education and turned to registering people for official certification as professional sex educators. The nonprofit fronted their literature and outreach on a campaign based on the philosophy of pluralistic society. Along the concept of "the new morality" as proposed by Joseph Fletcher in 1966 in *Situation Ethics: The New Morality*, SIECUS presented sexual decision making as a value of context. In their ambition to promote "value free" sex education choosing between the right and wrong was situational and dependent on context.[56]

The creation of SIECUS paved the way for other "pro-sex", feminist, and progressive groups. Betty Friedan created the National Organization of Women in 1966; Patricia Schiller, a leader in SIECUS, created the American Association of Sex Educators and Counselors and Therapists; and, the Alan Guttmacher Institute—initially a research institution formed as a part of Planned Parenthood—formed in 1968. All three organizations stand as forerunners in conversations of the contemporary Reproductive Justice Movement, continuing to reform their original institutional mandates due to political and social context but also advancement in research.

"The Pill" achieved even wider spread popularity among women of a wider scope of socioeconomic boundaries, so schools and advocacy groups began to take divisive stances on how to incorporate—or exclude—oral birth control as an option for family planning in accordance to their respective governing bodies. When the FDA licensed the pill in 1960, taking the pill turned into political statement as opposed to a personal medical practice.[57] As the "threat" of premarital pregnancy disappeared, opponents of oral contraceptives raved that

[56] Huber and Firman, *International Journal of Educational Reform*.
[57] Huber and Firman, *International Journal of Educational Reform*.

distribution of the pill corrupted society by promoting casual sex. And, even after the 1965 *Griswold v. Connecticut* Supreme Court case identified use of birth control by married couples as a right of Constitutional privacy—not individual privacy, as one should note—schools were hesitant in broadly educating adolescents in the newest form of contraceptive. This right to privacy for adolescents would not be extended to unmarried minors at this time.

Title X, Supreme Court cases including *Roe vs. Wade*, the Adolescent Health Services and Pregnancy Prevention and Care Act, the Hyde Act, and a variety of amendments to these policies and programs, tied family planning to pregnancy prevention in federal political commitment.[58] Partisan delineations entered the debate on individual health rights and decision-making while advocates attempted to battle a new rising. Sex education advocates publicly accepted safe-sex education endorsing information on contraceptives. During the 1970s, ideas of pleasure, descriptions of specific sexual acts, masturbation, and sexual orientation emerged in programming, but in an extremely limited and school-by-school basis.[59]

Premarital pregnancy had always been frowned upon, but with the sexual revolution many turned vocally against the stigmatization of premarital sex. In addition to funding 645 agencies to develop sex education programming, the Department of Education turned to SIECUS to develop a sex education manual geared toward educators. Continuing in the pattern of executive participation in the conversation, President Richard Nixon held the White House Conference on Youth which supported sex programming in all public elementary and secondary schools. The programming of this decade era was often driven by the consequences posed by premarital sex rather than dissuading young people from sexual experimentation altogether. Consequently, those vehemently against the infiltration of the sexual revolution began rebuilding

[58] Reference timeline.
[59] Huber and Firman, *International Journal of Educational Reform*.

their case against public funding for sex education. American opposition of public sex education was strongly correlated with "traditional family values" and abstinence until marriage, according to a 1997 U.S. survey.[60]

iv. The Modern Era of Sex Education (1980-present)

Opposition movements utilized tactics and rhetoric of AOUME even prior to federal policy imposition. In warning students against premarital sex, abstinence proponents yielded the potential emotional and physical threats alongside the issue of morality. Sex education rose in visibility on the political agenda as the public followed the federal comfort and actions in favor of expansion in public school-based sex education. But, two waves of opposition schemes responded with lasting repercussions.

Even within the 17 states who mandated public school sex education by 1989, discussions on birth control, abortion, and homosexuality were sparse with the role of community standards present in curriculum decisions. Local school boards declared the deterministic stance in most, if not all, circumstances, even if the goals delineated in state policy conflicted. Actual determinations on the content of sex education in a state or region were virtually impossible to collect because of skewed perceptions of "comprehensive sex education" versus "abstinence only."

Federal positioning in sex education

The span between President Reagan's 1981 Adolescent Family Life Act (AFLA) to President Bill Clinton's 1996 block grant toward abstinence education included in the Section 510 Title V Abstinence Education Program, confirmed a federal commitment toward AOUME and other prohibitive tactics. The AFLA required schools to bring religious entities into

[60] Huber and Firman, *International Journal of Educational Reform*.

programming to "promote self-discipline and other prudent approaches to the problem of adolescent premarital sexual relations."[61] The AFLA was locally recognized as the "chastity bill" already raising heightened concern from those who aimed to restrict religious practice in public institutions. In 1985, a district court declared the AFLA unconstitutional in the case of *Kendrick v. Sullivan*, but the decision was directly appealed to the U.S. Supreme Court. Concluding that governments had control over the direction distribution of federal funding to religious institutions, the final 1988 decision of *Bowen v. Kendrick* overturned the district court decision.[62] Although the ACLU pointed at direct contradiction in the mandate to involve religious intervention before a school was granted federal funding for sex education programs, protectors of the AFLA maintained that religious participation in school curricula decision-making was only fair to defend morality in communities. Throughout the Reagan and Bush administrations, attorneys surveyed the array of grants and found expansive evidence of First Amendment violations. And finally, in 1993, the Department of Justice Counsel of the Department of Health and Human Services settled with AFLA adversaries to construct greater levels of revision for grantees. The DHHA finally declared that federal oversight would be critical of institutions promoting religion and would require medical accuracy.[63] [64] Although the courts decided on greater practices in revision, the impact of political approval of religious presence in public sex education created an opening for President Clinton's budgetary movement in favor of AOUME.

With federal funding as the only real parallel for sex education across states' borders, Section 510(b) of Title V of the Social Security Act outlines the eight criteria states must adhere

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[61] Patricia Donovan, "The Adolescent Family Life Act and the Promotion of Religious Doctrine," *Family Planning Perspectives* 16, no. 5. 222.
[62] "Bowen v. Kendrick," *Oyez.*
[63] Saul, *Guttmacher Policy Review*, 10.
[64] Donovan, *Family Planning Perspectives*, 222-224.

to for grant funding. Referred to as the A-H guidelines, the following eight requirements for eligibility are as follows:

A. Has as its exclusive purpose teaching the social, psychological, and health gains to be realized by abstaining from sexual activity;
B. Teaches abstinence from sexual activity outside marriage as the expected standard for all school-age children;
C. Teaches that abstinence from sexual activity is the only certain way to avoid out-of-wedlock pregnancy, sexually transmitted diseases, and other associated health problems;
D. Teaches that a mutually faithful, monogamous relationship in the context of marriage is the expected standard of sexual activity;
E. Teaches that sexual activity outside the context of marriage is likely to have harmful psychological and physical effects;
F. Teaches that bearing children out of wedlock is likely to have harmful consequences for the child, the child's parents, and society;
G. Teaches young people how to reject sexual advances and how alcohol and drug use increase vulnerability to sexual advances; and
H. Teaches the importance of attaining self-sufficiency before engaging in sexual activity.

The A-H guidelines drew from philosophies of morals, ethics, and religion and set a federal commitment to abstinence as the solution toward teen pregnancy and birth rates.[65] Regardless of the current emergence of sex-positive organizations, the option for community-organizers to request funding for faith-based programming allows for these civil society groups to maintain control over this aspect of adolescent health and wellness.

Strengthening of Pro-Sex Advocacy Groups

The transition into the modern era of sex education is marked by the distribution of federal support for both sides of the public sex education debate. SIECUS, Advocacy for Youth, and Planned Parenthood were granted large sums under government health and education initiatives while federal policy continued to propagate and fund AOUME. Although AOUME received prominent federal earmarks, pro-sex advocacy organizations continued to gain traction and recognition. In 1991, SIECUS produced the first edition of the *Guidelines for Comprehensive Education* which brought educators lessons in masturbation, sexual orientation,

[65] Patrick Malone and Monica Rodriguez, "Comprehensive Sex Education vs. Abstinence-Only-Until-Marriage Programs," *American Bar Association Human Rights* 38, no. 2, (Spring 2011).

abortion, contraception, and the role of sexual fantasies in sexual health.[66] Although, once again, the proportion of public schools who implemented SIECUS guidelines remains indeterminate, production of the *Guidelines* brought about an updated stance of pro-comprehensive sex education of the 1990s.

In the earliest stages of reproductive justice rhetoric, the American Civil Liberties Union, Advocates for Youth, the American Social Health Association (formerly the American Social Hygiene Association), Planned Parenthood, and the NEA embraced abortion rights, feminist, and homosexuality rights movements. Civil society also began implementing lobbying and other political affiliations in their comprehensive education advocacy. Parent organizations decisively began participating in the conversation of school-based education as the final pillar of influencers in pro-sex advocacy. Participating in school board meetings and district agenda setting laid the groundwork for increased parental advocacy for adolescent health education improvement. Parents achieved increased awareness of sex education programs actually provided to their students with a lessened stigma and greater emphasis on the parent-child relationship in education. As parent-based advocacy is still relatively untapped, parent organizations could provide the next monument opening for political advocacy organizations to approach school systems.

Pro-sex advocacy organizations antagonized AOUME proponents for instigating public policy founded on religion and morality. President George W. Bush's administration attempted to foster a connection between abstinence-based tactics and comprehensive sex education. But in later years, his true affiliation surfaced in the Community Based Abstinence Education (CBAE) program. Because the CBAE program incentivized pro-abstinence rhetoric in public school

[66] Huber and Firman, *International Journal of Educational Reform*.

programming, comprehensive contraceptive-based programs responded with rebranding. "Abstinence-plus" education entered as a category of sex education which prompted programs to include tactics on abstinence as the only "fool-proof" alternative for avoiding the imminent threats of sex.[67] Programs framed under this mandate had to follow certain guidelines. But many advocates for comprehensive sex education were able to avoid reformation by reframing existing protocols for educators.

Although AOUME funding was on the rise, an unopposed public health agenda calling for HIV/AIDS prevention took center precedence beginning in the early 1980s. In education on prevention and risks associated with HIV/AIDS, dedicated funding commanded attention to the use of contraceptives. With HIV/AIDS looming as both a local and global threat, much of the panic, stigma, and misconception surrounding the newly discovered disease did fuel the increase of discussion on the needs of homosexual populations and prevention methods for young people.

An increase of surveying in adolescent populations revealed that students still participated in premarital sex and other sexual activity reprimanded in AOUME programs. So, although many of the programs continued to denounce all those who did not "Just Say No," some schools added sexual health clinic services to address the medical needs of students experiencing STDs/STIs. President Clinton's attempts to implement funding for public school-based clinics, resulted in over 500 by 1993. During his 2008 campaign, President Barack Obama also included SIECUS K-12 programming in his platform including federal funding to school resources and personnel in addition to curriculum-based interventions. The Obama administration was able to pass legislation for the introduction of school-based clinics under the 2009 health care debate initiating the modern surge against AOUME. Additionally, his 2010

[67] Huber and Firman, *International Journal of Educational Reform*.

budget included the elimination of all funding previously devoted to AOUME and he formally announced a political commitment to contraceptive-based sex education programs—a transition out of the pregnancy prevention models of the two decades prior. But, in line the aforementioned pattern of the Global Gag Rule, President Donald Trump's first executive orders cut all federal supports to anything but AOUME resources.

