MICROFILM DIVIDER

OMB/RECORDS MANAGEMENT DIVISION
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ROLL NUMBER

1398

DESCRIPTION

2003 HOUSE EDUCATION

HB 1398

2003 HOUSE STANDING COMMITTEE MINUTES
BILL/RESOLUTION NO. HB 1398

House Education Committee

☐ Conference Committee

Hearing Date January 29 2003

Tape Number	Side A	Side B	Meter #
1	x		100-end
1		x	00-4000
Committee Clerk Signature	Linda Fiechtner		

Minutes: **Chairman Kelsch** opened hearing on HB 1398

(140) Rep. Sitte introduced Dr. Scott Bennett, Child Psychologist, Bismarck

I have worked with students in the preschool, elementary, middle and high school levels.

This is an interesting bill, that it is more problematic than reading and math. I had some experiences with my daughter, where she had some problems reading, and got several years behind. Because the schools do standardized testing, and have a means of measuring. We were able to assess the need and discovered she has a learning disability. W needed to teach her with a different method, now she is several grades ahead.

How do you address a child's needs and assess on how the program is working or not working?

What is one method for the state standard that will work for most of the kids most of the time?

With the understanding that there is no one approach that will work for every child all of the time. If safe practices are not taught, the down side is pregnancy, STD, and cost for health care, if abstinence is taught there is not much down side. The cost to society and the individuals is very little. So the issue is, is it more realistic to teach abstinence programs. Problems with any

curriculum, is that they don't work all that well. The broader cultural influences and the normal growing up of teens, hormones, outweigh the effect of sexual education program. Whether you teach an abstinence program, how to use contraceptive program, programs that have looked every thing from student lead programs to teacher/profession lead.

What does work to a certain level and when and where abstinence programs do in fact work? And what I have found is that they work well in the elementary and high school level and not to well in the middle school level. But unfortunately, nothing seems to work in the middle school level. A lot of peer pressure, hormones, etc. They work well with immigrants groups, apparently when they come to the US, their is much more peer pressure from previous cultures, so teaching abstinence programs back up what families and previous cultures teach.

Abstinence programs also work well when they are multifaceted. So if you look at section 2c, the social dynamics are at play. But when combined with alcohol, drugs, parent involvement programs, community involvement, as stated in section 3. They do have measurable affects.

And when underlining values are backed up by the cultural norm and morals.

In the Midwestern states, such as ND demographics, this is the best area to introduce these types of programs. Studies have shown that the rural communities in conservative areas, with religious backgrounds, with ND fits. They don't work well on the coastlines.

I feel that HB 1398 will impact our children in a positive way, states like ND it could have its biggest and strongest impact.

Rep. Mueller This program is in affect in surrounding states, where are those at and your understanding of how they are working?

Bennett: I don't have statistics with me, I can get for you. They are working minimally. What ever program you try in schools, it is not going to adequately address the problem. The problem is simply broader that cultural problems.

Rep. Mueller What states or districts has this been adopted in?

Bennett: it is more school districts that have applied this program.

Rep. Herbel You mentioned that when they deal with contraceptives, that it should involve a doctor or social worker and the parent.

Bennett: That is one thing I liked about the house bill is that it address the involvement with parents. We fault the parent so many times for not doing this, and when it is talk they feel they have to go in and clean up what was taught. Any program you do, as much as possible, get these people involved.

Rep. Hunskor Abstinence programs work best at elementary and high school, but not middle school, can you expand on that?

Bennett: The research shows that all education is problematic in the middle school level. That is when we developmentally we start to break away from our parents more and joke around with the process.

Rep. Meier At what age level in elementary do you start?

Bennett; I feel it is best to time it w/ the start of puberty, girls 5th, boys 6th grade.

Rep. Williams Are you aware of any states that mandate this type of program?

Bennett: I don't have that research, It would be hard to do that on a statewide effort because of the rural and urban splits.

Rep. Hunskor Over the years we have heard both sides of the coin, that these issues should be handled by the parents, by the church and not by the school. And now we are talking about sex education in the school? What is your take on that, is this a church/ parent affair or can a school be a positive thing?

Bennett: The school can be a positive thing to back up parents. Some parents are not comfortable with teach it, some parents just don't address it. The schools are just trying to pick up where families fell. Sexuality is such a broad spectrum, that it is easy for schools to teach physiology part of it, but the problems is when you don't address the values and morals/ emotional aspects of it. You are only giving the children half of it. A parents feel out of the loop or that their values are being opposed.

