Hearing Records ... HR

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WISCONSIN STATE LEGISLATURE COMMITTEE HEARING RECORDS

2009-10
(session year)

Assembly
(Assembly, Senate or Joint)

Committee on Education

(AC-Ed)

(FORM UPDATED: 06/28/2010)

COMMITTEE NOTICES ...

Committee Reports ... CR
**

Executive Sessions ... ES
**

Public Hearings ... PH
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Record of Comm. Proceedings ... RCP
**

INFORMATION COLLECTED BY COMMITTEE FOR AND AGAINST PROPOSAL ...

Appointments ... Appt
**

Name:

Clearinghouse Rules ... CRule
**

Hearing Records ... HR (bills and resolutions)
**

Miscellaneous ... Misc
**

( )

AB 458
(Pt. 02)

10/6/09 PH AB 458 & AB 461


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AB 458 3/4 Date?

PLANNED PARENTHOOD® ADVOCATES OF WISCONSIN

Please Support the Healthy Youth Act, AB 458

Good morning Chair Pope-Roberts and Committee members. My name is Nicole Safar and I am the policy analyst for Planned Parenthood Advocates of Wisconsin. I'm pleased to be joined this morning by Meghan Benson, Planned Parenthood of Wisconsin's Dane County Educator and Chris Taylor, Public Policy Director.

With 28 health centers through Wisconsin, PPWI is the state's largest and oldest reproductive health provider. In 2008, PPWI served 71,960 patients in Wisconsin. Over 60% of our patients live at or below the federal poverty level.

In addition to patient care, PPWI also has an Education Department that offers age-appropriate and medically accurate sexuality education for students, young adults and families. Our education department provides instruction in both schools and community based organizations. In 2008, PPWI education department:

- Provided direct education to over 9,500 youth and adults
- Conducted over 400 sexual and reproductive health workshops
- Held 143 home health parties to discuss topics like puberty, adult/child communication skills, contraception, and prevention of STIs
- Trained professionals who work with youth
- Provided comprehensive sex education in 31 schools across Wisconsin

Because providing age-appropriate, medically accurate sexuality education is a critical part of Planned Parenthood's mission, our education work is subsidized solely through grants and private donation. These services are provided without charge in the community.

I. Why the Healthy Youth Act? Why now?

As an essential public health provider, educator and advocacy organization, Planned Parenthood strongly supports the Healthy Youth Act and the comprehensive sex education it encourages. We need this legislation now, as the health and future of teens in Wisconsin is shadowed by the risk of unintended pregnancy and STIs. The most recent data from Wisconsin youth assessments demonstrates an increase in risky behaviors among our youth, including more unprotected sexual activity, more abuse of drugs and alcohol and an increase in dating violence. With this increase, negative health outcomes for youth follow.

For the first time in 14 years, teen birth rates in Wisconsin (and across the country) are rising! After a decline in the 1990s and a leveling off in 2003, the data from 2006 and 2007 has shown an increase across the state. If you look at the map of Wisconsin created by the Healthy Youth Alliance, you can see that the WI average birth rate is 30.3 births / 1000 teens. The U.S. average is 42 / 1000 teens, so we are doing a bit better than the country as a whole. But this is not nearly good enough. Both the U.S. and Wisconsin average are much too high when you put them in context with the rest of the developed world whose teen birth rates are significantly lower.

- France 7.1 / 1000
- Germany 9.6 / 1000
- The Netherlands 4.8 / 1000

About 20 WI counties have teen birth rates exceeding the state's average and at least half of those also exceed the national average of 42 births / 1000 teens. (A table indicating the teen birth rates in each committee member's district is attached.) In addition, 11,000 Wisconsin teens will get pregnant this year, a number that is just far too high.

The consequences of more teen pregnancies and births have a huge impact not only on the public, social and fiscal health of the state, but also on teens, their children and families.

- Teen moms are more likely to drop out of high school—in fact less than 40% of teen moms graduate from high school.

- Teens are also more likely to live in poverty for the decade following their pregnancy. And children born to teen mothers are 9 times more likely to live in poverty.

- Babies born to teen moms have higher infant mortality rates. And these children are more likely to have lower cognitive development, to be incarcerated and to have an adolescent pregnancy themselves.

- Nationally, teen childbearing costs over $9.1 billion a year. **An analysis from the National Campaign to Prevent Teen and Unintended Pregnancy found that in 2004 alone, teen childbearing cost WI taxpayers $156 million.** (A copy of the report, The Public Costs of Teen Childbearing in Wisconsin, November 2006, is attached to this testimony.)

- The costs associated with teen childbearing include lost labor market productivity and increased social services costs.

- In Wisconsin, 88% of all teen births are actually paid for by the Medicaid program—costing the state over $25 million in 2008 just for labor and delivery costs.

Another consequence of risky teen sexual behavior is an increase in sexually transmitted infections. Again, nationally the number of teens with STIs is skyrocketing. A 2009 report from the U.S. Center for Disease Control and Prevention estimated that 1 in 4 teen girls have at least one STI. In Wisconsin, STIs like Chlamydia are exploding among youth. The Healthy Youth Alliance created a map to indicate what WI counties have Chlamydia rates higher than the WI average. (A table indicating the teen Chlamydia rates in each committee member's district is attached.) As you can see, most counties in Wisconsin have teen Chlamydia rates that far exceed the state average.

STIs also negatively affect the public and fiscal health of the state.

- In the United States, direct medical costs associated with STIs are estimated at up to $14.7 billion annually. This total cost does not include lost wages and productivity, out-of-pocket expenses, or the costs associated with transmission of diseases to infants.

- Left untreated, STIs like Chlamydia can lead to serious health problems including infertility, chronic pain and deadly ectopic pregnancies.

II. <u>What is comprehensive sex education?</u>

Sexuality education is a lifelong process of acquiring information on a range of topics related to sexuality – from anatomy to relationships to reproduction – and using that information to form attitudes, beliefs, and values about sexuality. This information should be medically-accurate and age-

appropriate. Information about sexuality comes from many sources, including parents, other family members, teachers, schools, peers, faith-based institutions, community, and the media.

Parents, guardians, and other caregivers are – and should be – the primary sexuality educators for their children. These adults have the unique role of sharing personal, family, and community values about sexuality with their children. However, talking about issues related to sexuality is not always easy, so parents often look to schools, faith-based institutions, and community organizations for support and encouragement.

One of the most compelling arguments for comprehensive sexuality education is to protect Wisconsin youth from harm. Children need information and skills to protect themselves against sexual abuse. Teens need information and skills to avoid the risky sexual behaviors that lead to negative health outcomes; and they need information to protect themselves against sexual assault and dating violence.

Essential to comprehensive sexuality education is a requirement that materials include medically-accurate information. In the current statute concerning human growth and development instruction, there is no requirement that the material be medically accurate. To determine if information is medically-accurate, it should be supported by the weight of research conducted in compliance with accepted scientific methods. This information is published in peer-reviewed journals and recognized by leading professional organizations and agencies with relevant experience.

Comprehensive sexuality education must also be age-appropriate. This means information is based on the typical cognitive, emotional, behavioral, physical, and sexual development for a particular age group. Long before the tumultuous changes of puberty and adolescence, children have questions and concerns about their bodies, how their bodies work, relationships with family members and friends, and much more. These topics are all covered by comprehensive sexuality education in an age-appropriate manner.

Examples of age-appropriate information for younger elementary school children (ages 5-8) include messages such as:

- Each body part has a correct name and function
- Children this age can make some decisions by themselves, such as what shirt to wear to school today, but often need help from adults to make decisions.
- No one should touch the private parts of a child's body except for health reasons or to clean them.

Examples of age-appropriate information for older elementary school children (ages 9-12) include messages such as:

- During puberty, internal and external sexual and reproductive organs mature in preparation for adulthood.
- Many skills are needed to begin, continue, and end friendships.
- To make good decisions, one must consider all the possible consequences and choose the actions that will have the best outcomes.

Examples of age-appropriate information for middle school students (ages 12-15) include messages such as:

- The best decision is usually one that is consistent with one's own values and does not involve risking one's own or others' health and safety
- Sexual abstinence is the best method to prevent pregnancy & STDs

- Young people who are considering sexual intercourse should talk to a parent or other trusted adult about their decision and about preventing pregnancy & STDs

Examples of age-appropriate information for high school students (ages 15-18) include messages such as:

- Dating relationships can be enhanced through open, honest communication
- Sexual intercourse is not a way to achieve adulthood
- Gender role stereotypes can be harmful to both women and men

III. Comprehensive Sex Education is successful in reducing teen pregnancy and STI rates

There have been dozens of comprehensive sexuality education programs that have been rigorously evaluated and published in peer-reviewed journals. The vast majority, if not all, have been shown to reduce risky behaviors and decrease negative health outcomes, such as teen pregnancy and STIs. These comprehensive sexuality education programs contain the same core elements as those outlined by Healthy Youth Act.

Comprehensive sex ed programs are developed with the needs of all students in mind, and as such, do not promote bias against any student. They also promote self-esteem and positive interpersonal skills, with an emphasis on healthy relationships. Positive self-esteem and healthy relationships provide students with the motivation and the means to avoid risky sexual behaviors, including saying no to sex or insisting on condoms and contraception, if they do choose to have sex.

The alternative to comprehensive sex education programs are abstinence only programs, which typically provide information only on the negative consequences of pre-marital sex and give students no information on contraception and STI prevention. In all of the research available on sex education, there has not been one single peer-reviewed evaluation finding that abstinence only programs are effective in reducing teen sex, pregnancy or STI rates. In fact, numerous studies, including one commissioned by the Bush administration, demonstrate that abstinence-only curricula contain inaccurate and inconsistent information. In some cases, this "information" is biased, fear based and promotes harmful gender stereotypes. Additionally, it provides misinformation about the effectiveness of condoms and contraception for preventing STIs and pregnancy. Most importantly, this study showed that abstinence-only education does not achieve its goal of reducing sexual activity among teens.

And, as one astute high school student asked during a program, "Well, isn't abstinence-only better than nothing?" No—the evidence has found that even though teens exposed to abstinence-only education were just as likely as their peers to engage in sexual activity, they had more negative attitudes about condoms and contraception, which means they were probably less likely than their peers to practice sexual risk-reduction behaviors.