At this point in time, it would be difficult to draw the line separating a modern era of discourse on sex education from the contemporary. But the latter decades of the 20th century and the earlier years of the 21st century do reveal a progression in governmental involvement in sex education programs and further evolution in public dialogues. Much of the discourse within sex education is reliant on terminology and framing the policy propositions. The following section will be a bit of an introduction to the way policy around sex education is functions to this day.

v. Contemporary discourse

The undeniable visibility of pivotal political moments—passage of the 18th Amendment, WWI and WWII, the Vietnam War, *Roe v. Wade*, etc.—shocked many discussions on school-based sex education. With the responsibilities of parents at the front of many opposition movements, school boards have wavered on the line of acceptance of sex education programs. The precluding discussions displayed how individuals gained traction and recognition in their respective institutions by strategically framing their position to appease governing bodies, as Young used vague terminology to promote distinctive sex education programs and Yarros amended her talks to use the rhetoric of social hygiene movements. Today, sex education advocates still appeal to parental concern, widespread district skepticism, and political opponents through the language of AOUME to avoid censorship measures.

Although a variety of framing methods are utilized in today's discussions of sex education, much of the opposition to holistic programming revolves around censorship, rights of parents, the resilience of AOUME programs, and morality. The current promotion of "abstinence plus" programs use "just say no" rhetoric with mere addendums of contraception information and potential for other concepts without standardized terminology.

Without parallel commitments to a standard program across state borders, students observe wide variance in information and delivery. While some schools rely on textbooks and traditional classroom format, some have introduced mobile and/or computer applications to provide supports. Many schools choose to outsource their sex education programming to local Planned Parenthood educators or other entities, but once again, many still lend their classrooms to local religious groups. This variance points to the potential for diverging outcomes. Classrooms teaching sex education are often gendered, especially in teaching curricula to younger students. Only the most of inclusive curricula include non-binary sexuality information, so in the deterrence of transgender adolescent needs in public schools altogether, implementation of adherent inclusive curricula is being ignored.

III. STATE CASES: FOUR STATE ALTERNATIVES BENEFITTING FROM FEDERAL FUNDS

As control of the White House shifts from one party to another, AOUME gains traction and/or loses appeal. In the transition from President Bush's presidency to President Obama's presidency, AOUME proponents had to drastically reorganize their methods and outreach to gain support under the new public order surrounding sex. Much of this groundwork included rebranding of rhetoric to appeal to wider audiences. AOUME programming is now being referenced as Sexual Risk Avoidance Education (SRAE), and abstinence-only proponents have

utilized the phrases ‘medically accurate and complete’ and ’evidence-based’ to avoid a clear religious or ideological leaning in public discourse. Ambiguous use of the phrases ‘youth empowerment’ and language around ‘healthy relationships’ have been cited in promoting abstinence-only programming as well. In each of these circumstances, idea of youth decision-making and freedoms have been utilized by socially conservative movements. In February 2018, the U.S. Congress officially stripped abstinence-only education of its title ‘abstinence education’. The Guttmacher Institute stated that the newly assigned moniker ‘sexual risk avoidance’ may be framed with newly exploited bipartisan language, the new federal policies are clearly rephrasing of socially conservative ideologies present in AOUME. SRAE rhetoric implicates that premarital sex increases the likelihood that adolescents will fall into poverty and that “even with consent teen sex remains a youth risk behavior” in all circumstances. Additionally, SRAE avoids any normalization of teen sexuality and implicates resistance and goal setting in eluding sexuality. The Title V programming with an attached $75 million was also renewed with the requirement that education curricula should exclude demonstrations, simulation exercises or distribution of barrier methods.[68] Overall, the Guttmacher Institute calls the conservative agenda the wrong approach asserting that coercion is being facilitated by conservative members of Congress by withholding information and restricting access to resources.[69] With the shift and rebranding of AOUME, states are left to refer back to their visible actors and active policy players to decide whether or not their curricula should align with the federal agenda.

Through the following four state-level examinations, funding streams are mentioned. Each Program has specific intentions and objectives as entities within each state can apply for

[68] Jesseca Boyer, "New Name, Same Harm: Rebranding of Federal Abstinence-Only Programs," *Guttmacher Institute,* (2018).
[69] Joerg Dreweke, “Coercion Is at the Heart of Social Conservatives’ Reproductive Health Agenda,” *Guttmacher Institute,* (2018).

funding under one or more of the programs. The following are just a few of the federal grant programs which Texas, Virginia, Colorado, and California notably receive. The Teen Pregnancy Prevention Program (TPPP) was established through the Affordable Care Act (ACA) to provide federal grant money to "medically-accurate, age-appropriate, and be either based on or informed by evidence" programs.[70] This program initiated a new wave of sex education in the form of technical assistance and intervention methods to address teen pregnancy rates. The Personal Responsibility Education Program (PREP) federal program was also created through the ACA but specifically earmarked holistic education on sexuality, STD prevention, HIV/AIDS, contraception, etc. The funding is primarily disbursed to health agencies and does not have a state dollar matching requirement. PREP funding has three sub-categories 1) Competitive Personal Responsibility Education Program (CPREP), 2) Tribal Personal Responsibility Education Program (TPREP), and 3) Personal Responsibility Education Innovative Strategies (PREIS). CPREP is allocated for those states who did not apply for PREP funding and serves to finance faith-based and community-oriented organizations. TPREP funding is dedicated to organizations in tribes and tribal communities targeting youth aged 10-19 who face increased vulnerability, i.e. ageing out of foster care, homelessness, living with HIV/AIDS, pregnant and/or parenting under the age of 21, or living in communities with high adolescent birth rates. PREIS federal grants aid in the development, testing, and distribution of innovative teen pregnancy prevention models. PREIS funding can be allocated to public or private entities as well. Title V AOUME funding is a reworking of the federal grant programs from President Reagan's administration. Title V has a matching component where states must match every $1 in federal grant money with a $0.75 match. As defined by A-H guidelines, Title V AOUME

[70] "State Profiles Fiscal Year 2017: Federal Funding Overview," *SIECUS*, (2017).

programs cannot facilitate programs which mention contraceptive uses or methods unless the information is skewed to portray failure rates. With abstinence as the intended outcome, Title V-funded programs can include the intervention of outside entities, counselors, or mentors. SRAE funding programs depart from the aims of Title V earmarks and fund comprehensive/holistic curricula in line with SRAE ideologies as mentioned prior.[71] Information on these federal grant programs are used to indicate the priorities and practices present within the four cases.

Close examinations of the political openings from which sex education policies emerge are outside of the scope of this paper, but the following set of cases introduce some of the actual policies and themes present in U.S. state policy. The cases were not chosen through any singular criteria, but the following representations aim to demonstrate the range of policies currently in place throughout the U.S.

i. Texas

Texas was one state which failed to survey any of the eight critical indicators of adolescent health and wellness and reported to the CDC's YRBSS. Texas is selected as one of the states with the highest visibilities in leading teen pregnancy prevention and AOUME and has one of the highest U.S. state populations. In a Guttmacher Institute editorial, Kinsey Hassted wrote that Texas lawmakers are charging a campaign against adolescents by restricting healthy and truthful information in sex education practices. In 2015, Texas State Representative Stuart Spitzer convinced the House to transfer $3 million dollars intended for HIV/STD prevention in the public-school system to AOUME resources. In supporting this restriction of information of disease, Texas lawmakers promote the ideologies of abstinence as the ultimate preventative method. Of course, sex education can only offer adolescents access to resources when those

[71] "State Profiles Fiscal Year 2017: Federal Funding Overview," *SIECUS*, (2017).

resources are available and accessible—or even lawful at all.[72] Promotion of abstinence is propelled by lawmakers who incite initiatives to cut public funding for women's health care services and providers. According to a report by the Texas Health and Human Services Commission, one in four women enrolled in Texas' Medicaid Women's Health program, named the Women's Health Program, Texas Women's Health Program, and Healthy Texas Women in various regions, had never consulted a health care provider on women's health or family planning.[73] Conservative state lawmakers produced a waiver request to Centers for Medicare and Medicaid Services (CMS) to exclude any family planning provider which also include promotion or referrals to abortion services from coverage. With the approval of this waiver the federal government would be setting a detrimental precedent, according to the Guttmacher Institute.[74]

Texas hosts the highest prevalence of repeated teen births and has the third-highest state teen pregnancy rate, and the fourth-highest state teen birth rate. With one main driver of the state-level study in Section 4 targeting collection of information on teen dating violence, experience of sexual assault, and/or force and coercion during sex, Texas fails to report any of these measures. Ideology based campaigns and AOUME were championed by former Governor George W. Bush and Texas was one of the first states to adopt AOUME into standardized health curricula. The state continues to be one of the largest recipients of AOUME—now SRAE—and has denied millions of dollars in federal funding toward Personal Responsibility Education

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[72] Kinsey Hasstedt and Adam Sonfield, "At It Again: Texas Continues to Undercut Access to Reproductive Health Care," *The Guttmacher Institute,* (2017).
[73] Texas Health and Human Services Commission, Medicaid and CHIP Services, *Comments on the Draft Healthy Texas Women Section 1115 Demonstration Waiver Application*, by Stacey Pogue (Austin, TX: Center for Public Policy Priorities, 2017).
[74] Hasstedt and Sonfield, "At It Again: Texas Continues to Undercut Access to Reproductive Health Care."

Program (PREP) which incites healthy decision-making and contraception information in public-schools.[75]

Sex education is not required to be medically accurate, culturally appropriate, or unbiased; and, any references to sexual orientation alternative to the heteronormative are mandated to be negative. The Texas Education Code from the State Board of Education requires any school-based information to present curricula in the following manners:

- ✓ "Present abstinence from sexual activity as the preferred choice of behavior in relationship to all sexual activity for unmarried persons of school age;
- ✓ "Devote more attention to abstinence from sexual activity than to any other behavior;
- ✓ "Emphasize that abstinence from sexual activity, if used consistently and correctly, is the only method that is 100% effective in preventing pregnancy, sexually transmitted diseases (STDs), infection with HIV or acquired immune deficiency syndrome (AIDS), and the emotional trauma associated with adolescent sexual activity;
- ✓ "Direct adolescents to a standard of behavior in which abstinence from sexual activity before marriage is the most effective way to prevent pregnancy, STDs, and infection with HIV or AIDS;
- ✓ Teach contraception and condom use in terms of human-use reality rates instead of theoretical laboratory rates, if instruction on contraception and condoms is included in curriculum content."

The CDC produced the School Health Profiles, an attempt to collection true information on the actual delivery of sex education in public schools. Questionnaires were distributed to principals and lead health educators to access the delivery of more "positive policies and practices." The *16 Critical Sexual Education Topics Identified by the CDC* are as follows:

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

[75] Kinsey Hasstedt, "The State of Sexual and Reproductive Health and Rights In the State of Texas: A Cautionary Tale," *The Guttmacher Institute,* (2014).

15) How to access valid and reliable information, products, and services related to HIV, STDs, and pregnancy
16) Preventive care that is necessary to maintain reproductive and sexual health.