Rep. Sitte stated the legislation was passed in Mississippi, Arizona, Alabama passed legislation.

(1500) Rep. Sitte, District 35 See Attached Testimony

(2500) Rep Kerzman, District 31

I was pleased to sign on to this piece of legislation for many reasons. I think Rep. Sitte gave you enough information to think about. I have always felt that abstinence should be the focal point of sex education. Firmly believe that the parent should be the first teacher. And for the most part fairly straight forward and factual. It is disturbing that when you hear of schools for whatever reason sometimes send the wrong message. Just teaching safe sex without abstinence as the focal point is an underlying message the kids pick up in a hurry that sexual promiscuity is okay as long as you are protected. As Rep. Sitte pointed out the only 100% protection is abstinence.

Joan Lee, wife, mother and a nurse that has worked with abstinence resources. See Attached Testimony .

Suzie Sund Klundt, volunteer at the New Life Pregnancy Center

Basically what we do is offer host of supportive services for those young girls, teens that come to us thinking they are pregnant. We have a 24-hour hotline, provide clothing, baby clothing, homes, haircuts, love, anything to enable her to carry her baby to term. If she chooses to have an abortion, that is her choice because it is legal, we tell the girls that if after their abortion they are experiencing any emotional, health problems whatever, that we are there for them. And we do referrals to professional agencies. And I also get referrals from these professional agencies.

We promote abstinence. We have brought in speakers so that the message can be heard in the area as much as 60-80 mile radius. And because their message send such a positively received we also hold rallies on Wednesday night at the Bel Meheus. It was jam backed, there were over 800 kids there and the official at the door had to turn away about 200 kids. So since then we have moved to the Civic Center. this is because kids are hearing the abstinence message and they know that they only thing that will protect them physically, emotionally, spiritually. And I have seen the heartbreak as a result of kids being sexually active from as early as 13 years all the way up. It breaks my heart that some of the junior high level, are like rabbits, they were changing partners and thinking that this was okay. Most of them would not use protection because it was in the heat of the moment, the ones that did, condoms are 1 in 4 chance of not working. I have demonstrated the effect with a tennis racket and a sack of beans, the beans go through the racket. This is the chance you are taking. The largest HIV virus can go through the smallest hole in a condom. Condoms are not effective against STD's and 1 out of 4 in pregnancy.

We are privately funded. We do not receive any state or federal money, we don't the money because we do not want the interference. So we send letters and knock on doors for support.

Rep. Williams : You said that you have worked with students of a young age and in the middle school, who thought that it is was okay to swap partners.

Klundt: Their parents may not have had healthy conversations with them, they get their information in the schools. In those conversation I have asked were you offended by what you were taught by the teachers. And they say oh yes, I was only in the 5th grade and they were telling us how to use a condom, how to put it on, and that we know you are going to do it anyway so you should use a condom. Without the information about all that comes with it.

Jessica Shaw, student, See Attached Testimony

Rep. Mueller A troubling concept - You were told by the teacher that it was okay to have sex but this is safe when you do.

Shaw: Absolutely, Teachers are not able to say that this is right and this is wrong, they are able to say is that this is safe or this is safe. And if you choose to have sex, that is okay for you. Not having sex is the only way to be safe, but if you choose to this is what you use to reinvent those things.

Dr. Gaylord Kavely, as a parent.

Encourage a Do Pass on this. When I read through this I thought what a great idea, Excellence. Let me tell you what I mean about that. When I teach my kids whether it is sexuality, manners. And when I teach medical students in the family practice residence, I teach excellence. I think it is very important that we let people know the highest standard by which everything should be measured. When we talk about medications or surgery, ethically or safety or in surgery, risks and benefits. When we look medications/surgery if we found something that was 100% safe, 100% ethic, in that it always works and is always safe, then that is unquestionably the gold standard.

Now if you are in business , government, or medicine, we like to think of the importance of those standards, benchmarks, gold standards, or excellence or other terminology that we use. In teaching sex education to your children, we should think about the gold standard. If there is any birth control method that is 100% safe and 100% effective, I would think we would want that to be our Gold Standard. If we are going to tell them how to accomplish the gold standard, when there is only one method that is 100% we need to teach abstinence. Tell our children to strive for the Gold Standard. This is the best thing that you can do for yourself.