After 25 years and $1.5 billion federal dollars supporting these failed programs, the writing is on the wall regarding abstinence only sex education: it has been a miserable failure in preventing teen pregnancy and STIs.

Really, the bottom line is that both the research and practical experiences of educators show that comprehensive sexuality education programs work. Even if a school district does not purchase "pre-packaged" evidence-based curricula but instead develops their own local curricula based on the criteria in the Healthy Youth Act, they will have success because they are providing honest, accurate information about sexuality coupled with practical life skills. Young people are only able to make healthy decisions when they have both the information and the skills to do so.

IV. The Healthy Youth Act strengthens and enhances current WI law

The Healthy Youth Act ensures that the most current standards of sex education are being taught in Wisconsin and that *public schools* are using programs proven to reduce teen pregnancy and STI rates. The bill updates the core elements of what a sex education program must include if offered in Wisconsin and does away with ineffective abstinence only policies. There are 5 key components of the bill.

1. Requires that school boards deciding to offer sex education do so in a medically accurate, age appropriate way that addresses key elements proven to work at reducing sexually transmitted infections and unintended teen pregnancies, including providing information about both abstinence and contraceptives. Elements specified in the bill only need to be taught when it is age-appropriate.

2. Requires that school districts who do not offer sex education programs to notify parents that while Wisconsin law encourages school boards to provide sex education, the school has chosen not to offer any programs.

3. Requires that the state apply for federal funds that are allocated for evidence-based teen pregnancy prevention programs.

4. Deletes a provision in current statutes that forbids volunteer health care providers from providing sex education instruction in areas concerning human sexuality and contraception.

5. Maintains the current ability of parents to opt children out of sex education curriculum; for parents to review sex education programs and for them to participate in an advisory committee that chooses the district's sex education program. The HYA preserves every right parents have under current statute while enhancing their rights to know when their children will not receive any human growth and development instruction.

The Healthy Youth Act is a commonsense, middle of the road approach to sex education. According to the Guttmacher Institute, a health policy think tank, 21 states and the District of Columbia mandate that all public schools teach sex education. AB 458 does not mandate that a school district teach sex ed. School districts can still opt out of providing this instruction. It does require that if taught, sex ed curriculum must include the important elements outlined in the bill.

The bill also maintains the ability of districts to work with teachers, parents and community members in developing a curriculum that addresses the community's needs.

AB 458 also ensures that students receive lifesaving information about barrier methods to prevent the spread of STIs in addition to the importance of abstinence as the only 100% certain way to avoid disease. The current statute only requires that abstinence be taught as a method of avoiding STIs/HIV.

V. What is happening nationally and in other states regarding sex education?

The federal government and states from Washington to Texas to New Jersey to South Carolina are moving in a clear direction when it comes to sex education—and that is away from abstinence only programs to comprehensive sex education that includes information about abstinence and birth control to prevent unintended pregnancy and STIs; and skills that enhance students decision-making, communication and health skills.

President Obama has indicated that teen pregnancy prevention is one of his administration's top priorities. He included allocations for evidence based pregnancy prevention programs in his 2010 budget from at least two funding streams awaiting passage in the Health and Human Services appropriations bill that could end up providing up to $120 million for comprehensive sex education.

In addition, Congress has introduced the Responsible Education About Life (REAL) Act, which would provide additional federal money for comprehensive sex education programs. The REAL Act requires that schools receiving the funding provide sex education programs that are age-appropriate and medically accurate, and include information about abstinence, contraception and condoms to prevent pregnancy and STIs. The REAL Act's components are consistent with the core elements outlined in AB 458.

VI. Who supports comprehensive sex education programs like those encouraged by the Healthy Youth Act?

Comprehensive sex education programs like those encouraged by the Healthy Youth Act are not only commonsense approaches to addressing devastating public health problems, but they are also overwhelmingly supported by parents, professional organizations, advocates and voters alike. Groups like the American Medical Association, the American Public Health Association, the National Education Association, the American Academy of Pediatrics, the American Foundation for Aids Research and the Institute of Medicine all support comprehensive sex education programming like that encouraged by AB 458.

In addition, the Healthy Youth Alliance is a coalition of almost 50 organizations and 30 individual members across Wisconsin who believe that comprehensive sex education is the best way to address the huge public health problems we have among our teens. The Healthy Youth Alliance strongly supports AB 458 and PPAWI is a proud partner in this coalition.

Other professional groups have also spoken out in favor of AB 458—the WI Public Health Association, NARAL Pro-Choice Wisconsin, WI ACLU, the Wisconsin Council and Children and Families, Wisconsin Association of Local Health Departments and Boards, Fair Wisconsin, and the Wisconsin Education Association have all registered their support of the Healthy Youth Act. Likely, you will hear testimony from more groups this morning.

PPAWI has done extensive polling in Wisconsin. In a 2007 poll of 600 registered WI voters, support of comprehensive sex education was the most popular issue.

- 87% of Wisconsin voters believe that schools should be *required* to offer comprehensive sex education that includes information about both abstinence and contraception. Even 67% of Republicans support this instruction.

The truth is that the public strongly supports giving students accurate and age-appropriate information about protecting themselves from unintended pregnancy and STIs.


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The ACLU of WI Supports the Healthy Youth Act to Ensure Comprehensive Sex Education in Wisconsin Schools

For Immediate Release: Tuesday, September 29, 2009
Contact: Stacy Harbaugh, Community Advocate, ACLU of Wisconsin, (608) 469-5540 or sharbaugh@aclu-wi.org

The ACLU of Wisconsin supports the Healthy Youth Act, a proposed bill in the state legislature that would raise state standards for public school human growth and development instruction. The Healthy Youth Act would give Wisconsin teens the tools they need to make healthy and responsible life decisions by setting a standard of comprehensive sexuality education.

Evidence shows that stressing the importance of waiting to have sex while providing accurate, age-appropriate, and complete information about using contraceptives can help teens delay sex and reduce sexual risk taking. This approach is effective and is associated with lower teen pregnancy rates. Comprehensive sexuality education is needed from both a public health perspective and to save taxpayer money in a time when economic challenges strain our social safety net.

"From a Constitutional perspective, the Healthy Youth Act would honor equal protection, free speech and freedom of religion," said ACLU of Wisconsin Community Advocate Stacy Harbaugh. "Our public schools should have a human growth and instruction curriculum on relationships and reproduction that recognizes equality in gender and sexual orientation. Our schools should also respect diversity in religion by notifying all parents about what is being taught in school and allowing them to opt out without repercussions for their children. Ultimately, our schools should teach the facts about reproduction, not promote religion or discrimination."

Comprehensive sexuality education enjoys a broad base of support including major medical organizations such as the American Medical Association, the American Academy of Pediatrics, the American College of Obstetricians and Gynecologists, the Society of Adolescent Medicine, the American Nurses Association, the American Public Health Association, and the Institute of Medicine. Comprehensive sex education is also supported by major educational organizations including the American Federation of Teachers, the National Education Association, and the National School Boards Association. More than 85 percent of Americans support school-based sexuality education programs that teach students how to use and where to get contraceptives.

The ACLU of Wisconsin has approximately 9,000 members who support its efforts to defend the civil liberties and civil rights of all Wisconsin residents.

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ACLU
AMERICAN CIVIL LIBERTIES UNION of WISCONSIN

Pass the Healthy Youth Act for Comprehensive Sexuality Education for Wisconsin Students

Comprehensive sexuality education gives teens the tools they need to make healthy and responsible life decisions. Evidence shows that stressing the importance of waiting to have sex while providing accurate, age-appropriate, and complete information about using contraceptives can help teens delay sex and reduce sexual risk taking.

The Health Youth Act is good policy for Wisconsin because:

1. *Comprehensive sexuality education is effective*: it is associated with lower teen pregnancy rates; it helps teens make healthy and responsible life decisions; and it doesn't waste taxpayer money on ineffective human growth curriculum in Wisconsin's public schools.

2. *Comprehensive sexuality education has a broad base of support*: Americans want students to get information about contraception from their school; major medical and educational organizations support it.

3. *Comprehensive sexuality education is non-discriminatory*: it will give all students complete, age-appropriate information about relationships and reproduction in a way that is taught in a way that is free of bias; it respects diversity in religion by notifying parents or guardians about the curriculum and parents who object on religious grounds may opt their children out of the classes without repercussion.

4. *Comprehensive sexuality education honors free speech:* students will be able to ask questions, teachers will be able to share science-based facts, without censoring health care information.

The ACLU of Wisconsin is a proud member of the:

Healthy Youth Alliance


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Healthy Youth Act
Assembly Education Committee
October 6, 2009

Testimony of Rabbi Bonnie Margulis
Chair, Wisconsin Religious Coalition for Reproductive Choice
608-827-9482

Good morning. I am Rabbi Bonnie Margulis, Chair of the Wisconsin Religious Coalition for Reproductive Choice. The members of Wisconsin RCRC are Presbyterian, Episcopal, Methodist, United Church of Christ, Unitarian, and Jewish. We are pro-faith, pro-family, and pro-choice, and we support the Healthy Youth Act! As people of faith, we believe it is a moral imperative to provide our children with all the information they need to keep themselves safe and healthy. This includes information on how to establish healthy relationships, how to build self-esteem, how to make wise choices, and, if and when they decide to be sexually active, how to protect themselves from sexually transmitted infections and unwelcome pregnancy.

Millions of religious Americans support providing comprehensive sexuality education to our young people. The national bodies of major religious denominations have official statements demonstrating this support. For example, the Evangelical Lutheran Church of America has said, "Education about sexuality should emphasize monogamy, abstinence, and responsible sexual behavior, as well as practices intended to prevent the transmission of disease during sexual intercourse."

The Presbyterian Church (USA): "Calls upon state legislatures to require that all schools provide comprehensive kindergarten through twelfth grade human growth and development education that is complete, factual, accurate, free of bias, and does not discriminate on the basis of sex, race, national origin, ancestry, creed, pregnancy, marital or parental status, sexual orientation, or physical, mental, emotional, or learning disability. "

As far back as 1987, the United Church of Christ said, "Sex education beginning early in elementary school, as called for by the Surgeon General, is a major component of the effort to contain the AIDS pandemic. Curricula need to address the physical, social and ethical nature of human sexuality and teach skills for responsible personal decision-making."