For the 2013-14 school year, Texas abstained from reporting.[76]

In FY2017, with regards to federal funding, the following Texas-based initiatives/organizations received considerable grants to be distributed to faith-oriented activities. The University of Texas Health Science Center at San Antonio partnered with San Antonio Teen Pregnancy Prevention Collaborative and other youth-serving organizations to implement TPPP. Faith-based organizations, along with after-school programs, middle and high schools, and community organizations would receive $2,000,000 under the FY2017 grant. The Future Leaders Outreach Network (FLON), a community faith-based organization aiming to promote development for individuals age 10 to 21, received $667,687. FLON touts character-based, testimony-based youth and family programs in abstinence.[77] FLON works in community centers, schools, and faith-based organizations in Arlington, Dallas, Fort Worth, and Tarrant. The Texas Department of State Health Services received $7,448,450 in federal Title V abstinence-only funding to be aimed at students aged 15-19 throughout urban, suburban, and rural communities. The Department utilizes Heritage Keepers' curricula in after-school programs and community centers advocating for building relationships exclusive of sex and teaching skills and tactics to resist sex.[78] Ambassadors for Christ Youth Ministries, Inc. received $668,764 under CPREP and $548,103 under an SRAE grant. The 501(c)3 organization delivers development programming to displaced and/or at-risk youth and incorporates similar tactics in sex education programming to

[76] "State Profiles Fiscal Year 2017: Texas," *SIECUS*, (2017).
[77] Clemons, Diana, "FLON History," *Future Leaders Outreach Network,* Accessed April 15, 2018, http://flon.org/history.html.
[78] U.S. Department of Health and Human Services, *Heritage Keepers Abstinence Education,* by Anne M. Badgley, Carrie Musselman, Tracey Casale, and Sally Badgley-Raymond, (Teen Pregnancy Prevention Evidence Review). https://tppevidencereview.aspe.hhs.gov/document.aspx?rid=3&sid=74&mid=2.

adolescents in Texas. As a caveat to the implications underlying this section on faith-based grantees receiving federal funding, it is possible for religiously-affiliated centers to deliver sex education programming. But, when state mandates do not require medically accurate or culturally-appropriate presentation of materials, highly-concentrated conservative movements are able to overwhelm the reach of comprehensive sex educators. With limited checks on the true content of materials, specifically by abstaining from surveying, Texas public schools are able to evade oversight measures which would reform malpractice in sex education as defined by SIECUS and the Center for Sex Education.

ii. Virginia

Virginia's sex education program functions under the moniker 'Family Life Education.' While the state has made several progressive amends propelled by Delegate Eileen Filler-Corn (D), there are still enduring policies which create difficulties for AOUME opponents. The Virginia Board of Education and Standards of Learning for Virginia Public Schools outlined abstinence and the "social, psychological, and health" gains of refraining from premarital sex as the first section within the Family Education model. Virginia's K-12 programming does include the following advantageous information and prevention interventions:

> dating violence; the characteristics of abusive relationships; steps to take to deter sexual assault, and the availability of counseling and legal resources, and, in the event of such sexual assault, the importance of immediate medical attention and advice, as well as the requirements of the law; the etiology, prevention, and effects of sexually transmitted diseases; and mental health education and awareness.[79]

But the bulk of the program and content of the state guide rests on the benefits of resisting premarital sex, the value of postponing sexuality, and adoption as the solution in circumstances of unwanted pregnancy. As an example of curricula which has garnered

[79] Commonwealth of Virginia, Department of Education, *Family Life Education Board of Education Guidelines and Standards of Learning,* (Richmond, VA, 2017), 2-5, PDF. http://www.pen.k12.va.us/instruction/family_life_education/ index.shtml.

significant attention from today's sex education advocates, the policies as they stand confirm the state's commitment to AOUME with progressive amendments and additions.

The 2004 Individuals with Disabilities Education Act requires that all students regardless of ability or disability status have access to age-appropriate, comprehensive Family Life Education adapted from the state plan. Compulsory content areas included relationships, abstinence, stress management, peer pressure, child abuse, prevention of sexual assault and others. The Special Education program stresses the vulnerabilities of students with disabilities in circumstances of abuse or neglect and pays extra attention in objectives and goals for prevention. But, as the general Family Life Education program lists, the Special Education version reinforces the importance of privatization of sexuality, resistance methods, and emphasizes adoption as the main alternative to unplanned pregnancy. While the provisions and adaptations serve as a framework to ensure all students receive education mandated by the state, the instructional resources retain many of the shortcomings of Virginia's broader policies, and the guide has not been updated since 2005.[80]

For FY2017, Virginia did not host any TPPP grantees, but the Department of Health did receive a total of $1,254,747 in Title V AOUME funding to be distributed to eight local health departments. The local health departments did earmark these funds to be dedicated toward students aged 10-14 which excludes high school populations from the interventions. Virginia did not apply to SRAE funding for their abstinence-based curriculum. All CPREP funding was distributed to civil society organizations with no mention of faith-based organization in their mission statements: Family Service of Roanoke Valley ($267,048); James Madison University's Institute for Innovation in Health and Human Services ($565,674); City of Alexandria

[80] Virginia Department of Education. *Family Life Education: Special Education.* (Richmond, VA, 2005).

($299,699); and the Virginia League for Planned Parenthood ($338,880). The public programming is aimed at students in and out of schools, in detention centers, residential treatment centers for students aged 10-21 throughout the state.

In 2016, Delegate Filler-Corn was successful in passing "An act to amend and reenact § 22.1-207.1:1 of the Code of Virginia, relating to high school family life education curricula; programs on the prevention of dating violence, domestic abuse, sexual harassment, and sexual violence," requiring identification and prevention of inappropriate/abusive relationships to be taught whenever family life education is delivered.[81] And, in 2017, Virginia Governor Terry McAuliffe passed House Bill 2257 to allow public schools to incorporate age-appropriate, evidence-based programs on the meaning of consent.[82] The bill received some criticism in the terminology that, "high school family life education curriculum offered by a local school division *may* incorporate," not that consent education is *required* when sex education is provided. But, any introduction of consent into family life education programming acknowledges that adolescent sexuality exists and students should be equipped with the tools for appropriate decision-making. As of 2017, Virginia does not mandate Family Life Education for all public schools, and if it is provided materials is not required to be culturally appropriate or medically accurate.[83] Delegate Filler-Corn and decision makers, alike, have been successful in introducing and enacting greater content guidelines, but in the face of a restrictive legislature committed to AOUME, attempts to strip the associated funding and support networks might be a greater obstacle.

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[81] Virginia. Title 22.1. Education. Chapter 13. Programs, Courses of Instruction and Textbooks. *§ 22.1-207.1:1. Family life education; certain curricula and Standards of Learning.* (VA, 2017).
[82] Virginia's Legislative Information System, 2017 Session, *HB 2257 High school family life education curricula; effective and evidence-based programs on consent,* Introduced by Eileen Filler Corn, (VA, 2017).
[83] "State Profiles Fiscal Year 2017: State Laws and Policies Across the United States," *SIECUS*, (2017).

iii. Colorado

Under Colorado state law, sex education is not mandated but the state recognizes the need "to ensure that all young people in Colorado have access to [1] evidence-based, [2] medically accurate, [3] culturally sensitive, and [4] age-appropriate comprehensive sexuality education, information, and resources to guide them in making informed decisions about their health and relationships." If sex education is provided in a public institution each of the four criteria are mandated for sexuality education, HIV/STD education, and healthy relationship education, and programs must incorporate all three content categories.[84] Critics of Colorado's "if-then" treatment of sex education propose that a system that doesn't have an overarching requirement is permissive of unchecked programming. But, sex education advocates in the state are aware that digression from abstinence-only makes is a stride in the right direction. However, the state continues to receive funding from federal AOUME grants.[85]

Grantees in Colorado received $818,713 in Title V AOUME funding, $749,900 in TPPP funding and $524,533 in SRAE funding. Although, the mandates coordinated with sex education if it is provided at all is tied to funding from a 2013 program of funding, the state continues to deliver abstinence-only in other settings. With Colorado entities unqualified for CPREP funding, there is also a large gap in population coverage between urban and rural populations. No tribe or tribal population received TPREP funding in 2017. Of the CDC's 16 critical sex education topics, Colorado did not report the results of the school-level questionnaires.[86]

In Colorado's *A Call to Action*, a report prepared by Colorado Youth Matter and The Healthy Colorado Youth Alliance, the Department of Public Health and Environment put

[84] "State Profiles Fiscal Year 2017: State Laws and Policies Across the United States," *SIECUS*, (2017).
[85] Liz McKay, "The State of Sex Ed in Colorado and Beyond," Colorado Youth Matter, March 3, 2015.
[86] "State Profiles Fiscal Year 2017: Colorado," *SIECUS*, (2017).

forward the first comprehensive plan for education curricula in 2012. Leading with promotion of healthy decision making, creation of safe relationships, self- and identity- acceptance, and an emphasis on programs that introduce accessible resources, the guide lists four objectives: 1) Decreased STI incidence, including HIV, rates, 2) Decreased teen pregnancy 3) Decreased sexual assault and dating violence, 4) Increased participation by youth in educational and career opportunities. Colorado was one of the first states to report that education in defense of healthy relationships and consent directly correlates with improved youth wellness outcomes, and the model for relationship building has tools for targeting and responding to the comprehensive list of physical, psychological, verbal, emotional, and sexual abuses. The *Call to Action* emphasized the interaction of civil society with public school systems by supplementing research methods and coverage, incorporating youth interviews, holding community conversations and focus groups, and community-wide surveying.[87] This provided a comprehensive guide for Colorado communities who observed the adolescent need. With special attention to outcomes and youth voice in programming, the Colorado model stands as a well-founded resource for comprehensive sex education programming.

Colorado often appears highly ranked in listings of best state sex education programs as the state led the country in declining teen pregnancy prevention. When the *Colorado Family Planning Initiative* launched in 2009, the teen pregnancy rate dropped by 15 percent within five years.[88] As a model for both urban and rural communities, Colorado lawmakers in support of AOUME maintained much of the traditional wording and rhetoric in state sex education guides

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[87] Colorado Department of Public Health and Environment, Y*outh Sexual Health in Colorado: A Call to Action*, (Denver, CO, 2012), http://co9to25.org/wp-content/uploads/2012/09/Youth-Sexual-Health-in-Colorado-A-Call-to-Action1.pdf.