OPPOSITION:

(5600) Jean King, mother and resident of Bismarck, See Attached Testimony

Rep. Sitte What is your source on the data of 80% of teens are engaging in sexual activity?

King: It comes from Alan Guttmacher Institute, HEIUSA. They compile information off of the CDC web site, survey and from the National institute of Health.

Rep. Sitte When you are looking at birthrates, ages 15-19, and certainly the rate is going down. May be that leads us to question the validity of any sexual discussions. Do you know the rate of out of wedlock pregnancies births of women 20-25, have you graphed that?

King: I think women are choosing to have children on their own with out being married first. These women are independent and on their own, not receiving assistance.

(300) Mary Wahl, Council for Educational Leaders

I would like to spend just a few minutes talking to you about the philosophy with regard to sex education. And our belief that sex education curriculum should be developed at the local level. Last week this room was over flowing with home schoolers who were upset with an attempt being made to impose state standard based testing upon their children, they were upset that such

tests would interfere with rights to teach what they wanted and how they wanted to teach their children. Today you have before you a bill that will establish a state standard that would impose and abstinence based sex education curriculum upon all school districts in the state. A prescriptive and restrictive curriculum that would require all school districts to teach a very specifically defined six point sex education curriculum. last week some of you on this committee seems to empathize with the home schoolers position to don't interfere with us. Other of you seemed empathetic because you didn't feel that was appropriate to impose state testing based on state standards on home schoolers. We hope that you will likewise empathize with school districts when we say in opposition to this bill, 'don't interfere'. We hope that you Rep. Williams empathize with school districts when we say 'don't impose the state standard for sex education upon us'. Why because we believe the development of the curriculum is developed best at the local level. If presented with this bill, and asked to comment I believe that some of the responses of those who have been involved with local efforts might be, 'you know we have really worked hard in our community to establish a sex education curriculum for our community one that works for our community, we have no desire to go back and revisit our curriculum based on the requirement of this bill' and yet another response might be 'we have a carefully crafted sex education program and you know it has been agreed upon and reinforced by our schools, community, parents and churches. And it has many of the characteristics and requirement listed in this bill but not all of them, we don't teach for example about characteristics of contraception as this bill would require'. I personally believe that abstinence based education as described in this bill might work for our community, the only part I have reservations about is the requirement quote ' to teach the skills and attitudes needed to make marriage sacred.' unquote. I'm pretty

sure that our community would want to push that teaching assignment on our teachers and you know perhaps teaching of skills and attitudes need to make marriage sacred needs to come from our homes and churches.

Different responses and the similar part is 'our community'. We believe that the majority of school patrons would agree that sex education curriculum development works best at the local community level involving people who have deep feelings about this issue. passed out the **North Dakota Health Standard, See Attached Testimony .**

Rep. Mueller Do you know how many school districts that have sex education curriculum that they teach?

Wahl: deferred to Linda Johnson of Department of Public Instruction

Rep. Mueller Do you have knowledge to contrast with the one we have here in 1398?

Wahl: I do not.

Rep. Sitte have you read the state health standards?

Wahl: Yes I have, on line.

Rep. Sitte And so I asked Greg Gallagher from Department of Public Instruction, to give me a copy of all the state standards. So in those there was a copy of the health standards and as they are given to schools, are not these standards given as the state's official policy.

Wahl: the information that I received is that the components of the document were first were current standards, benchmarks and examples of specific knowledge and examples of activity. That what was presented to the individual district in terms of guidance for the type of sex education program they should develop.

Rep. Sitte as I read them, I did not find anything that has a clear message of abstinence going out to our youth. I did see on the bottom of page 11, 5-8th graders is to be recreating the birth, with all the proper technical language. I could go into several details of what I read there in here.

Wahl: It was my understanding, that when I looked at those types of activities, those subjective not prescriptive. They were suggestions to do with students not required. I would agree also that I don't see the word abstinence, I frankly don't think the word needs to be in state standards. That is what this bill is really about.

(1133) Linda Johnson, Director of School health programs at Department of Public Instruction. See Attached Testimony.

Rep. Jon Nelson you mentioned in your testimony that there some abstinence schools in ND, how many are there?

Johnson: They do not have to report to us, the money is run through the children's services coordinator because there is 1-4 match on this money. Schools may apply to the Regional Children's Services Coordinating committee for these dollars. There are not many programs, may be 10 or so.

Rep. Jon Nelson Your opposition to this bill is because it doesn't carry money with it?