My own rabbinic organization, the Central Conference of American Rabbis, passed the following resolution in 2003, stating: "Therefore, the Central Conference of American Rabbis resolves to: Support federal, state, provincial, and local legislation to provide for the inclusion of comprehensive and age-appropriate sexuality education in the public schools on all levels (from grade school through high school), while opposing federal, state, provincial, and local funding exclusively for abstinence-only programs."

Last week Jews around the world celebrated Yom Kippur, the Day of Atonement. During this sacred occasion, we read from the book of Leviticus, chapter 19, the Holiness Code. Among the many ethical laws included in this ancient social justice manifesto is the injunction – "do not place a stumbling block before the blind." As a rabbi and a Jew, I look to our schools to remove

the stumbling block of ignorance from before our young people. Finally, as the mother of two school-age children, I look to our schools to be a partner and an ally in the struggle to provide my children the information and the tools they need to make good choices. As a parent, I know our children look to their parents and their teachers for guidance; they look to us for information; they look to us to keep them safe. Please pass the Healthy Youth Act, and help our young people stay safe!


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Marj Passman
10/6/09 remarks

Good morning, my name is Marj Passman and I am here today to support Sen. Taylor and Rep. Grigsby in their introduction of the Health Youth Act. I am a former educator, spending over 25 years in area schools and a current school board member. I'm speaking this morning on behalf of myself as an individual and not for my board.

Sex education is an important and lifelong conversation that begins in the home. However, the responsibility to ensure our youth have the information they need regarding healthy decision-making also extends to our schools and communities. As a mother, grandmother, teacher, community and school board member, I have had much experience with this very important conversation! Any parent who has that famous conversation with their child looming over them wants the school to reinforce that discussion. In my years of teaching Sex Education to children only one parent in all those years ever opted out.

Over the years, one fact has remained the same when it comes to teenagers: they are having sex. And, as recent studies show us, many are doing it dangerously—either before they are physically and emotionally ready, under the influence of drugs or alcohol, or without protection from pregnancy and STDs.

Public schools have a responsibility to ensure that students receive age-appropriate and medically accurate sex education that provides them with the information and the skills to make healthy decisions. Especially in light of the startling health statistics we are seeing here today!

In my experience, many, if not most, parents *expect* their children to receive comprehensive sex education at school: in fact, many parents rely on it! For those parents who do not want this discussion in the schools they have the right to opt out of the curriculum. The Healthy Youth Act does not mandate but ensures that schools take this responsibility seriously and provide only sex education that meets the standards of professional organizations like the American Medical Association, the National Education Association and the American Academy of Pediatrics.

As is demonstrated by the broad support here today, the Healthy Youth Act is a policy that we all can get behind—educators, parents, policy makers and students too. I want to thank Sen. Taylor and Rep. Grigsby for introducing this very important bill and prioritizing the needs of Wisconsin's youth!


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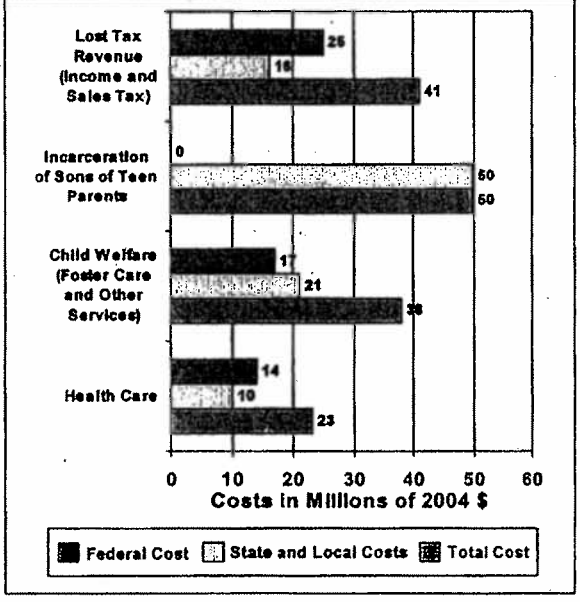
By the Numbers:
The Public Costs of Teen Childbearing in Wisconsin
November 2006

Highlights

- A new analysis from the National Campaign to Prevent Teen Pregnancy shows that teen childbearing (teens 19 and younger) in Wisconsin cost taxpayers (federal, state, and local) at least $156 million in 2004.
- Of the total 2004 teen childbearing costs in Wisconsin, 31% were federal costs and 69% were state and local costs.
- Most of the costs of teen childbearing are associated with negative consequences for the *children* of teen mothers. In Wisconsin, in 2004, annual taxpayer costs associated with children born to teen mothers included: $23 million for public health care (Medicaid and SCHIP); $38 million for child welfare; $50 million for incarceration; and $41 million in lost tax revenue, due to decreased earnings and spending.*
- The costs of childbearing are greatest for younger teens. In Wisconsin, the average annual cost associated with a child born to a mother 17 and younger is $5,133.
- Between 1991 and 2004 there have been more than 97,400 teen births in Wisconsin, costing taxpayers a total of $2.8 billion over that period.
- The teen birth rate in Wisconsin declined 31 percent between 1991 and 2004. The progress Wisconsin has made in reducing teen childbearing saved taxpayers an estimated $97 million in 2004 alone.
- Nationally teen childbearing costs taxpayers at least $9.1 billion a year.
- For more information, including a national report and state-by-state comparisons, please visit www.teenpregnancy.org/costs.

Figure 1: Selected Annual Costs in Wisconsin for Children of Teen Parents, In Millions of 2004 $



* Careful readers will note that the cost breakdown for the *children* of teen mothers does not match the total costs. This is because the total costs include costs associated with both teen *parents* and their *children*. Also note that because we cannot measure and include all outcomes and all costs, the analysis should be considered conservative; that is, it is likely that the full costs of a teen birth are greater than the figures presented here. Due to rounding, federal and state and local costs may not add to the totals presented in Figure 1 and throughout.

Teen Childbearing

Despite impressive declines in teen pregnancy and a 33 percent decline in teen birth rates between 1991 and 2004, the United States still has the highest teen pregnancy and birth rates in the industrialized world. One in three teenage girls becomes pregnant at least once before the age of 20. More than 400,000 children are born to teen mothers in the United States each year. Approximately 80 percent of teen births are to unmarried teen mothers.

In Wisconsin, there were 6,085 births to teens in 2004. The Wisconsin teen birth rate in 2004 was 30.2 per 1,000 girls aged 15 – 19 (the national rate was 41.1 per 1,000 girls aged 15 – 19). Among all states, the 2004 teen birth rate in Wisconsin ranks 10th (50 = highest).

Consequences of Teen Parenting

Research closely links teen parenthood to many negative consequences for mothers, fathers, and their children. For example, compared to those who delay childbearing, teen mothers are more likely to drop out of school, remain unmarried, and live in poverty; their children are more likely to be born at low birth weight, grow up poor, live in single-parent households, experience abuse and neglect, and enter the child welfare system. Daughters of teen mothers are more likely to become teen parents themselves and sons of teen mothers are more likely to be incarcerated (Hoffman, SD (2006). *By the Numbers: The Public Costs of Teen Childbearing*. The National Campaign to Prevent Teen Pregnancy: Washington, DC.)

What This Analysis Measures

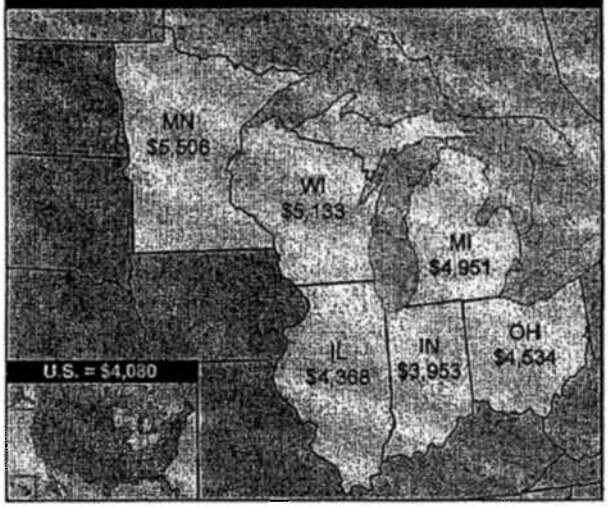
This new analysis by the National Campaign documents the economic costs of teen childbearing by measuring the participation of the children of teen mothers in public health care systems, primarily Medicaid and SCHIP, the child welfare system (foster care and child protective services), and the criminal justice system. The analysis also measures the participation of teen mothers in public assistance programs.

Additionally, the analysis measures lost labor market activity (which translates into lost tax revenue) of the children of teen mothers when they become adults and reduced earning capacity for teen mothers and their partners. This reflects the decreased educational attainment of teen mothers and their children. Specifically, the analysis compares costs associated with teen mothers, their partners, and their children with the same costs for women who delay childbearing until they are 20 – 21 years old. That is, the analysis takes many steps to isolate the net costs associated with teen childbearing rather than just the gross costs. There are many ways in which teen childbearing has a negative effect on the life prospects of teen mothers and their families; however this analysis only focuses on the economic costs to taxpayers.

Key Wisconsin Findings

In Wisconsin, the cost to taxpayers (federal, state, and local) associated with teen childbearing is estimated to be at least $156 million in 2004, of which $49 million (31%) are federal costs and $107 million (69%) are state and local costs. Put another way, the average annual cost in Wisconsin of teen childbearing is $1,707 per teen birth. However, it is important to note that costs of births to young teens are much greater than costs of births to older teens, and the average annual cost associated with a child born to a mother 17 and younger is $5,133. Figure 2 shows the average annual costs for births to younger teens in Wisconsin as compared to neighboring states and the nation.

Figure 2: Cost per Teen Birth (17 and under) in Wisconsin Compared to Other States in the Region



Nationally, the overall cost to taxpayers is estimated to be at least $9.1 billion a year. The total costs include those attached to teen mothers, their partners, and children born to teen mothers. The most significant costs are associated with poorer outcomes for the children of teen parents as compared to the outcomes for children born to mothers who are 20-21 years old. Please see figure 1 for detailed information on specific costs.

Between 1991 and 2004 there have been more than 97,400 teen births in Wisconsin, costing taxpayers a total of $2.8 billion over this period. However, the state has made significant progress in reducing teen childbearing, leading to significant annual savings. Specifically, the progress Wisconsin has made in reducing teen childbearing (as noted previously, the teen birth rate in the state actually declined 31 percent between 1991 and 2004) has saved taxpayers an estimated $97 million in 2004 alone, of which $32 million represent federal costs and $65 million represent state and local costs.