[88] Ingold, John, "Colorado Sex Ed Program Closes After Trump Administration Cuts Federal Grant," *The Denver Post*, (September 20, 2017).

from the early 2000s as advocates are able to promote and succeed with expanded definitions within existing programs.

iv. California

In January 2016, California enacted the California Healthy Youth Act (formally known as the California Comprehensive Sexual Health and HIV/AIDS Prevention Education Act) to mandate that all students in seventh through twelfth grade receive comprehensive sexual health education and HIV prevention education.[89] The California guidelines began with redefined terms for "comprehensive sexual health education" and "HIV prevention education," and mentioned in a noted bold font "**abstinence-only education is not permitted in California public schools.**" [90] The Healthy Youth Act prohibits any religious influence as well. The 2016 enactment included cooperation of all in-school personnel and that in-service training be delivered through joint agreements, contract services, or regional planning to all educators working within the district.[91]

Among several notes of inclusion, the Act mandates the following:

- ✓ "Instruction and materials shall be appropriate for use with pupils of all races, genders, sexual orientations, and ethnic and cultural backgrounds, pupils with disabilities, and English learners."
- ✓ "Instruction and materials shall be made available on an equal basis to a pupil who is an English learner, consistent with the existing curriculum and alternative options for an English learner pupil as otherwise provided in this code."
- ✓ "Instruction and materials shall not reflect or promote bias against any person..."
- ✓ "Instruction and materials shall teach pupils about gender, gender expression, gender identity, and explore the harm of negative gender stereotypes."[92]

Beginning in grade seven, the district must provide educators equipped and cooperative in teaching about the safety and effectiveness of all forms of FDA-approved contraceptives—

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[89] California Department of Education, Coordinated School Health and Safety Office, *Comprehensive Sexual Health & HIV/AIDS Instruction: California Healthy Youth Act,* (April 3, 2017).
[90] *Comprehensive Sexual Health & HIV/AIDS Instruction: California Healthy Youth Act,* (April 3, 2017).
[91] California Education Code, Title 2 Elementary and Secondary Education, Division 4 Instruction and Services, Part 28 General Instructional Programs, Chapter 5.6 California Healthy Youth Act, Article 3 In-Service Training [51935 - 51936], *California Legislative Information,* (CA, 2016).
[92] Chapter 5.6 California Healthy Youth Act, Article 3 In-Service Training [51935 - 51936], *California Legislative Information,* (CA, 2016).

including anti-retrovirals, barrier methods, Long-Acting Reversible Contraception, other hormonal methods, etc.[93] In October 2017, the Healthy Youth Act amended the original required content to include information on human trafficking—as opposed to just sex trafficking—and sexual abuse. Sexual health educators are to impart skills in identifying early signs of abuse or violence from partners, intimately or not. [94]

The 2017 SIECUS State Profile on California included a break-down of all federal funding in California's sexuality public education. In FY2017, California conclusively decided not to apply for Title V AOUME federal funding and did not receive any grant appropriations from SRAE grant programs. In participating in TPREP the state was awarded a total of $725,607. With both intervention programs in California adapting the Becoming a Responsible Teen (BART) and the Student Together Against Negative Decisions (STAND) programs to the cultural expectation of American Indian and/or Alaskan Native populations. With TPREP targeting adolescents in susceptible living and/or working conditions, and combined the programming is expected to approach approximately 1,000 young people aged 10-19.[95]

California is the first state to have introduced a plan which requires all individuals to undergo comprehensive sex education twice throughout their secondary public education, and was the first to introduce information on human trafficking in sex education curricula.

IV. SEX EDUCATION MANDATES AND ASSOCIATED HEALTH AND WELLNESS OUTCOMES

i. Approaching new methods of assessment

[93] "Fast Facts about the California Healthy Youth Act," *California Health Youth Act Sexual Health Education Toolkit,* ACLU Northern California, (CA, 2016), Accessed April 15, 2018.
[94] "2017 Sex Ed State Legislative Year-End Report," SIECUS, (2017).
[95] "State Profiles Fiscal Year 2017: California," *SIECUS,* (2017).

To date, proponents of AOUME and mere pregnancy prevention plans proudly tout dropping adolescent pregnancy rates as the only indicator for successful sex education programs. Adolescent pregnancy rates are dropping undeniably. The chart in **Table 1** from the CDC's 2010 Pregnancy Rates Among Women Report shows pregnancy rates dropping from 116.8 births per 1,000 in 1990, to 85.8 births in 2000, to 58.9 births in 2010.[96] When programs are clearly titled, packaged, and tied to parallel outcomes the New Christian Right and other conservative movements can take credit for successes of more comprehensive—or holistic—movements.

In *The State of Sex Education in the United States*, Stidham Hall, et. al. point to a critical gap in information between policy and the actual education students receive. In many cases school boards may have policies on how they see sex education to be instituted, but the material and delivery are hugely dependent on a variety of stochastic components which are largely variable due to individual morality, time restraints, curricula restraints, and general misinformation. Stidham Hall, et. al mentions that teen birth rates are declining; however, pregnancy prevention programs do not encompass the larger needs of adolescents throughout the U.S. Additionally, these programs which rest on policy initiatives of the 1980s and 1990s are majorly abstinence only until marriage education (AOUME) based, which deflect from many of the true concerns and needs of younger populations. As far as policy design, President Barack Obama proposed a national commitment to youth access to age-appropriate, accurate information on health and an elimination of AOUME programs in favor of more holistic programs in his FY2017 budget.[97] However, well-substantiated position in opposition to AOUME has yet to find

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[96] Sally C. Curtain, Joyce C. Abma, and Kathryn Khost, "2010 Pregnancy Rates Among U.S. Women," Centers for Disease Control and Prevention, (Atlanta, April 6, 2010), https://www.cdc.gov/nchs/data/hestat/pregnancy/2010_pregnancy_rates.htm#fig1.

[97] Kelli Stidham Hall et al., "Editorial The State of Sex Education in the United States," *Journal of Adolescent Health 58*, no. 6 (June 2016).

itself in a widespread manner across youth health and education policy within state governments who do have the authority to systemically change the way adolescents receive sex education. This project is the priming for a further examination in the ways that policy can infiltrate school systems in a mass scale for the betterment of population health and wellness.

A 2015 study from the Guttmacher Institute found evidence of significant declines in certain aspects of sex education instruction and highlighted many of the gendered implications. The study noted that from the time periods of 2006-2010 to 2011-2013:

- ✓ Adolescent female receipt of formalized education on birth control declined from 70% to 60%
- ✓ Adolescent female receipt of formalized education on STDs/STIs declined from 94% to 90%
- ✓ Adolescent female receipt of formalized education on HIV/AIDS declined from 89% to 86%
- ✓ Adolescent male receipt of formalized education on birth control declined from 61% to 55%
- ✓ Observed instruction on a variety of topics from either one or both parents did not change significantly and remained at approximately 21% for females and approximately 35% of males who did not receive instruction about birth control in any form or method.[98]

Guttmacher found that much of the decline was prominent for those students living in nonmetropolitan areas. With a specialized look into the actual receipt of sex education instruction, current advocates are directing their attention to bringing parents into the conversations with public schools. In continuing to address the gap between policy, reception, and practice measures in practical health and wellness outcomes will be the next large angles advocates should take to truly measure the success and failures of programs in place. While institutionalizing instruction on birth control, and a variety of other formally mentioned topics are key, there is still a large variability in accuracy and delivery. To observe impact-evaluation, which assesses interventions have desired outcomes, researchers must actually measure desired outcomes in relation to implemented or reformed programs.

Although, direct associations between state-wide policies and outcomes are difficult to attain, there is a large potential in this directional hypothesis because of the literature on which

[98] Lindberg, Maddow-Zimet, and Boonstra 2016, 624.

my thesis was founded. Laura Duberstein Lindberg, of the Guttmacher Institute, found a negative correlation between sex education programs and risky sexual behavior from the National Survey of Family Growth including 4,691 males and females. Lindberg and Maddow-Zimet's findings concluded that receipt of sex education resulted in delay in the point of first intercourse and likelihood of using at least one form of contraception at first intercourse. The emerging discourse among those who seek to expand sex education which underlines the value in discussing sexual violence within an instituted sex education curriculum.

As holistic sex education programs aim to establish healthy sexuality, discussions on gendered sexuality and the morality of sexuality could help to eliminate sexual violence among those who receive this education.[99] Wazlawik claims experiencing sexual violence has "undisputed" psychosomatic consequences. He demonstrates that sexual health should not only imply the absence of infections but also "the genuine individual ability to make positive sexual experiences free of constraints, discrimination and violence."[100] His paper is a part of the growing philosophy that holistic sexuality education should reach further than medically accurate biology and mechanics, but adolescents should be provided with the life skills to embrace and promote healthy sexuality and relationship. Both studies clearly support the directional nature of the hypotheses supporting this research.

Nancy Kendall used a policy-as-practice research strategy to construct her comparative ethnographies of the state systems and actors who influenced the schools and classrooms she observed. Policy-as-practice frameworks take the discordance between the codification of

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[99] Lindberg, Laura Duberstein and Isaac Maddow-Zimet. *Consequences of Sex Education on Teen and Young Adult Sexual Behaviors and Outcomes*, (2012).

[100] M. Wazlawik, B. Christmann, and A. Dekker, "Sex Education and Prevention of Sexual Violence. Contributions to a Differential-Sensitive Prevention of Sexualised Violence," Bundesgesundheitsblatt-Gesundheitsforschung-Gesundheitsschutz 60, no. 9 (2017): 1040-1045. doi:10.1007/s00103-017-2594-x.

government regulation and the actual outcomes of those policy decisions into account. In an attempt to determine the qualitative effectiveness of policy and law, policy-as-practice works account for the context and key actors in evaluating outcomes. The comparative piece does not illustrate parallel circumstances in each state but rather the uneven "constellation of forces" including varied levels and ideologies of governmental policy, school policy, curriculum construction, parent associations, etc. She observed the persistence of church or other religious influence and how other community organizations organized to influence curriculum. In classrooms, she made qualitative assessments on the medicalization of language, the function of social stigmas, inclusion or exclusion of the students' experiences, graphic nature of the imagery used to educate on STDs and STIs, tone of discussions on abortion, presence of tension or resistance to certain topics, and a variety of pedagogical approaches and practices. The ethnographies aimed to display how this array of forces interact and produce the daily sex-education practices students receive, including the hidden narratives within. In her book, *The Sex Education Debates*, Kendall suggests a shift toward measuring the "hidden" sex education students often receive within their schools. In a variety of settings, the hidden agenda can materialize in: “

> speech, norms, and practices in all of the students' classrooms, school cafeterias, locker rooms, dances, nurse's offices, libraries, principals' offices, and so forth... Hidden curriculum could include teachers monitoring how girls and boys dress, physical and verbal abuse directed by teachers and students towards sexual- and gender-identity norm-breaking students, student and teach responses to such abuse, debates over whether students should be allowed to for GSAs, and peer pressure to adhere to particular sexual norms."[101]

Kendall's work was formative in constructing the framework supporting this study. Kendall's observations resulted from in-person recording of school classrooms, parent association meetings, student social gatherings, etc. She had the capability to construct

[101] Kendall, 12.

comparative sections through policy-as-practice research. While I did not have this capacity to reveal the student experience as she did, the state aggregate furthers the presentation of the argument at hand. Further exposition of Kendall's categorization system is explained in the Discussion section, but a key takeaway should stand that regardless of scope, evaluation should extend to cover a larger breadth of measures.

ii. Deriving a hypothesis from the literature

By comparing state mandates to an expanded set of measurable adolescent outcomes, advocates can begin comparing individual state programs and promoting holistic programming. To reiterate my argument in favor of introducing more holistic measures of evaluation to reflect and reinforce new movements in sex education, the hypothesis expects preferable student health and wellness outcomes from states with preferable mandates. The included policies and surveys which support this study only cover high school students educated in public schools, but the indicated population is still evidently quite broad. Sex education can include a variety of topics such as abortion, abstinence, conception, contraception, family planning, masturbation, pregnancy, puberty, reproductive biology, sexual abuse, sexual activities, sexual orientation, sexual pleasure, sexually-transmitted diseases and infections, venereal diseases, and sexual morality.[102] This topics list has a broad scope, but implemented programs rarely integrate them all—especially in a preferable format. While state requirements are still rather loose, this study uses state mandates as a predictor for positive or negative health and wellness outcomes. The included state policies are the exposure, the interventions which students experience. The included dependent variables all fall under categories of healthy sex practices or experiences of risk, violence, force, or coercion in a student's sexual experience which underline Lindberg's

[102] Robin E. Jensen, *Dirty Words: Ta (Urbana, Chicago, IL: University of Illinois Press, 2010), xiv.*

conclusion. While the presence of a mandate might not be entirely indicative of the student experience, when asserting broad proposals about the success of a state's program, the actual policy is key.