What does this all mean?

Teen pregnancy and child-bearing have significant economic and social costs. Making further progress in reducing teen pregnancy will both benefit the national and state economies as well as improve the educational, health, and social prospects for this generation of young people and the next.

Despite the impressive strides all states have made in reducing teen pregnancy and childbearing, there is still much work to be done. The new cost data presented in this fact sheet makes a powerful case for investing additional resources, attention, and effort in reducing teen pregnancy. Prevention offers a terrific return on investment and represents sound fiscal policy. If states are able to sustain the progress in reducing teen pregnancy and childbearing, they will not only improve the well-being of children, families, and communities, but will also reduce the burden on taxpayers, thereby freeing up funds that could be invested in other priority areas as policymakers see fit.

In order to maintain a focus on this important health and social issue, a number of states have set goals to reduce the teen pregnancy and/or birth rates. For more information on state goals, please see www.teenpregnancy/stategoals.

Related Information

These first-of-their-kind state estimates are part of a larger National Campaign project on the costs of teen childbearing. Those who want to learn more about the national costs of adolescent parenting are encouraged to read, *By The Numbers: The Public Costs of Teen Childbearing* (available at: www.teenpregnancy.org/costs).

A related analysis by the National Campaign shows that declining teen birth rates have significantly improved overall child well-being in all 50 states and the District of Columbia (see www.teenpregnancy.org/whycare/whatif.asp). According to the *What If* analysis, between 1991 and 2002 (the most recent year available at the time the analysis was done), the teen birth rate for girls aged 15-19 had declined 26 percent in Wisconsin. If the teen birth rate had not improved in the state:

- Nearly 17,000 additional children (under age 18) in the state would have been born to teen mothers between 1991 and 2002, and
- Fully 74 percent of these children would have been under age six in 2002.

Focusing specifically on children in Wisconsin under age six in 2002:

- 7 percent more of these children would have been living in poverty, and
- 10 percent more of these children would have been living in single mother households.

Methodology

The total costs of a teen birth are based on three factors: 1) the best current estimates from the research literature of the impact of a teen birth, adjusted for other risk factors, on each of the outcomes that generate public sector costs; 2) the cost of providing a particular public sector service in 2004; and 3) the number of teen births in 2004. For most analyses, the costs are those associated with the first fifteen years of motherhood, beginning either with a teen birth or, in the case of the comparison group, if the birth were delayed to ages 20 or 21. The only costs included in the analysis are those for which there are reliable national estimates of the net impact of a teen birth and for which there are explicit dollar costs associated with that outcome. For example, the analysis does not include special education or juvenile justice costs for children of teen parents, which may be sizable but for which there are no national impact estimates. **Because we cannot measure and include all outcomes and all costs, this costs analysis should be considered conservative; that is, it is likely that the full costs of a teen birth are greater than the figures presented here.** In addition, the analysis does not isolate factors that may be of significant interest to policymakers such as the citizenship or marital status of teen parents. Further information on the methods used can be found in Hoffman (2006). www.teenpregnancy.org/costs

For more information

To read a technical description of the analysis, detailed cost tables, or citation information, go to *By the Numbers: The Public Costs of Teen Childbearing* at www.teenpregnancy.org/costs. For more information about teen pregnancy prevention generally or the National Campaign in particular, please visit www.teenpregnancy.org.

Funding information

This work was made possible by a generous grant from the William T. Grant Foundation in fulfillment of their mission to further the understanding of human behavior through research. The Foundation's mission focuses on improving the lives of youth ages 8 to 25 in the United States. For information about the William T. Grant Foundation, please visit www.wtgrantfoundation.org.

About the National Campaign to Prevent Teen Pregnancy

The National Campaign is a nonprofit, nonpartisan organization supported largely by private donations. Our mission is to improve the well-being of children, youth, and families by reducing teen pregnancy. Our goal is to reduce the teen pregnancy rate by one-third between 2006 and 2015.

Teen Birth & Chlamydia Rates in WI: Too High

Assembly District	County	Chlamydia rates per 100,000 for teens 15-19	Birth Rates per 1000 for women <20
Rep. Pope-Roberts	Dane	1332	22
	Chippewa	1384	29.3
Rep. Dexter	Eau Claire	1077	19.4
	Rock	1999	46.1
Rep. Hixson	Walworth	476	29.7
	Dunn	615	22.1
Rep. Smith	Eau Claire	1077	19.4
	Pepin	198	n/a*
Rep. Radcliffe	Clark	459	27.8
	Jackson	767	42.8
Rep. Davis	Dane	1332	22
	Green	426	26.4
Rep. Townsend	Fond du lac	964	29.9
	Milwaukee	5479	64.3
Rep. Vukmir	Waukesha	551	10.5
	Iowa	631	n/a*
Rep. Hilgenberg	Lafayette	781	n/a*
	Sauk	1418	n/a*
Rep. Sinicki	Milwaukee	5479	64.3
Rep. Krusick	Milwaukee	5479	64.3
	Jefferson	568	22.0
Rep. Nass	Walworth	476	29.7
	Waukesha	551	10.5
Rep. Nygren	Marinette	608	24.2
	Oconto	1084	23.7

The average WI Chlamydia rate for the entire population is 371 / 100,000 people. The U.S. national average is 370 / 100,000. All WI Chlamydia data is from WI STD Program Data, 2008.

The average WI teen birth rate is 32.4 / 1000 teens. The U.S. national average is 40.5 / 1000. All WI data is from WI DHS, Births to Teens in Wisconsin, 2007.

* A birth rate is not calculated if there are fewer than 20 births for an age group.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What the Research Says...

Over the past 25 years, Congress has spent over $1.5 billion on abstinence-only-until-marriage programs, yet no study in a professional peer-reviewed journal has found these programs to be broadly effective. Scientific evidence simply does not support an abstinence-only-until-marriage approach.

Federal Evaluation Finds Abstinence-Only-Until-Marriage Programs Ineffective
In April 2007, a federally funded evaluation of Title V abstinence-only-until-marriage programs was released. The study, conducted by Mathematica Policy Research Inc. on behalf of the U.S. Department of Health and Human Services, found that abstinence-only-until-marriage programs are ineffective. Of the more than 700 federally funded abstinence-only-until-marriage programs, the evaluation looked at only four programs. These programs were handpicked to show positive results and they still failed.[1]

- Mathematica's evaluation found no evidence that abstinence-only-until-marriage programs increased rates of sexual abstinence—the entire supposed purpose of the programs.
- Students in the abstinence-only-until-marriage programs had a similar age of first sex and similar numbers of sexual partners as their peers who were not in the programs.
- The average age of sexual debut was the same for the abstinence-only-until-marriage participants and control groups (14 years, 9 months).

Abstinence-Only Programs Do Not Impact Teen Sexual Behavior
In early November 2007, the National Campaign to Prevent Teen and Unplanned Pregnancy released Emerging Answers 2007, a report authored by Dr. Douglas Kirby, a leading sexual health researcher, discussing what programs work in preventing teen pregnancy and sexually transmitted diseases, including HIV. The report found strong evidence that abstinence-only-until-marriage programs do not have any impact on teen sexual behavior.[2]

- The study found that no evidence to support the continued investment of public funds.
  "In sum, studies of abstinence programs have not produced sufficient evidence to justify their widespread dissemination...Only when strong evidence demonstrates that particular programs are effective should they be disseminated more widely."
- The study also found that, to date, no abstinence-only-until-marriage program that is of the type to be eligible for funding by the federal government has been found in methodologically rigorous study to positively impact teen sexual behavior.
  "At present, there does not exist any strong evidence that any abstinence program delays the initiation of sex, hastens the return to abstinence, or reduces the number of sexual partners. In addition, there is strong evidence from multiple randomized trials demonstrating that some abstinence programs chosen for evaluation because they were believed to be promising actually had no impact on teen sexual behavior."

Abstinence-Only Programs Do Not Affect Rates of HIV Infection or Sexual Behavior
A July 2007 "meta-study" published in the British Medical Journal reviewed the most recently available data examining the results of 13 abstinence-only trials including almost 16,000 students.[3]

- Abstinence-only-until-marriage programs were ineffective in changing any of the behaviors that were examined including the rate of vaginal sex, number of sexual partners, and condom use.

- The rates of pregnancy and sexually transmitted diseases (STDs) among participants in abstinence-only-until-marriage programs were unaffected.

- As a result of this meta-study, the researchers concluded that recent declines in the U.S. rate of teen pregnancy are most likely the result of improved use of contraception rather than a decrease in sexual activity.

Abstinence-Only-Until-Marriage Programs Negatively Impact Young People's Sexual Health
Virginity pledges—promises that young people make to remain abstinent until marriage—are becoming increasingly popular in schools and communities across the country. While not a program in and of themselves, virginity pledges are so common in abstinence-only-until-marriage interventions that having taken such a pledge is often an indication that a young person has been involved in an abstinence-only-until-marriage program.

- Research on virginity pledges found that for a select group of young people, pledges did delay the onset of sexual intercourse for an average of 18 months (a goal still far short of the average age of marriage).[4] However, the same study also found **that young people who took a pledge were one-third less likely to use contraception when they did become sexually active** than their peers who had not pledged.[5] In other words, pledges can cause harm by undermining contraceptive use when the young people who take them become sexually active.

- The researchers also found that **pledgers have the same rate of sexually transmitted diseases (STDs) as their peers** who had not pledged. Not only were pledgers less likely to use condoms to prevent STDs, they were less likely to seek medical testing and treatment, thereby increasing the possibility of transmission.[6]

- Further research found that, among those young people who have not had vaginal intercourse, **pledgers were more likely to have engaged in both oral and anal sex than their non-pledging peers.** In fact, among virgins, **male and female pledgers were six times more likely to have had oral sex than non-pledgers, and male pledgers were four times more likely to have had anal sex than those who had not pledged.**

- According to the researchers, in communities where there are a higher proportion of pledgers, overall STD rates were significantly higher than in other settings. Specifically, in communities where more than 20% of young adults had taken virginity pledges, STD rates were 8.9% compared to 5.5% in communities with few pledgers.[7]

Numerous State Evaluations Fail to Find Abstinence-Only-Until-Marriage Programs Effective
Since1996, the federal government has spent over half a billion dollars on Title V abstinence-only-until-marriage programs despite the fact that numerous evaluations prove these programs to be, at best, ineffective.

- In 2003, **Pennsylvania's** evaluation found that, **"taken as a whole, this initiative was largely ineffective in reducing sexual onset and promoting attitudes and skills consistent with sexual abstinence."**[8]
  The report also states that "overall, the evidence indicates that abstinence-only programs should be focused on early adolescence (grade seven). Programs for urban youth, especially females, should begin in grade six. Beyond the eighth grade, abstinence-only programs can continue to play a valuable role in reinforcing and supporting youth who choose to remain sexually abstinent. **For those youth who do not remain abstinent, however, the reduction of teenage pregnancies, STDs, and HIV/AIDS requires an alternative strategy."**[9]

- **Texas'** 2004 evaluation included five self-selected "abstinence education" contractors who participated in a study conducted by researchers at Texas A&M University. Analysis found that there were ***"no significant changes"*** in the percentages of students who "pledg[ed] not to have sex until marriage."[10] In addition, the analysis revealed that **the percentage of students reporting having ever engaged in sexual intercourse increased for nearly all ages between 13 and 17.**
  One of the study's investigators said, **"we didn't see any strong indications these programs were having an impact in the direction desired...these programs seem to be much more concerned about politics than kids, and we need to get over that."**[11]

- **Arizona's** evaluation states that "sexual behavior rates do not appear to be changing." Despite claiming some success with short-term outcomes and "abstinence success rate" among virgins, the final report, released in 2003, recognizes that "abstinence-only programs work best for sexually inexperienced youth" and that young people's **"intent to pursue abstinence...showed significant decline from post-test to follow-up."**[12]

- **Kansas'** 2004 evaluation revealed that there were **"no changes noted for participants' actual or intended behavior; such as whether they planned to wait until marriage to have sex."**[13] The evaluation also revealed negative changes in attitudes. After participating in abstinence-only-until-marriage programs, students surveyed were less likely to respond that the teachers and staff cared about them and significantly fewer students felt they "have the right to refuse to have sex with someone."[14]

  Researchers concluded, **"rather than focusing on Abstinence-Only-Until-Marriage, data suggests that including information on contraceptive use may be more effective at decreasing teen pregnancies."**[15]

- An independent study commissioned by the **Minnesota** Department of Health found that **sexual activity doubled among junior high school participants in the state's *Education Now and Babies Later* (*ENABL*) program at three schools between 2001 and 2002.** The number of participants who said they would "probably" have sex during high school almost doubled as well. Although it found some positive effects on parent-teen communication, the study found no positive impact of the *ENABL* program on teen sexual behavior. Almost a decade earlier, the state of California also found no impact after state-wide use of the *ENABL* program.[16]

- The **Maryland** Center for Maternal and Child Health evaluated its Title V abstinence-only-until-marriage program in 2002. Although the report was not made public, it was possible to determine from the information available that participants' pre- and post-test scores showed no significant change in attitudes or practices regarding abstinence. In addition, the **proportion of youth who reported that they would remain abstinent until the completion of high school and the proportion of youth who reported abstinent behavior in the year prior to the survey both declined** between pre- and post-test.[17]

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[1] Christopher Trenholm, et. al., "Impacts of Four Title V, Section 510 Abstinence Education Programs: Final Report," (Trenton, NJ: Mathematica Policy Research, Inc., April 2007), accessed 6 September 2007, <www.mathematica-mpr.com/publications/pdfs/impactabstinence.pdf>.

[2] Douglas Kirby, *Emerging Answers 2007: Research Findings on Programs to Reduce Teen Pregnancy and Sexually Transmitted Diseases*, (Washington, DC: The National Campaign to Prevent Teen and Unplanned Pregnancy, 2007), p. 15, accessed 5 February 2007, <http://www.thenationalcampaign.org/EA2007/EA2007_full.pdf>.

[3] Kristin Underhill, Paul Montgomery, Don Operario, "Sexual abstinence only programmes to prevent HIV infection in high income countries: systematic review," *British Medical Journal* Online *(July* 2007), accessed 13 August 2007,<http://bmj.com/cgi/content/full/335/7613/248>.

[4] Peter Bearman and Hanah Brückner, "Promising the Future: Virginity Pledges and the Transition to First Intercourse," *American Journal of Sociology* 106.4 (2001): 859-912.

[5] Ibid.

[6] Peter Bearman and Hanah Brückner, "After the promise: The STD consequences of adolescent virginity pledges," *Journal of Adolescent Health* 36.4 (2005): 271-278.

[7] Peter Bearman and Hanah Brückner, "The Relationship Between Virginity Pledges in Adolescence and STD Acquisition in Young Adulthood." Portions of study were presented at the *National STD Prevention Conference*, Philadelphia, PA, 9 March 2004, 10.

[8] Edward Smith, Jacinda Dariotis, Susan Potter, *Evaluation of the Pennsylvania Abstinence Education and Related Services Initiative: 1998-2002* (Philadelphia, PA: Maternal and Child Health Bureau of Family Health, Pennsylvania Department of Health, January 2003) 10, accessed 15 April 2005, <http://www.dsf.health.state.pa.us/health/lib/health/familyhealth/evaluationpaabstinence1998-20021.pdf>.

[9] Ibid., 21.

[10] Patricia Goodson, et al., *Abstinence Education Evaluation Phase 5: Technical Report* (College Station, TX: Department of Health & Kinesiology–Texas A&M University, 2004), 170-172. Emphasis included in original document.

[11] "Texas Teens Increased Sex After Abstinence Program," *Reuters*, 2 February 2005, accessed 17 February 2005, <http://news.yahoo.com/news?tmpl=story&u=/nm/20050131/hl_nm/health_abstinence_texas_dc>.

[12] LeCroy & Milligan Associates, *Final Report Arizona Abstinence Only Education Program 1998-2003*, (Phoenix, AZ: June 2003).

[13] Ted Carter, *Evaluation Report for The Kansas Abstinence Education Program* (Topeka, KS: Kansas Department of Health and Environment, November 2004), 19.

[14] Ibid.

[15] Ibid.

[16] Douglas Kirby, Meg Korpi, P. Barth Barth, Helen H.Cagampang, "The impact of the Postponing Sexual Involvement curriculum among youths in California," *Family Planning Perspectives 29* (1997): 100-108, accessed 15 April 2005, <http://www.guttmacher.org/pubs/journals/2910097.pdf>

[17] L.K. Olsen and D. Agley, "Analysis of Four Years of Abstinence-Only Human Sexuality Programs in Maryland," abstract of paper presented at 130 the Annual Meeting of the American Public Health Association, 13 November 2002.


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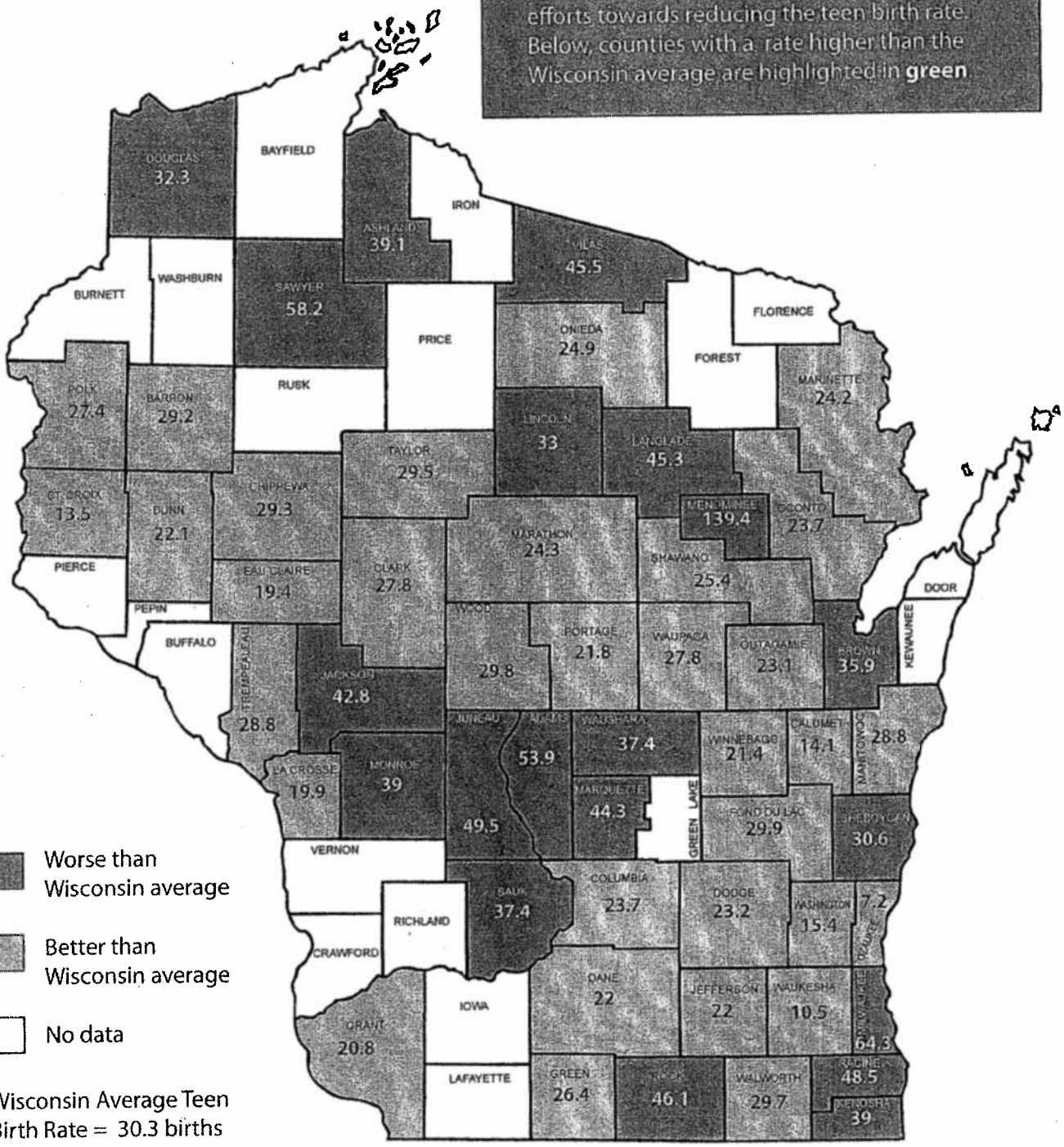
Healthy Youth alliance

Teen Birth Rates: Too high in Wisconsin

Many Wisconsin counties show a strong need for efforts towards reducing the teen birth rate. Below, counties with a rate higher than the Wisconsin average are highlighted in **green**.