Varying errors and limitations make extrapolating regression-based predicted outcomes on any given mandate essentially impossible, but the presence and absence of survey data is consistent with the theory. The discussion following also asserts that constructive surveying should not depend on one-dimensional measures of student experiences such as condom usage, incidence of sexual force or coercion, or age of first intercourse. Evaluations should advance by including multi-dimensional measures of inclusion and exclusion, education on resource and guidance accessibility, comfort in the classroom and other school environments, gender empowerment, and/or consent education with both qualitative and quantitative indicators.

iii. Operationalization and methodology

My hypothesis stands that holistic sex education delivered to multiple age groups with an appropriate delivery of the material will show a decline in risky sexual behaviors/experience[103] and an increase in healthy sexual behaviors. The independent and dependent variables used to operationalize the theory were derived from the Sexuality Information and Education Council of the United States (SIECUS) state profiles and Youth Risk Behavior Surveillance System (YRBSS) data. My controls included 1) The Commonwealth Fund's Scorecard on State Health System Performance used to rank the health systems of each state in along the dimensions of Access & Affordability, Prevention and Treatment, Avoidable Hospital Use & Cost, Healthy Lives, and Equity and 2) total school expenditures spending, per pupil by state. The Commonwealth Fund created a matrix by which they assessed the access and affordability,

[103] The distinction between behavior and experience rests on the assumption that behaviors are an individual's choice and/or preference; whereas, experience would include unintended incidences of violence or harassment.

prevention and treatment, voidable hospital use and cost, healthy lives, and equity by categorizing each state within top, second, third, and bottom quartiles of each of these measures. Then, each state was ranked in the way of how well the health system performed in an additive measure.[104] The 2015 Commonwealth Fund Score rankings were used as this information is contemporaneous with the regressions' dependent variables all from the 2015 YRBSS data collection. The rank is the first included control. The second control included in the models derive total public-school expenditures per pupil from Census Bureau data.

While the following methodology rests on a limited operationalization, it grounds the overall argument in a manner that should prove that a more complex collection of data is required if those implementing interventions observed which programs preferred health outcomes.

Each of these response variables were derived from the CDC High School YRBSS Online Data Analysis Tool. In search of survey data reflecting the proposed assessment measures, the CDC high school YRBSS seems to provide the greatest collection at the present. Additionally, much of my greater thesis research is oriented toward what information and access students actually gained from their public-school sex education programs, so survey data is appropriate for this intention.

2011 state mandates were chosen as predictors for effects in youth health and wellness outcomes because the most recent iteration of the YRBSS youth online data analysis tool presents data from 2015. It would be safe to assume that all students who responded to the 2015

[104] Douglas McCarthy, David C. Radley, and Susan L. Hayes, *Aiming Higher: Results from a Scorecard on State Health System Performance, 2015 Edition*, The Commonwealth Fund, The Commonwealth Fund, December 2015, 4.

YRBSS entered high school during or after 2011, so the lag accounts for the oldest survey responders. This study included the following five parameters as defined by state law:

1) Broad mandate requiring sex education in any form *(SE_mandated11)*
2) Broad mandate requiring HIV/STD education in any form *(HIV/STD_mandated11)*
3) State policy prohibits information or referrals on abortion services, and any related information must be addressed in the context of negative consequences *(abinfo_prohibited11)*
4) Mandate requires promotion of heterosexual marriage, regardless of sex education requirement *(heteromarriage_promoted11)*
5) Presence of discriminatory policy towards LGBTQQIA students through exclusive promotion of heterosexual marriage or excludes homosexuality as a socially acceptable alternative to heterosexuality *(negativeLGBTQ11).*

The ideological direction of the policy is indicated in the phrasing of each mandate. For example, the first predictor of interest is the broad requirement of public sex education written in state policy. Under the hypothesis, that holistic sex education will result in positive health outcomes, there should be a positive correlation with this predictor and positive wellness outcomes and a negative correlation with negative outcomes. In suit, the fifth predictor of interest would be expected to have negative correlations with positive wellness outcomes and a positive relationship with negative outcomes. In assessing the results and findings, directionality in the relationships are the true indicators of the effects of state mandates.

All of the included outcome measures were obtained from the 2015 high school survey within the sexual behavior and unintentional injuries and violence categories. The YRBSS poses a school-based survey to middle and high school students covering a large scope of health topics. The resulting variables convey state rates of affirmative responses in accordance with the directionality of the question at hand. The following eight measured variables indicate more apt measures of sex education programming from the 2015 YRBSS:

1) Experienced sexual dating violence—counting kissing, touching, or being physically forced to have sexual intercourse when they did not want to by someone they were dating or going out with one or more times during the 12 months before the survey,

among students who dated or went out with someone during the 12 months before the survey *(pct_sexdatingviolence15)*
2) Were currently sexually active—had sexual intercourse with at least one person during the 3 months before the survey *(pct_sexactive15)*
3) Did not use any method to prevent pregnancy—during last sexual intercourse, among students who were currently sexually active *(pct_nocontrause15)*
4) Had sexual intercourse before age 13 years—for the first time *(pct_sexbefore1315)*
5) Drank alcohol or used drugs—before last sexual intercourse, among students who were currently sexually active *(pct_alcdrugssex15)*
6) Were ever physically forced to have sexual intercourse—when they did not want to *(pct_forcedsex15)*
7) Experienced physical dating violence—counting being hit, slammed into something, or injured with an object or weapon on purpose by someone they were dating or going out with one or more times during the 12 months before the survey, among students who dated or went out with someone during the 12 months before the survey *(pct_physdatingviolence15)*
8) Had sexual intercourse with four or more persons—during their life *(pct_fourormorepartners15)*

Each measure is directionally phrased where a student's affirmative response would imply greater risk. The discussion section will emphasize that current surveying cannot provide a comprehensive understanding of the successes and failures of sex education programming, but the current YRBSS is a foundational starting point.

The two controls examined within this project look to limit the influence that a confounding factor might have on the dependent variables of interest. First, total school expenditure per pupil, by state control for the measure that money in education systems are major limiting factors on the education programs instituted in all subjects. This variable was derived from the Census Bureau's data on education spending in 2015.[105] The second, state health system ranking, controls for the possibility that it may not be the mandates specifically to sex education which result in lowered outcomes in sexual health and wellness. The

[105] Education Spending Per Student by State, E.Republic: Smart Media for Private Sector Innovation, *Governing: The States and Localities*, December 8, 2017, Accessed December 2017, http://www.governing.com/gov-data/education-data/state-education-spending-per-pupil-data.html.

Commonwealth Fund creates a health system scorecard for each state along five difference dimensions, finalized with a ranking system which places each state on a scale of 1-51.[106] If access to information as a child and/or access to the services that one needs are already a limiting factor, it could be those confounders which diminish adolescent sexual health and wellness.

The series of regression models pairing the SIECUS and YRBSS data were inconclusive. The mandates rarely revealed a direct relationship with the dependent variables of interest. And, those models including the possible confounders did not add to the explanatory value either. Springing straight from policy to health and wellness outcomes cannot reveal the state of sex education outcomes among U.S. States alone—indicating the greater need for study of specific interventions and causal mechanisms. Starting with a limited sample size—because many states do not report back to the CDC on any given measures—confounders within the model further the probability that an included regression will be significant. The following findings sections represent the models of interest, but also elude to many of the limitations posed directly because of limited reporting by state health departments.

iv. Findings

I expected a positive relationship between the outcomes and those states prohibiting abortion information and referrals, those states that promote heterosexual marriage, and those states with negative LGBTQ policies. One would expect a negative relationship between the outcomes of state mandates of sex education in general and mandated HIV and STD/I information in public education. Both of these expectations fall in line with the survey questions for each of the outcomes being skewed where greater percentages indicate greater risky behavior

[106] Douglas McCarthy, David C. Radley, and Susan L. Hayes. Aiming Higher: Results from a Scorecard on State Health System Performance, 2015 Edition, The Commonwealth Fund, (December 2015), Accessed October 2015, http://www.commonwealthfund.org/~/media/files/publications/fundreport/2015/dec/2015_scorecard_v5.pdf.

prevalence. The results from this study are mainly inconclusive when examining each relationship between state mandates and reported rates of the outcomes. No single mandate signified a significant relationship across all of the measured outcomes. When looking to **Table 2** each bolded coefficient indicates a significant relationship with a directionality that supports the hypothesis of this paper.

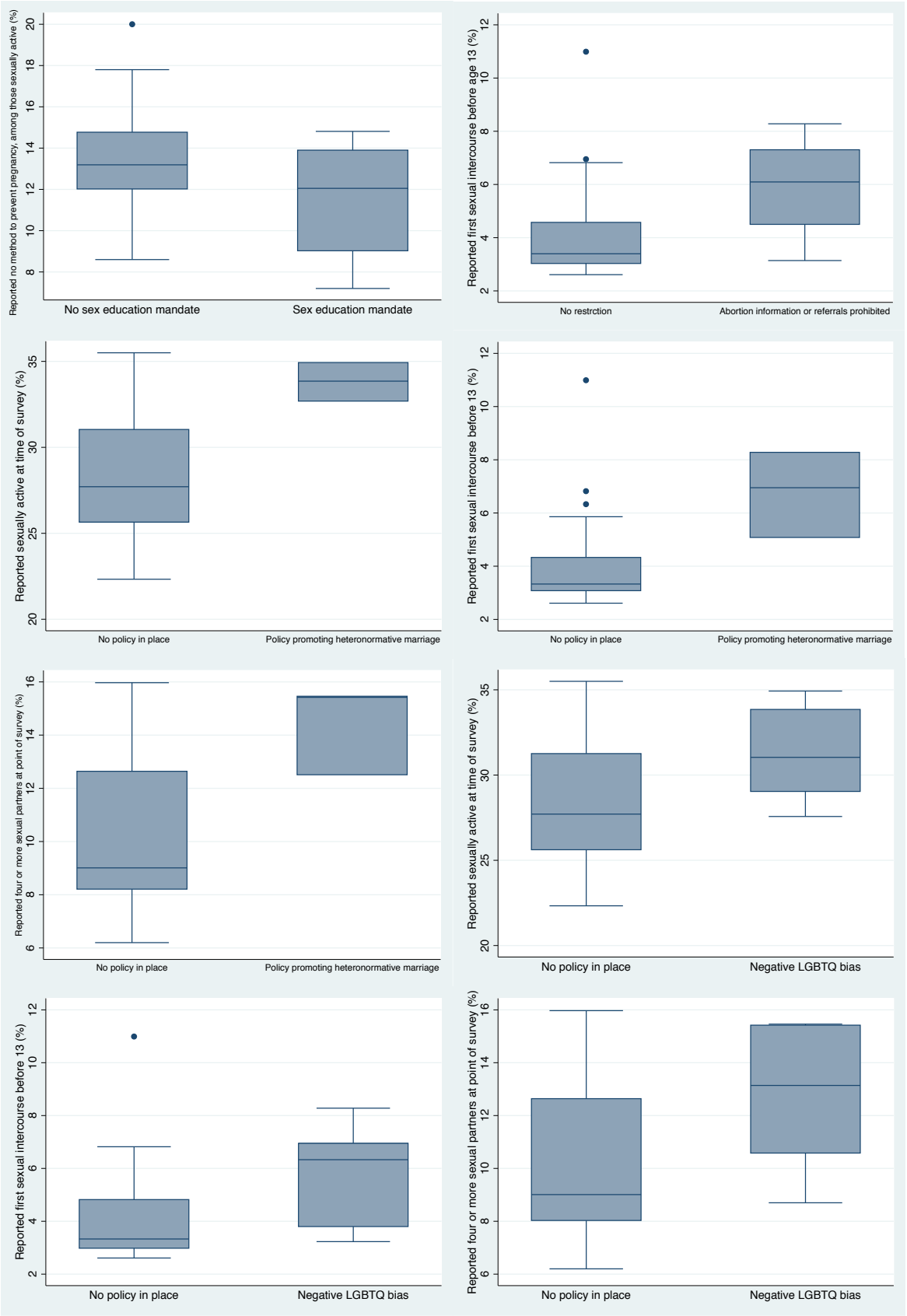
In examining further models to examine the relationship between policies and outcomes, an additive variable for the mandates was created for a multi-dimensional look at state sex education policies. Ideally, when evaluating state sex education programs, an indicator could rate states on the absence or presence of certain policies. With the indicators at hand, all five policy categories of interest were added together. With the general sex education mandate variable and the HIV/STD/I information mandate reversed (0=1, 1=0) I created the variable 'fivepoliciescount' which ranked states on their policies. A score of zero would indicate a state with the best policy options for the five included variables and a score of five would indicate the combined set of: no sex education mandate, no mandate requiring HIV/STD/I information, policies promoting heterosexual marriage, policies prohibiting abortion information and referrals, and policies with a negative LGBTQ bias. Neither the simple regression model nor the multi-variate model including the controls resulted in significance, indicating a greater additive index must be adapted for future studies.