Worse than Wisconsin average

Better than Wisconsin average

No data

Wisconsin Average Teen Birth Rate = 30.3 births per 1000 teens.

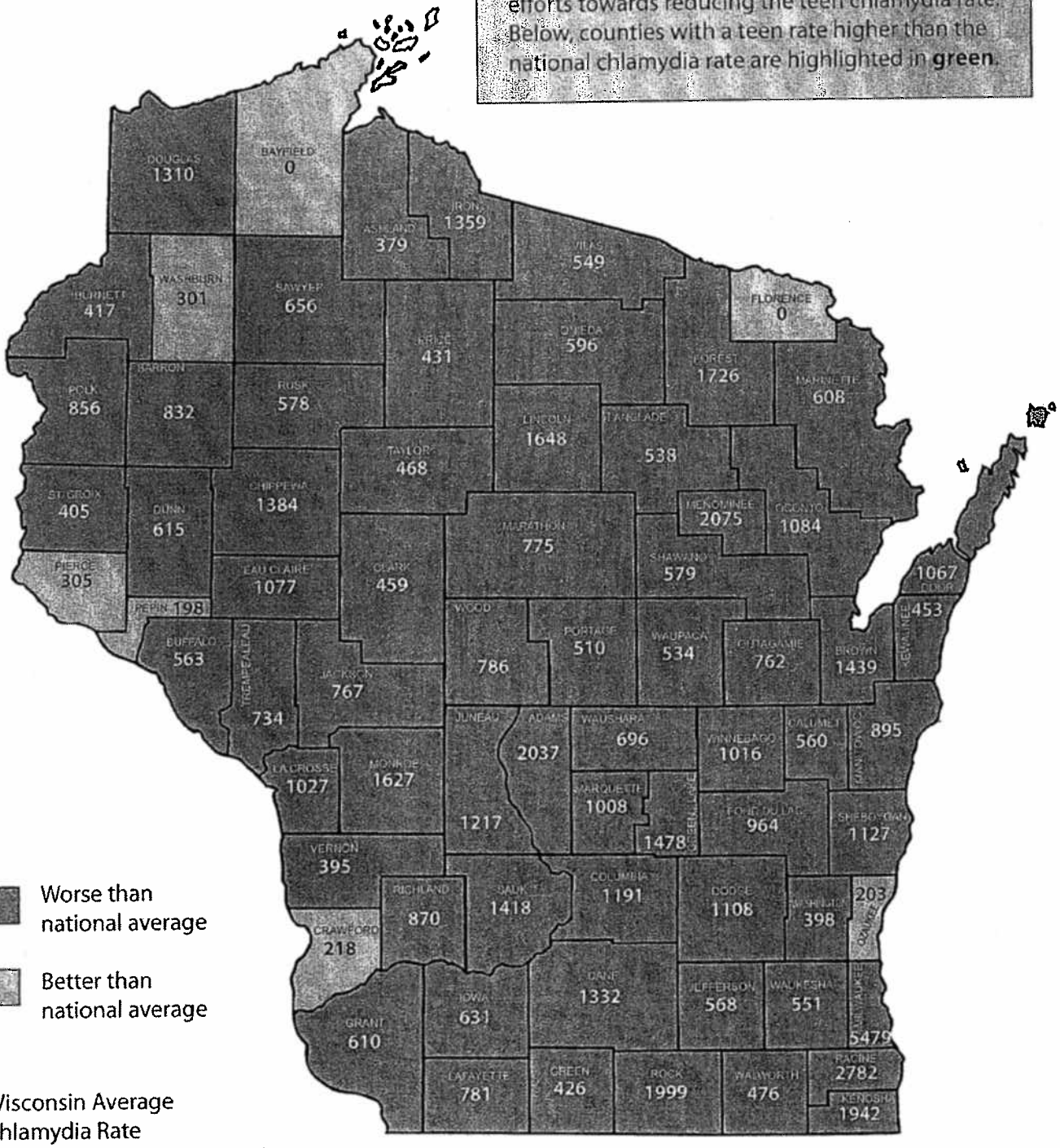
Source: *Births to Teens in Wisconsin, 2007. Bureau of Health Information and Policy, Division of Public Health. Wisconsin Department of Health Services.*

Healthy Youth alliance

Chlamydia Rates:

Too high in Wisconsin Teens

Many Wisconsin counties show a strong need for efforts towards reducing the teen chlamydia rate. Below, counties with a teen rate higher than the national chlamydia rate are highlighted in **green**.



Worse than national average

Better than national average

Wisconsin Average Chlamydia Rate
371 cases per 100,000 people.

Source: *Sexually Transmitted Disease in Wisconsin, 2008: Persons 15-19 years of age. Wisconsin STD Program.*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Science and Success
Second Edition

Sex Education and Other Programs That Work to Prevent Teen Pregnancy, HIV & Sexually Transmitted Infections

Second Edition

Advocates For Youth

Rights. Respect. Responsibility.®

Science and Success, Second Edition: Sex Education and Other Programs that Work to Prevent Teen Pregnancy, HIV & Sexually Transmitted Infections

Introduction

Until recently, teen pregnancy and birth rates had declined steadily in the United States in recent years. Despite these declines, the United States has the highest teen birth rate and one of the highest rates of sexually transmitted infections (STIs) among all industrialized nations. To help young people reduce their risk for pregnancy and STIs, including HIV, program planners should look to the body of available evaluation and research to identify effective programs. To this end, Advocates for Youth established a set of stringent criteria for determining program effectiveness. Staff then conducted an exhaustive literature review. This paper describes only those programs that meet the rigorous criteria listed below.

Criteria for Inclusion—The programs included in this document all had evaluations that:

- Were published in peer-reviewed journals (a proxy for the quality of the evaluation design and analysis);
- Used an experimental or quasi-experimental evaluation design, with treatment and control / comparison conditions;
- Included at least 100 young people in treatment and control / comparison groups.

Further, the evaluations either:

- Continued to collect data from both groups at three months or later after intervention

And

- Demonstrated that the program led to at least two positive behavior changes among program youth, relative to controls:
  - Postponement or delay of sexual initiation;
  - Reduction in the frequency of sexual intercourse;
  - Reduction in the number of sexual partners / increase in monogamy;
  - Increase in the use, or consistency of use, of effective methods of contraception and/or condoms;
  - Reduction in the incidence of unprotected sex.

Or:

- Showed effectiveness in reducing rates of pregnancy, STIs, or HIV in intervention youth, relative to controls.

Program Effects: Twenty-six programs met the criteria described above: these 26 programs strongly affected the behaviors and/or sexual health outcomes of youth exposed to the program.

- **Risk Avoidance Through Abstinence:** 14 programs demonstrated a statistically significant delay in the timing of first sex among program youth, relative to comparison / control youth. One of these programs is an intervention for elementary school children and their parents. The other 13 programs target middle and high school youth and all include information about both abstinence and contraception, among other topics and/or services. (See Table A, Page viii)
- **Risk Reduction for Sexually Active Youth:** Many of the programs also demonstrated reductions in other sexual risk-taking behaviors among participants relative to comparison / control youth. (See Table A, Page viii)
  - 14 programs helped sexually active youth to increase their use of condoms.
  - 9 programs demonstrated success at increasing use of contraception other than condoms.
  - 13 programs showed reductions in the number of sex partners and/or increased monogamy among program participants.
  - 7 programs assisted sexually active youth to reduce the frequency of sexual intercourse.
  - 10 programs helped sexually active youth to reduce the incidence of unprotected sex.
- **Reduced Rates of Teenage Pregnancy or Sexually Transmitted Infections**—Thirteen programs showed statistically significant declines in teen pregnancy, HIV or other STIs. Nine demonstrated a statistically significant impact on teenage pregnancy among program participants and four, a reduced trend in STIs among participants when measured against comparison / control youth. (See Table A, Page viii)
- **Increased Receipt of Health Care *or* Increased Compliance with Treatment Protocols**—Six programs achieved improvements in youth's receipt of health care, compliance with treatment protocols, or other actions that improved their health. (See Table A, Page viii)

Program Content: Of the 26 effective programs described here, 23 include information about abstinence *and* contraception within the context of sexual health education. Of the three that do not include sexual health education, two are early childhood interventions and one is a service-learning program.

Programs' Setting: The programs and their evaluations are grouped in this document in three sections.

- Section I describes 11 effective programs designed for and evaluated in school settings, including some that are linked to reproductive health care.
- Section II describes 10 effective programs implemented by community agencies outside of the school or clinic environment.
- Section III describes five effective, clinic-based programs.

To view a table summarizing programs' settings as well as the grade range, locale, and populations served by each, please see Table B, page x. For a more detailed description of each program and its evaluation refer to the relevant sections of this document.

Within the description of each program, Advocates for Youth includes information about the program's components, the populations with whom the program is most effective, evaluation methodology, and evaluation findings. When applicable, Advocates includes this same information regarding replications. Finally, each program summary includes contact information for learning more about and/or ordering the program.

Table A. Effective Programs: Impact on Adolescents' Risk for Pregnancy, HIV & STI Programs

☐ *School-Based Programs* ☒ *Community-Based Based Programs* ☐ *Clinic-Based Programs*

	Delayed Initiation of Sex	*Reduced Frequency of Sex*	*Reduced Number of Sex Partners*	*Increased Monogamy*	*Reduced Incidence of Unprotected Sex*	*Increased Use of Condoms*	*Increased Use of Contraception*	*Increased Use of Sexual Health Care/ Treatment Compliance*	*Reduced Incidence of STIs*	*Decreased Number or Rate of Teen Pregnancy/ Birth*
1. AIDS Prevention for Adolescents in School			★	★		★			★	
2. Get Real about AIDS			★			★				
3. Postponing Sexual Involvement (Augmenting a Five-Session Human Sexuality Curriculum)	★	★					★			
4. Postponing Sexual Involvement: Human Sexuality & Health Screening	★						★			
5. Reach for Health Community Youth Service	★	★				★	★			
6. Reducing the Risk	★				★		★			
7. Safer Choices	★				★	★	★	★		
8. School / Community Program for Sexual Risk Reduction among Teens	★					★				★
9. Seattle Social Development Project	★		★			★				★
10. Self Center (School-Linked Reproductive Health Care)	★				★		★	★		★
11. Teen Outreach Program										★
12. Abecedarian Project										★
13. Adolescents Living Safely: AIDS Awareness, Attitudes & Actions		★	★			★				

Note: Blank boxes indicate either 1) that the program did not measure nor aim at this particular outcome/impact or 2) that the program did not achieve a significant positive outcome in regard to the particular behavior or impact.

Table A. Effective Programs: Impact on Adolescents' Risk for Pregnancy, HIV & STI Programs

☐ *School-Based Programs* ☒ *Community-Based Based Programs* ☐ *Clinic-Based Programs*

	Delayed Initiation of Sex	*Reduced Frequency of Sex*	*Reduced Number of Sex Partners*	*Increased Monogamy*	*Reduced Incidence of Unprotected Sex*	*Increased Use of Condoms*	*Increased Use of Contra-ception*	*Increased Use of Sexual Health Care/ Treatment Compliance*	*Reduced Incidence of STIs*	*Decreased Number or Rate of Teen Pregnancy / Birth*
14. Be Proud! Be Responsible!		★	★			★				
15. Becoming a Responsible Teen	★	★			★	★				
16. California's Adolescent Sibling Pregnancy Prevention Project	★						★			★
17. Children's Aid Society – Carrera Program	★					★	★	★		★
18. Community-Level HIV Prevention for Adolescents in Low-Income Developments	★					★				
19. [illegible]		★	★		★	★				
20. Making Proud Choices!	★	★			★	★				
21. Project Latino: Community AIDS Prevention Program for Inner City Latino Youth	★		★							
22. HIV Risk Reduction for African American & Latina Adolescent Women			★		★				★	
23. Project SAFE: Sexual Awareness for Everyone			★	★	★			★	★	
24. SiHLE			★		★	★			★	★
25. Tailoring Family Planning Services to the Special Needs of Adolescents							★	★		★
26. TLC: Together Learning Choices			★		★			★		

Note: Blank boxes indicate either 1) that the program did not measure nor aim at this particular outcome/impact or 2) that the program did not achieve a significant positive outcome in regard to the particular behavior or impact.

Table B. Effective Programs:Settings & Populations Served

☐ *School-Based Programs* ☒ *Community-Based Based Programs* ☐ *Clinic-Based Programs*

	Urban	*Suburban*	*Rural*	*Elementary School*	*Middle School*	*Sr. High*	*18-24*	*White*	*Black*	*Hispanic/ Latino*	*Asian*	*Sex*
1. AIDS Prevention for Adolescents in School	★					★		★	★	★	★	Both Sexes
2. Get Real about AIDS	★	★	★			★		★		★		Both Sexes
3. Postponing Sexual Involvement (Augmenting a Five-Session Human Sexuality Curriculum)	★				★				★			Both Sexes
4. Postponing Sexual Involvement: Human Sexuality & Health Screening	★				★				★	★		Females
5. Reach for Health Community Youth Service	★				★				★	★		Both Sexes
6. Reducing the Risk	★	★	★			★		★	★	★	★	Both Sexes
7. Safer Choices	★	★				★		★	★	★	★	Both Sexes
8. School/Community Program for Sexual Risk Reduction among Teens			★	★	★	★		★	★			Both Sexes
9. Seattle Social Development Project[§]	★	★		★				★	★		★	Both Sexes
10. Self Center (School-Linked Reproductive Health Care)	★			★	★	★			★			Females
11. Teen Outreach Program	★	★	★			★		★	★	★		Both Sexes
12. Adolescent Living Safely: AIDS Awareness, Attitudes & Actions	★	★		★					★			Both Sexes
13. Adolescent Living Safely: AIDS Awareness, Attitudes & Actions	★			★	★	★	★		★	★		Both Sexes

[§] This program is also effective with Native American youth.

Table B. Effective Programs:Settings & Populations Served

☐ *School-Based Programs* ☒ *Community-Based Based Programs* ☐ *Clinic-Based Programs*

	Urban	*Suburban*	*Rural*	*Elementary School*	*Middle School*	*Sr. High*	*18-24*	*White*	*Black*	*Hispanic: Latino*	*Asian*	*Sex*
14. Be Proud! Be Responsible! A Safer Sex Curriculum	★			★	★	★	★		★			Males
15. Becoming a Responsible Teen	★			★		★	★		★			Both Sexes
16. California's Adolescent Sibling Pregnancy Prevention Project	★	★	★	★	★	★				★		Both Sexes
17. Children's Aid Society – Carrera Programs	★			★	★	★			★	★		Females
18. Community-level HIV Prevention for Adolescents in Low-Income Housing Developments	★			★	★	★			★		★	Both Sexes
19. ¡Cuídate!	★			★		★				★		Both Sexes
20. Making Proud Choices	★			★	★				★			Both Sexes
21. Poder Latino: A Community AIDS Prevention Program for Inner-City Latino Youth	★			★		★	★			★		Both Sexes
22. HIV Risk Reduction for African American and Latina Adolescent Women	★			★	★	★	★		★	★		Females
23. Project Safe – Sexual Awareness for Everyone	★			★		★	★		★	★		Females
24. SiHLE	★	★		★		★	★		★			Females
25. Tailoring Family Planning Services to the Special Needs of Adolescents		★	★	★		★	★	★				Females
26. TLC: Together Learning Choices	★			★	★	★	★		★	★		Both Sexes


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will improve the burden of taxation in ways that will improve the performance of our economy, but the budget outlook tells us that unless we exert a much more effective discipline over the volume of Federal spending we cannot undertake these needed measures of tax relief without courting larger and larger deficits. All the evidence points to the need for a searching scrutiny of expenditure priorities.

Great Lady From Ohio: Mrs. Bolton

EXTENSION OF REMARKS
OF
HON. WILLIAM E. MINSHALL
OF OHIO
IN THE HOUSE OF REPRESENTATIVES
Thursday, January 10, 1963

Mr. MINSHALL. Mr. Speaker, there are 67 new Members in this Congress. They have not had the privilege many of us enjoy of having worked and counseled with a charming and remarkable colleague, Congresswoman FRANCES P. BOLTON. I am indebted to her tenfold for the benefit of her wisdom and for the courtesies she has consistently extended to me and my office ever since I came to Washington as a freshman in 1955. I can think of no better way to introduce her than through an excellent article written recently by Alvin Silverman, chief of the Washington bureau of the Cleveland Plain Dealer. There is, of course, one of the 67 new Members who needs no introduction to Mrs. BOLTON—and that is her son, Congressman OLIVER BOLTON, whom we are delighted to welcome back to Capitol Hill.

The article follows:

GREAT LADY FROM OHIO: MRS. BOLTON
(By Alvin Silverman)

WASHINGTON.—The passing last week of Mrs. Eleanor Roosevelt and the resulting effusion of tributes to her character and achievements brought to mind the lamentable fact that not until death occurs is very much laudatory ever said about any individual.

Judged by any except the most illiberal of critics, Mrs. Roosevelt was a great woman. There are not many great women around. Their total only slightly exceeds the number of great men.

There is, however, a great woman who is a Clevelander. Since she is very much alive and very much disinclined to toot her own horn, this might be an appropriate time to discuss her.

Her name is FRANCES P. BOLTON.

Congresswoman from Ohio's 22d District since 1940, Mrs. BOLTON comes from a distinguished family long associated with public service. Both of her grandfathers served in the Ohio General Assembly and one of them, Henry B. Payne, became a U.S. Representative and then a Senator.

Mrs. BOLTON and her son, OLIVER, just elected to the House for another term after sitting on the sidelines for several years while recovering his health, comprise the only mother-son team ever to serve together in the Congress.

Mrs. BOLTON is regarded as an authority on legislation dealing with U.S. foreign policy, particularly Africa and France.

In 1955 she made a 20,000-mile study tour of Africa. Her visit to 24 countries south and east of the Sahara Desert was the first extensive mission to Africa by a Member of Congress.

Two years later, she returned to Africa as an official delegate to the Ghana independence ceremonies, and later in 1957 she made an official report on United Nation refugee camps in the Middle East.

There is not a single important official of any of the new African nations who does not consider Mrs. BOLTON a close friend and adviser. Her Washington home is virtually a headquarters for them when they are in the capital.

Far beyond her contributions in the field of foreign affairs, however, have been Mrs. BOLTON's activities in health and nursing.

The first Army school of nursing in World War I was largely the result of the pressure she personally applied on her friend from Cleveland, Secretary of War Newton D. Baker. During World War II, her Bolton bill created the U.S. Cadet Nurse Corps, an organization that graduated 125,000 nurses for the Nation's war effort. Western Reserve University's School of Nursing, named for her, eloquently bespeaks her efforts.

A friend recently was feeling pretty proud that he had been chosen to receive an honorary doctorate degree from a university. Mrs. BOLTON acted as if she could not have been more thrilled if she had received one herself. If she had, it would have been No. 16 for her.

France awarded her membership in the French Legion of Honor officer class for her work during and after World War II.

Her other awards include "Churchwoman of the Year," and the American Social Hygiene Association's award for distinguished service to humanity.

Mrs. BOLTON is vice regent for Ohio of the Mount Vernon Ladies Association, possibly the most exclusive organization in the Nation. For more than a century, it has been in charge of the George Washington National Shrine. Only recently, Mrs. BOLTON bought a large tract of land across the Potomac River from Mount Vernon so that the view would remain unchanged.

There is probably not a church or a hospital in northern Ohio that has not been saved in a major crisis by Mrs. BOLTON's financial help or other assistance.

All this, of course, does not make her a great woman.

Her greatness comes also from her character and personality and—well, you get the general idea by now.

Pay Increase for the Military

EXTENSION OF REMARKS
OF
HON. BOB WILSON
OF CALIFORNIA
IN THE HOUSE OF REPRESENTATIVES
Thursday, January 10, 1963

Mr. BOB WILSON. Mr. Speaker, for many months I have been extremely concerned at the delay of the Kennedy administration in pushing for a pay increase for the military, despite the fact that other governmental employees have benefited from pay raises on two occasions since the last general military pay increase in 1958.

Last fall I pledged to introduce, if necessary, and support legislation calling for a substantial pay increase. Included was to be a section correcting the inequities in the pay scales for those retired personnel who left the service prior to July 1958. These retired persons were discriminated against and a great inequity has existed for over 4 years as a result.