Presence of the included controls didn't result in a large difference. But, in the grand scheme of all five predictor variables of interest and the eight measurement variables of interest, the controls were not conducive to greater coefficients of determination or significance levels. One of the regressions proved to be significantly opposite of the hypothesized relationship. There was a counterintuitive significant relationship between the presence of the public-school sex

education mandate variable and the percent of students reporting having sex before age thirteen. The positive coefficient affirms that those states with a sex education mandate had higher percentages of students reporting first sexual intercourse before age 13. The discrepancy between the hypothesis and this specific regression could be suspect of two factors. With only 20 states mandating sex education in 2011, the remaining 30 states plus D.C. have the freedom to deliver education in whichever manner they see fit. Colorado, Connecticut, Massachusetts, and New York, are all among the best states for sex education, but all four (plus others) did not have an official sex education mandate in 2011. The expectation that the presence of a sex education mandate as a prerequisite for healthy outcomes is debunked as many states sans sex education mandate still delivered comprehensive programming This potential explanation and limited sample sizes could reveal misinformation bias and selective exclusion of data—in this case states self-selected out of collecting the important indicator. Of course, there are many confounders at play, but this relationship should be noted when looking at the findings of this study.

In weighing the analyses on the whole, the hypotheses were not confirmed. As many of the included models have moderate differences in means and moderate significance, the coefficients of the relationships did not confirm the anticipated story. In further studies, the magnitude of the effects of the predictors and the level to which model variables explain the variability are important when examining significant relationships.

The following charts reveal comparisons of the significant relationships as identified through the simple regression models. The visual representations illustrate the nuanced comparisons with the binary independent variables at hand:


Reported no method to prevent pregnancy, among those sexually active (%)
8
10
12
14
16
18
20
No sex education mandate
Sex education mandate
Reported first sexual intercourse before age 13 (%)
2
4
6
8
10
12
No restrction
Abortion information or referrals prohibited
Reported sexually active at time of survey (%)
20
25
30
35
No policy in place
Policy promoting heteronormative marriage
Reported first sexual intercourse before 13 (%)
2
4
6
8
10
12
No policy in place
Policy promoting heteronormative marriage
Reported four or more sexual partners at point of survey (%)
6
8
10
12
14
16
No policy in place
Policy promoting heteronormative marriage
Reported sexually active at time of survey (%)
20
25
30
35
No policy in place
Negative LGBTQ bias
Reported first sexual intercourse before 13 (%)
2
4
6
8
10
12
No policy in place
Negative LGBTQ bias
Reported four or more sexual partners at point of survey (%)
6
8
10
12
14
16
No policy in place
Negative LGBTQ bias

In looking at the raw differences in proportions it is difficult to determine whether or not the differences are significant because the survey data has quite a small range when comparing each of the binary independent variables. But all of the included plots are of the significant relationships. One main assessment should be noted when analyzing the included box plots. Each of the simple relationships have significant mean differences which appear quite small numerically. The plot showing the comparison of rates reporting no contraceptive usage between states with a sex education mandate and those without, only reveals a mean difference of 1%. The other mean difference ranges span around 4-5%, which is not apparently significant. Because difference in the ranges are nuanced, alternative graphics could further display the policy story of sex education in the United States.

In looking at the following visualizations of outcomes across states, the clear lack of reporting on youth risky behavior emerges. The stark takeaway from the following images is number of states shaded entirely black.

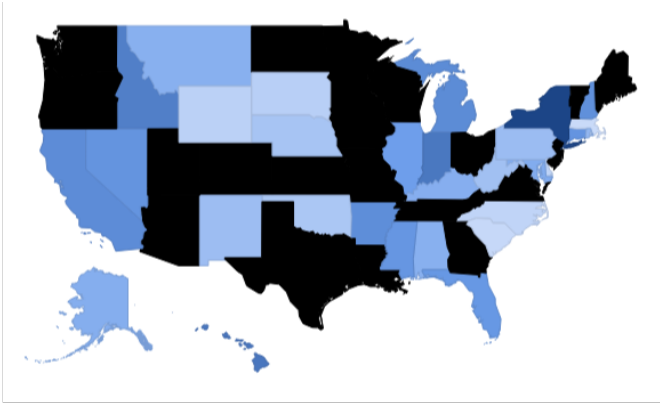


Figure 1 Reported experience of sexual dating violence from YRBSS 2015. Rates ranged from 7.84% in MA to 14.73% in NY. NY, HI (12.72%), IN (12.65%), ID (12.36%), and MI (11.85%) report the highest incidence rates. 31 out of 51 states reported this variable.

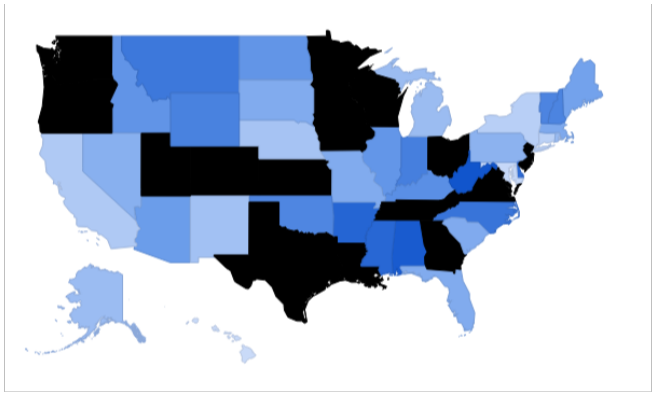


Figure 2 Reported sexually active at the point of survey from YRBSS 2015. Rates ranged from 22.33% in HI to 35.5% in WV. WV, AL (34.93%), AR (34.09%), MS(33.85%), and DE (33.52%) report the highest incidence rates. 36 out of 51 states reported this variable.

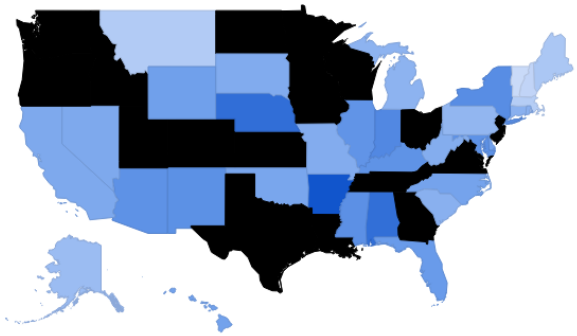


Figure 3 Reported no method of pregnancy prevention (no contraceptive usage) when engaging in sex within the past three months prior to survey from YRBSS 2015. Rates ranged from 7.2% in VT to 20% in AR. AR, NE (17.8%), AL (17.72%), IN (15.49%), and NY (15.09%) report the highest incidence rates. 34 out of 51 states reported this variable.

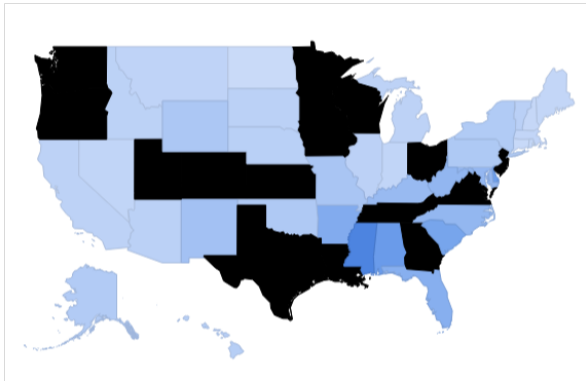


Figure 4 Reported first sexual intercourse before age 13 from YRBSS 2015. Rates ranged from 2.6 % in ND to 10.99% in DC. DC, MS (8.28%), AL (6.95%), DE (6.82%), and SC (6.33%) report the highest incidence rates. 36 out of 51 states reported this variable.

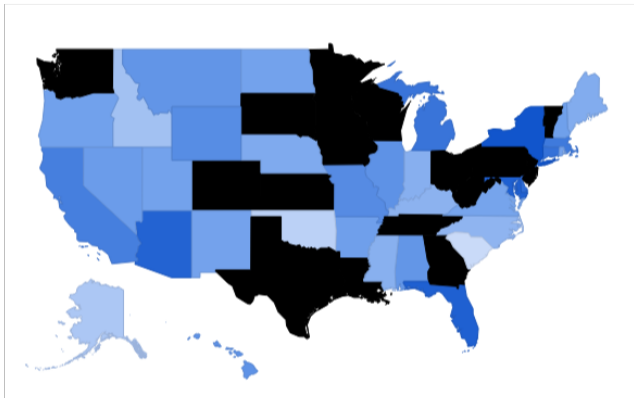


Figure 5 Reported using drugs or alcohol prior to engaging in sexual intercourse from YRBSS 2015. Rates ranges from 13.48% in SC to 24.56% in NY. NY, MD (23.74%), FL (23.74%), AZ (23.49%), and DE (22.83%) reported the highest incidence rates. 35 out of 51 states reported this variable.

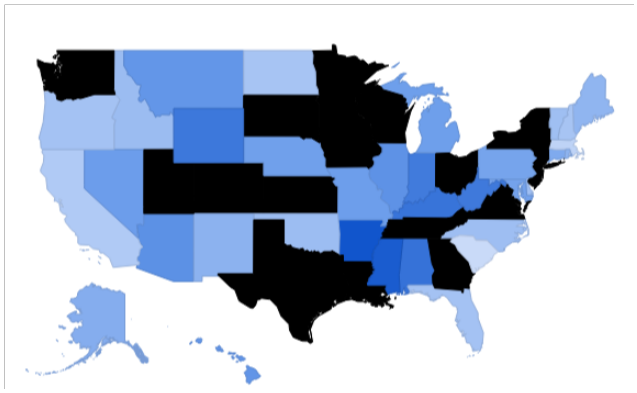


Figure 6 Reported experience of forced sexual intercourse from YRBSS 2015. Rates ranged from 5.09% in SC to 11.68% in AR. AR, MS (11.35%), AL (10.36%), KY (10.28%), and WY (10.11%) reported the highest incidence rates. 35 out of 51 states reported this variable.

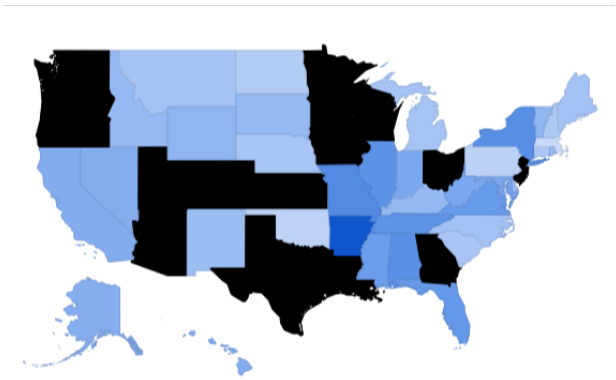


Figure 7 Reported experience of physical dating violence from YRBSS 2015. Rates ranged from 6.67% in MA to 14.57% in AR. AR, MO (11.71%), NY (11.51%), AL (11.41%), and IL (11.27%) reported the highest incidence rates. 37 out of 51 states reported this variable.

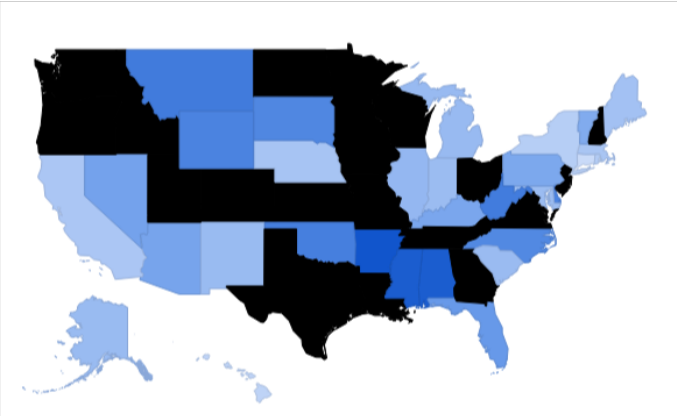


Figure 8 Reported four or more sexual partners in life time by the point of survey from YRBSS 2015.Rates ranged from 6.2% in CT to 15.97% in AR. AR, MS (15.46%), AL (15.42), DC (13.77%), and MT (13.44%) reported the highest incidence rates. 32 out of 51 states reported this variable.

Shaded states are indicative of the magnitude of reporting for each outcome. Once again, the survey questions are skewed where affirmative reporting indicates the greater risk. And, when taking a look at the variation in shading, it is important to consider the range of rates as mentioned in the captions below each graphic. The five darkest states are listed in each map's caption, and a few names emerge as repeats: Alabama, Arkansas, Mississippi, New York, and Washington D.C. In looking back to the control variable of ranked state health systems, Mississippi (no. 51), Arkansas (no.49), and Alabama (no.47) appear within the bottom five within the Commonwealth Fund scoring system. Underfunded health systems suffer in regards to cost and service accessibility, but Mississippi, Arkansas, and Alabama may reflect an underlying denial of sexual-social consequences. In the late 1980s and 90s—when teen pregnancy prevention was extremely visible as a national concern—these three states observed some of the highest rates. The country, as a whole, has paid mind to pregnancy rates and national funding for pregnancy prevention plans and services have been distributed to these states in the lowest quartile of the health care system ranking. But, when considering how some states have advanced past these measures, many considerations in favor of adolescent health and wellness have been neglected.

For each variable, 14-20 20 states do not report the included variables at all. Regardless of selection bias as described in the errors section to follow there is much to be said about those states who deny the YRBSS altogether. Students in states that underreport are clearly affected, but when a state refuses to widely proctor surveying as a whole, state health systems face an even larger hurdle. There are also regional trends present in those states who do not report altogether. Many of the mid-Atlantic states, a few key southern states, Pacific northwestern states, and a selection of Midwestern states repeatedly did not report certain survey questions. Those states that did not report a single one of the indicators are listed as follows: Colorado, Georgia, Iowa, Kansas, Louisiana, Minnesota, New Jersey, Ohio, Texas, Washington, and Wisconsin. And, Tennessee, and Utah only reported one of the eight variables each. How do we approach states who do not reported these variables of considerable concern for youth health and wellness? Is there a fear of the findings that may come from expanded surveying tactics? And, should surveying be implemented through the mechanism of improved sex education; or should surveying be the first priority of health advocates to drive program implementation? The 'constellation of forces'—as utilized by Nancy Kendall—must be a prominent guide for those attempting to improve sex education on a state level. As important actors and movements in certain regions are identified, advocates can then begin to leverage to their interests, accordingly.

v. Discussion

In the conclusions of this research, I could never point to certain students or even certain schools and conclude that better sex education programming provides a better foundation for students who may participate in risky or violent sexual behaviors. The conclusion from the scope of this research could not indicate education as a causal mechanism of improved adolescent outcomes simply because the data was not aggregated at an individual- or school-based level.

Instead this study intended to portray those states with better mandated programming as those with a greater outcome of youth health and wellness.

An ideal state-level model would record changes in the independent and dependent variables over time with respect to individual respondents and the aggregate rates. The current model is open to error because many students might have observed their sex education differently from that mandated by 2011 policy if the practice of policy changed. With a smaller scope of just one state or just one policy shift, there would be greater room for conclusions on causality or the true student experience. A study which accounts for changes in independent variables and dependent variables over time is far beyond the capacity of this project but is worth mentioning. Aggregate data might appear removed from the individual. But, this systems-based approach might be advantageous for advocates trying to convince policymakers to mandate student surveys in states with prevalent social stigmas against even asking the necessary questions.

Although the included controls did not increase significance for the most part, it is still crucial to consider the advantages of an established health care system in a holistic sense. There are often unpredictable benefits when health systems are created to provide the resources and accessibility for the greatest distribution of people. Additionally, when public school cost restraints are alleviated from overall budgets, it would be easier to reallocate funding to those programs which need additional support at any given time. The prediction that better health care systems and higher funding per student measures would confound the relationships between the independent and dependent variables of interest. In this study, the included controls were not found to be significant confounders, but further incorporation of similar variables could prove otherwise.

vi. Errors/Limitations

A variety of limitations and errors accompany my work, but they do lead straight to the theories guiding my overall thesis work. As mentioned before the independent variables are all 2011 mandates and the dependent variables are 2015 YRBSS survey data measures. While using these measures does account for the fact that some of the oldest survey respondents might have had sex education four years prior to taking the survey, it does not have the ability to consider changes over the years. And, because there are only 50 states included in the model, if even a few of the states changed their mandates—which they have—it would be possible that the data could have further supported the hypothesis.

A second error is found in the construction error present in the model. Each of the independent variables are quite broad when actually looking at the true outcome of school systems. As the structure of this project stands, the associated outcomes and state policies experience a large gap in dissemination of information as it is, so when concluding it is essential to recognize the flaw.

The YRBSS could be further examined for potential confounders as the same populations of students are surveyed on a variety of health topics. Measures of physical activity, dietary behavior, and obesity could be indicative of environmental influence on student health behaviors which could in turn implicate school systems and policy. Additional considerations to these potential confounders would be supplementary to the narrative, but of course would not prove causation.

The data is aggregated at the state level which poses a challenge when considering sample sizes and degrees of freedom in the actual regressions. It is incredibly important to note that state mandates aren't the best way to operationalize the type of sexuality education students

experience. But even when making judgements at the state-level, conclusions are stunted by the limited ranges in the outcome variables and the limited sample size. When examining the magnitude of any given relationship, it would be difficult to assert a definitive stance. Although most of the directions of the significant relationships support my hypothesis, the range of state reported percentages for any given dependent variable is quite limited in nature.

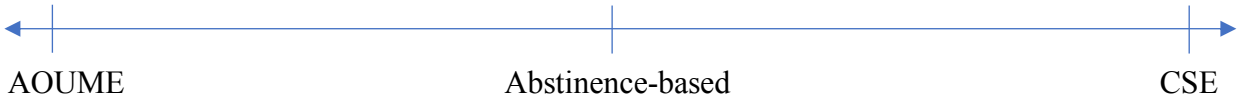
With regards to selection biases, YRBSS data is only inclusive of those students and schools who were compliant in the national survey initiatives in 2015. And along the same vein, those schools which choose to conduct the survey in its entirety may have a factor that is reflected and skews data as well. Because survey reporting itself is not mandated by law, the collected YRBSS data excludes many states for each of the included dependent variables. This leaves the models with a decreased power of the test which is important when aiming for significance. And finally, internal validity of the surveys could be questioned due to inaccuracy in personally responding to sensitive or uncomfortable survey questions while students may have various motivations to answer dishonestly.

In finding that state mandates, alone, do not portray the full story of how sex education is delivered by educators or received by students for the betterment of sexual health and wellness, the next steps in furthering associated research is expanding and experimenting with other models and elaborating on how current state education systems facilitate sex education.

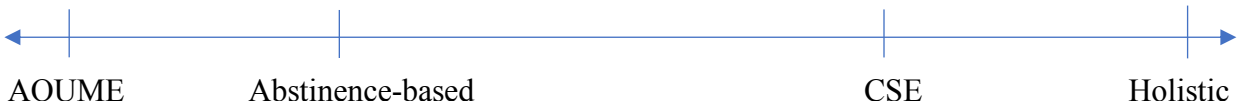
V. SOLUTION: A COLLABORATIVE STANDARDIZED POLICY

Regrouping to current movements in sex education

As mentioned previously, Nancy Kendall's *The Sex Education Debates* was formative in the construction of this study. Kendall's framework uses a spectrum of sex education programs as displayed below:



With AOUME and CSE at opposite sides of the categorization, she placed Florida under the AOUME category, Wyoming under the Abstinence-based education category, and Wisconsin and California under the CSE category.[107] This framework was helpful, but must be expanded to include holistic sex education at the farthest right, past CSE. Holistic sex education has emerged to discuss the Reproductive Justice movement addressing racialization and discrimination and inclusion of lesbian, gay, bisexual, transgender, queer, questioning, intersex, and allies (LGBTQQIA) communities. This paper has been constructed with 'holistic sex education' as the overarching title awarded to programs who are conscious of all of the aforementioned progressive ideologies. In further ethnographies, researchers should use a framework as proposed below:



It should be noted that AOUME and abstinence-based education are closer to one another on the spectrum line and CSE and holistic reflect the same. In considering the movements as described in the sections prior, those states maintaining abstinence compared to those states who continue to make advancements in the path of holistic comprehensive sex education as defined by the Federal Center for Health Education are becoming more polarized. This increased separation

[107] Kendall, 24.

between categories could prove to be a larger hurdle in future years. Transnational conversations on sex education are moving to include holistic programming as the ideal.