A few weeks ago I was heartened to learn that the Defense Department was supporting a pay increase measure amounting to as much as 14 percent in some categories and also correcting the inequities I mentioned previously.

Rather than introduce my version of a pay bill I have decided to defer such action until the administration's measure comes before the Personnel Subcommittee of the Armed Services Committee. As a member of the subcommittee, I recognize that legislation as introduced by the administration is merely the raw material from which a truly effective and meaningful pay bill can be molded by our subcommittee and subsequently by the Congress.

It is the responsibility of the Congress to act with dispatch on a substantial and constructive pay bill for active duty and retired personnel of our military service and I am looking forward to helping to expedite this much-needed legislation.

Current Communist Goals

EXTENSION OF REMARKS
OF
HON. A. S. HERLONG, JR.
OF FLORIDA
IN THE HOUSE OF REPRESENTATIVES
Thursday, January 10, 1963

Mr. HERLONG. Mr. Speaker, Mrs. Patricia Nordman of De Land, Fla., is an ardent and articulate opponent of communism, and until recently published the De Land Courier, which she dedicated to the purpose of alerting the public to the dangers of communism in America.

At Mrs. Nordman's request, I include in the RECORD, under unanimous consent, the following "Current Communist Goals," which she identifies as an excerpt from "The Naked Communist," by Cleon Skousen:

[From "The Naked Communist," by Cleon Skousen]

CURRENT COMMUNIST GOALS

1. U.S. acceptance of coexistence as the only alternative to atomic war.
2. U.S. willingness to capitulate in preference to engaging in atomic war.
3. Develop the illusion that total disarmament by the United States would be a demonstration of moral strength.
4. Permit free trade between all nations regardless of Communist affiliation and regardless of whether or not items could be used for war.
5. Extension of long-term loans to Russia and Soviet satellites.
6. Provide American aid to all nations regardless of Communist domination.
7. Grant recognition of Red China. Admission of Red China to the U.N.
8. Set up East and West Germany as separate states in spite of Khrushchev's promise in 1955 to settle the German question by free elections under supervision of the U.N.
9. Prolong the conferences to ban atomic tests because the United States has agreed to suspend tests as long as negotiations are in progress.
10. Allow all Soviet satellites individual representation in the U.N.

11. Promote the U.N. as the only hope for mankind. If its charter is rewritten, demand that it be set up as a one-world government with its own independent armed forces. (Some Communist leaders believe the world can be taken over as easily by the U.N. as by Moscow. Sometimes these two centers compete with each other as they are now doing in the Congo.)

12. Resist any attempt to outlaw the Communist Party.

13. Do away with all loyalty oaths.

14. Continue giving Russia access to the U.S. Patent Office.

15. Capture one or both of the political parties in the United States.

16. Use technical decisions of the courts to weaken basic American institutions by claiming their activities violate civil rights.

17. Get control of the schools. Use them as transmission belts for socialism and current Communist propaganda. Soften the curriculum. Get control of teachers' associations. Put the party line in textbooks.

18. Gain control of all student newspapers.

19. Use student riots to foment public protests against programs or organizations which are under Communist attack.

20. Infiltrate the press. Get control of book-review assignments, editorial writing, policymaking positions.

21. Gain control of key positions in radio, TV, and motion pictures.

22. Continue discrediting American culture by degrading all forms of artistic expression. An American Communist cell was told to "eliminate all good sculpture from parks and buildings, substitute shapeless, awkward and meaningless forms."

23. Control art critics and directors of art museums. "Our plan is to promote ugliness, repulsive, meaningless art."

24. Eliminate all laws governing obscenity by calling them "censorship" and a violation of free speech and free press.

25. Break down cultural standards of morality by promoting pornography and obscenity in books, magazines, motion pictures, radio, and TV.

26. Present homosexuality, degeneracy and promiscuity, as "normal, natural, healthy."

27. Infiltrate the churches and replace revealed religion with "social" religion. Discredit the Bible and emphasize the need for intellectual maturity which does not need a "religious crutch."

28. Eliminate prayer or any phase of religious expression in the schools on the ground that it violates the principle of "separation of church and state."

29. Discredit the America Constitution by calling it inadequate, old-fashioned, out of step with modern needs, a hindrance to cooperation between nations on a worldwide basis.

30. Discredit the American Founding Fathers. Present them as selfish aristocrats who had no concern for the "common man."

31. Belittle all forms of American culture and discourage the teaching of American history on the ground that it was only a minor part of the "big picture." Give more emphasis to Russian history since the Communists took over.

32. Support any socialist movement to give centralized control over any part of the culture—education, social agencies, welfare programs, mental health clinics, etc.

33. Eliminate all laws or procedures which interfere with the operation of the Communist apparatus.

34. Eliminate the House Committee on Un-American Activities.

35. Discredit and eventually dismantle the FBI.

36. Infiltrate and gain control of more unions.

37. Infiltrate and gain control of big business.

38. Transfer some of the powers of arrest from the police to social agencies. Treat all behavioral problems as psychiatric disorders which no one but psychiatrists can understand or treat.

39. Dominate the psychiatric profession and use mental health laws as a means of gaining coercive control over those who oppose Communist goals.

40. Discredit the family as an institution. Encourage promiscuity and easy divorce.

41. Emphasize the need to raise children away from the negative influence of parents. Attribute prejudices, mental blocks and retarding of children to suppressive influence of parents.

42. Create the impression that violence and insurrection are legitimate aspects of the American tradition; that students and special-interest groups should rise up and use united force to solve economic, political or social problems.

43. Overthrow all colonial governments before native populations are ready for self-government.

44. Internationalize the Panama Canal.

45. Repeal the Connally reservation so the United States cannot prevent the World Court from seizing jurisdiction over nations and individuals alike.

American Jewry Meets the Challenge

EXTENSION OF REMARKS

OF

HON. EUGENE J. KEOGH

OF NEW YORK

IN THE HOUSE OF REPRESENTATIVES

Thursday, January 10, 1963

Mr. KEOGH. Mr. Speaker, under leave to extend my remarks in the RECORD, I include the following address by Mr. Louis H. Solomon on September 28, 1961, at a dinner meeting of the New York University Jewish Culture Foundation, marking the beginning of the campaign to erect a Center for Jewish Culture at New York University.

Mr. Solomon, a trustee of the New York University Jewish Culture Foundation, is a distinguished attorney. He is a graduate of New York University and a noted leader in many civic activities. He is well known among business and community leaders as the head of the Greenwich Village Chamber of Commerce.

His tribute to American Jewish leadership follows:

AMERICAN JEWRY MEETS THE CHALLENGE

(Address presented by Louis H. Solomon on September 28, 1961).

There has been a great deal of provocative discussion of late on the subject of the role of Judaism and the Jew in Judeo-Christian world society. Too much of the discussion is a veiled attack upon the devotion of the Jew to the heritage and traditions that define his status as an identifiable, ethnic personality in a Christian-dominated world and his resistance to pressure for assimilation.

The discussions acknowledge, sometimes with evident reluctance, frequently with extravagant generosity, the importance of Judaism in world culture, as the source of the Judeo-Christian religions, and the essence of Judeo-Christian ethical philosophy. Yes, they say, the Jew has given to mankind the Judeo-Christian religions. He has given Jesus to Christianity. He has provided the concept of justice and the sense of social responsibility which make up the meaning of Judeo-Christian ethical philosophy. But the whole mood of the discussion radiates the sentimental regret that the Jew remains unchanged in his determined status as a Jew, as a separate, identifiable creature, loyal to Judaism in defiance of centuries of pressure for assimilation.

Toynbee, the English historian, reflects the pronounced assimilationist viewpoint. He projects the argument that the resistance of the Jew to assimilation is responsible in a large measure for the anti-Semitic posture of the world.

In a recent discourse by Toynbee, he acknowledges generous recognition of the Jew for fundamental contributions to world society. He even ventures the regret that the strong traits of the Jew, the character responsible for the miracle of survival and so much of the world culture, that this strain is not available to enrich the other segments of human society. The underlying tone of the Toynbee creed is the covert annoyance of the historian, that in spite of centuries of history, in defiance of the sword and the pen, this remains the heritage of the Jew, a relatively small identifiable group, immune to absorption. On the other hand, is the frustrating regret of the historian, that society as a whole is denied the special strain of character values that persist in the Jew and would be made available to the rest of society by intermarriage and full assimilation.

Sometimes one wonders what prompts the persistence of the Toynbee followers to argue for the assimilation of the Jew. What is it that pushes the endeavors of this historian and his disciples so vigorously to bury centuries of sacred traditions, to subvert loyalties to faith, to destroy the spiritual potential that has given so much to so many? There is persuasive authority for the premise that all anti-Semitism is a psychoneurosis. To the psychologist, "anti-Semitism," so-called, to conceal specific Jew hatred (Judenhass), is not explainable as a rational drive. One is tempted to ask—is the pressure for the assimilation of the Jew but an unrestrained sprout from the same sprig? Is it a symptom of the same complex?

THE "INTELLECTUALS"

Contemporaneously with the Toynbee discourse, an article appeared in a recent issue of the magazine Commentary, under the title "Intellectuals" which poses the problem, but with a wide difference in motivation. This article purports to review the attitude on assimilation of the Jew on the college campus. It emphasizes a seeming indifference to heritage and tradition among budding intellectuals.

The intellectuals, so called, are not by any means the sages of our day. Nor do they reflect the mature community judgment. These are students, budding scholars perhaps, living in an environment of challenge, of abstraction and speculation. This is not the climate conducive to respect for tradition or heritage. To them heritage and tradition are related to the dead past. History is important more for its dates than for its monuments. They present a pose of pride in sophistication, a sense of revolt against the authority of yesterday. This is a passing phase in the pursuit of wisdom. Sober assessment of spiritual values will come with maturity. They will learn that man does not live by bread alone. Then shall they claim their kinship to the people of the Bible and the treasured heritage of the Torah.

The infamous Nauman group of pre-Hitler Germany is the prototype for a small segment of American Jewish life emphasizing a pose of sophistication, ready to trade heritage and tradition. They do not want to be counted out of the fold, yet they cannot endure minority status, and they spurn affiliation with the "common herd." Devoid of intellectual insight, of moral vigor, of loyalty to tradition, and the capacity to