The Global Case

With global developmental goals targeting various measures of progress in reproductive health and reduction of sexual abuse and violence, the International Planned Parenthood Federation and the WHO are leading movements in favor of holistic sex education abroad the U.S. Among the Sustainable Development Goals as set for 2030, UN objectives include:

- ✓ Target 5.2: Eliminate all forms of violence against all women and girls in the public and private spheres, including trafficking and sexual and other types of exploitation.
- ✓ Target 16.2: End abuse, exploitations, trafficking and all forms of violence against and torture of children.

In 2008, the World Health Organization (WHO) entrusted the Federal Centre for Health Education (BZgA), a group of 19 experts from Western European countries, with creating standards of holistic sexuality education on. BZgA released the Standards for Sexuality Education in Europe: A framework for policy makers, educational and health authorities and specialists in 2010 and have since been working to propel the implementation throughout European countries with support of the European Union (EU). Since 2010, the task force has been evaluating the program and producing policy briefs on the status of the holistic programming throughout Europe. While some countries were forerunners in implementing the Standards, others are still in the beginning phases of bringing school systems into the process. BZgA is also working to find new methods of implementation which embrace the needs and constraints of certain communities, targeting rural populations. This model for setting the Standards and then working through a system of evaluation and program adjustment may seem far-fetched for the U.S., but could prove to be the solution for U.S. populations.

Opposition in America remains present in classrooms

As with any movement in policy change a series of opposition movements prove to be problematic. Starting with the current administration reframing AOUME as "youth empowerment" and SRAE, to state mandates which discourage certain health topics, to religious organizations continuing to have influence in public education systems, to parent groups creating large disruptive waves to health organization initiatives, the current opposition to holistic sex education comes in a variety of forms. Current students experience notions of this neotraditionalism in some sex education curricula. Under the pretense of "age-appropriate" avoidance of describing oral, vaginal, or anal sex, many AOUME programs gear students toward discussions on marriage. Kendall recognized an emphasis on gender norms when programming described emotional/mental, physical, and sexual differences in AOUME classrooms in Florida. Phrasing included:

> "Women tend to be more personal than men...Women tend to find their identity in close relationships, while men gain their identity through vocations."
> "Woman has several unique and important functions: menstruation, pregnancy, lactation. Women's hormones are of a different type and more numerous than man's..."
> "On the average, man possesses 50 percent more brute strength than woman..."
> "A woman's sexual drive tends to be related to her menstrual cycle, while a man's drive is fairly constant..."
> "While a man needs little or no preparation for sex, a woman often needs hours of emotional and mental preparation."
> "The man...does not generally have...instinctive awareness of what the relationship should be. He doesn't know how to encourage and love his wife or treat her in a way that meets her deepest needs."[108]

When educators do discuss actual sexual acts, specificity is lacking, and metaphors are often used. In one conservative classroom, Kendall noted one particular euphemism: "Men are microwaves; women are crock-pots."[109] Educators complicit in the New Christian Right point students to online resources for reinforcement measures. The bold heading of Marriage Missions International claims to be 'Revealing and Reflecting the Heart of Christ Within Marriage," and offers a series of Bible verses believed to be foundational for a healthy marriage. New Christian

[108] Kendall, 154-155.
[109] Kendall, 151.

Right literature outlines gender differences conducive to healthy marriages—including gendered guidance on how men and women can cope with marital trouble, infidelity, abuse, remarriage, etc.[110] If classroom rhetoric continues to reflect neotraditional patterns of gender roles and religious ideology, objectives of the Reproductive Justice Movement will be lost.

Potential for further study

The studies and literature mentioned in the introduction of the cross-sectional study had a greater capacity in expanding on survey data in a more specific manner. This cross-sectional examination was broader in scope because of the population-based data collection the YRBSS online tool provides. In future modeling, different versions of additive indices could combine the state mandates on a scale of how 'holistic-leaning' a state is in their policy could be a more apt independent variable for predicting adolescent outcomes. This would reflect a greater variance in the state input, and might reflect a better story of association. There is also potential in experimenting with other measures of sex education in school systems by looking at a more-narrow scope on a state-by-state basis. While the limiting factors of this research shielded what could be an increasingly valuable relationship in assessing policy programs, the lack of significance in many of the models reveal the need for greater indicators and survey assessments.

Concluding thoughts

The combination of a cross-sectional study and policy case stories underline the variation and complexity present in the patchwork quilt that is U.S. public sex education. First, to reiterate the objective of the timeline section, it is imperative to understand the history of sex education emergence and framework to understand how entrenched public opinion on programs influence curriculum. Second, the cross-sectional study exemplified that evidence against abstinence-only

[110] Marriage Missions, Accessed April 10, 2018, https://marriagemissions.com/category/marriage-insights/.

education may not exist because states do not always report harsh outcomes of youth abuse or risk. Third, the cases of Texas, Virginia, Colorado, and California, illustrate four divergent systems of sex education and functioning to further the argument that mere mandates do not always serve the needs of a classroom, and a variation of programs can be framed in a variety of manners.

With global objectives already set, the U.S. must remain cognizant of the true outcomes of the policies in place. When reforming health care systems, primary health care includes family planning—just a piece of the services mentioned within women's health and reproductive services. Family planning and contraceptives fall under prevention. So, in a similar vein, it's almost obvious to extend the same attention to sex education as prevention of negative adolescent outcomes as discussed in the study. When nations invest in prevention—as successful health care systems do—consideration to monitoring and evaluation resources are key. The challenge enters as sex educators and advocates realize that necessary information to make conclusive arguments in favor of holistic sex education doesn't exist, although infrastructure for conducting such surveying does. What consequences are states who do not report afraid of, and how can advocates convince decision makers of the possible consequences of neglecting these outcomes?

Students gain agency in decision making with proper delivery of holistic comprehensive sex education. In demanding a federal intervention in favor of progressive holistic sex education and correlated evaluation methods, advocates can function under state mandate to reach those most vulnerable. With the spectrum of sex education programs as they stand, programs are separated parallel to a conservative-liberal spectrum. In the hopes of garnering a united support system for sex education, the first step must be to convince states that collecting data and

assessing those indicators most appropriate is a worthy cause for the collective advancement of youth health and wellness.

VI. SUPPLEMENTARY FIGURES

TABLE 1.

Table 2. Pregnancy rates, by age of woman: United States, 1990-2010

[Rates are pregnancy per 1,000 women in specified group, estimated as of April 1 for 1990, 2000, and 2010 and as of July 1 for all other years.]

Year	[1]Total	Age of woman								
		[2]Under 15 years	15-19 years			20-24 years	25-29 years	30-34 years	35-39 years	[3]40-44 years
			Total	15-17 years	18-19 years					
2010	98.7	1.1	58.9	32.2	96.8	144.6	157.1	136.5	76.5	19.4
2009	102.1	1.2	65.3	36.4	106.3	153.8	162.0	138.0	77.0	19.2
2008	105.5	1.4	69.8	39.5	114.2	163.0	167.9	141.2	78.5	18.8
2007	107.0	1.5	71.9	40.6	119.6	167.5	171.8	142.5	79.5	18.3
2006	106.6	1.5	72.1	40.9	120.2	169.0	172.9	140.8	79.7	18.0
2005	103.7	1.6	70.2	40.2	116.2	163.4	170.5	137.5	77.7	17.5
2004	103.7	1.6	71.9	41.4	117.6	164.8	174.5	135.1	77.2	17.3
2003	103.7	1.6	73.6	42.9	119.9	166.6	172.0	136.6	73.7	16.8
2002	102.6	1.7	76.3	44.5	124.4	168.9	170.0	133.0	70.4	16.2
2001	103.1	1.8	80.8	47.1	130.8	173.7	169.1	131.9	68.8	15.7
2000	104.5	2.0	85.8	51.6	135.8	180.7	168.9	131.1	67.5	15.4
1999	102.2	2.1	86.9	53.1	136.6	177.8	166.0	125.1	64.7	14.6
1998	102.2	2.3	90.1	56.7	140.3	178.9	164.7	122.4	63.3	14.4
1997	101.6	2.4	92.7	59.5	144.3	178.7	162.5	119.5	61.4	13.9
1996	102.8	2.7	97.0	63.4	149.0	180.5	163.2	118.4	60.6	13.5
1995	103.5	2.9	101.1	67.4	153.4	179.8	162.8	117.0	59.1	13.1
1994	106.1	3.2	106.1	71.1	159.6	184.8	166.1	116.7	58.5	12.9
1993	108.8	3.2	109.4	72.7	164.1	190.4	169.8	116.6	57.7	12.4
1992	111.1	3.3	112.3	73.5	169.3	194.3	173.1	116.6	57.4	12.0
1991	112.7	3.3	116.4	76.1	172.1	196.8	174.9	116.2	56.8	11.3
1990	115.8	3.4	116.8	77.1	167.7	198.5	179.0	118.8	56.9	11.4
% change 2010 compared with 1990	-15	-68	-50	-58	-42	-27	-12	15	34	70

[1]Rates computed by relating the number of events to women of all ages to women aged 15-44 years.

[2]Rates computed by relating the number of events to women under age 15 years to women aged 10-14 years.

[3]Rates computed by relating the number of events to women aged 40 years and over to women aged 40-44 years.

TABLE 2. COMPARING SEX EDUCATION POLICIES TO REPORTED YOUTH OUTCOMES BY STATE

SIMPLE MODEL RESULTS	*Experienced sexual dating violence*	*Currently sexually active*	*Did not use any method to prevent pregnancy*	*Had sexual intercourse before age 13*	*Drank alcohol or used drugs before engaging in sex*	*Experienced forced sex*	*Experienced physical dating violence*	*Had sexual intercourse with four or more individuals*
Sex education mandated	--	--	**-1.978214** 0.051* n=33	1.188227 0.057* n=36	--	--	--	--
Information on HIV and STD/Is mandated	--	--	--	--	--	--	--	--
Information on abortion prohibited	--	--	--	**1.850312** 0.052* n=36	--	--	--	--
Heterosexual marriage promoted	--	**5.591818** 0.008** n=36	--	**2.740606** 0.010** n=36	--	--	--	**4.381609** 0.006** n=32
Negative LGBTQ bias	--	**3.006** 0.084* n=36	--	**1.695742** 0.050* n=36	--	--	--	**2.568889** 0.053* n=32
MULTI-VARIATE MODEL RESULTS INCLUDING CONTROLS	*Experienced sexual dating violence*	*Currently sexually active*	*Did not use any method to prevent pregnancy*	*Had sexual intercourse before age 13*	*Drank alcohol or used drugs before engaging in sex*	*Experienced forced sex*	*Experienced physical dating violence*	*Had sexual intercourse with four or more individuals*
Sex education mandated	--	--	**-1.785023** 0.052* n=33	1.347144 0.018** n=36	--	--	--	--
Information on HIV and STD/Is mandated	--	--	--	--	--	--	--	--
Information on abortion prohibited	--	**3.707736** 0.081* n=36	--	**2.296648** 0.032** n=36	--	--	--	**2.5918** 0.083* n=32
Heterosexual marriage promoted	--	--	--	--	--	--	--	--
Negative LGBTQ bias	--	--	--	--	--	--	--	--

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