Johnson: I'm sorry you have misunderstood me. My opposition is that it puts everyone in the state in one box. Schools are free to choose that money, they are free to go to the public health or tobacco money, whatever, however they choose to support these programs.

Rep. Jon Nelson Would it be safe to say that for these schools who teach this curriculum, is that in a area surrounding high amount of expenditures, is there any comparisons?

Johnson: I do not have those statistics.

Rep. Herbel how would you mandate into the highly qualified teachers to teach this?

Johnson: Health education does have a dilemma with highly qualified. We do offer majors in health education in ND. It is an issue. NDSU is going to offer a major next year , if they get it through.

Rep. Herbel We wouldn't have anyone qualified to teach based on that standard.

Johnson: I believe there is also the possibility that there could be a test administered to have the teachers qualify, if the major is required, there re ways we can do that by adding hours to what they have. Our teachers now have minors in the field. so we are not so far from reaching this.

Rep. Mueller How many districts have sex education curriculum and are teaching it.

Johnson: School health education profile that I have given you. Schools currently do not have to teach sex education. they have to teach about HIV and STD. What I have give you is weighted data, so that would mean that if we look at this currently 91% of the districts are teaching HIV, 82% STD, 82% Human Sexuality.

Rep. Mueller Based on what I imagine is a broad base of content curriculum, How this, in terms of curricula, would compare to those that are out their currently?

Johnson: The problem that I would see if you look at the Shep Document, the correct use of condoms is taught by 23% of the school districts. What we know about common use is if you don't teach this piece, the correct and consistent use of condoms for sexually active students, is problematic. That section of the law might be problematic to some, but other than that, any good health teacher is already teaching what is in this law.

Rep. Sitte Activity that came out of your division, red/yellow/green light. Are you familiar with this activity?

Johnson: Yes I am, it comes in a variety of levels. You were in an adult group, to teach beyond the High School level. Parents are uncomfortable with some of those subjects and the media is getting ahead of them.

Rep. Sitte It was specifically defined as a high school activity. As I sat there I thought if I am this uncomfortable, what about my 15 year old daughter.

Barb Lennington, Mom, Bismarck See Attached Testimony

Linda Garding, Bismarck, See Attached Testimony

Rep. Williams You said you worked in several states, what capacity?

Garding: As a HIV/ aids Educator. I also work with adults who then work with children.

Randi Schneider, student at the University of Mary.

I'm a virgin testifier. Resident of Bismarck, a graduate in social worker.

I do not want to criticize any one ideas, Rep. Sitte I have to agree that abstinence is an ideal it is the best. But I do have a couple of concerns, one of them as you look around the room lots of students. As legislators, as people and as a social worker, I want what is best for them. And abstinence would be the best, but there are people in this room, students who are engaging in sexual intercourse and if I think if we forget to educated them on how to do it the most safety. We know that it is not 100%, that it can't be, this is the best way if you are not going to remain in abstinence, please this is the safest way to do it. I think if we eliminate that from their education, they will slip through the cracks. They are missing out on valuable information that could prevent STD, unwanted pregnancy, and they are awful and we would not want students to have to deal with that. And so it is my main concern, if they don't get in school, and we know that parents should do it, and that parents don't do it, where do they get it.

I got it in school, my parents were always saying don't have sex!. And you know for a long time I really said this to myself. I can stand tall. Some of us can't always to that, and I didn't. And it almost my seem a bit of contradiction, but I'm a senior at the UofM, 21 years old, not married but engaged, but I'm having a baby in June. And so that makes it a little more personal to me. Not that I didn't receive the education, and that I'm standing in front of you because I didn't receive education on condoms and I'm having a baby. I'm not angry about that or upset. And I'm not saying that is what happened to me. I had the education and knowledge and I made the choice. I was lucky I think that I have parents that said, "Don't have sex", in school people in school said, 'don't have sex, but if you do, be safe'. It is important that we do emphasis abstinence, but that we also say, we have to look out for everybody, and to catch those that might fall through the cracks, and we are going to keep contraceptive education a major point of he sex education.

(4000) Close hearing on 1398

additional testimony entered:

Matt Herman, Ellendale, support

Christina Kindel, ND Family Alliance, support

Carol Two Eagle, Bismarck, opposition

2003 HOUSE STANDING COMMITTEE MINUTES
BILL/RESOLUTION NO. HB 1398
House Education Committee

☐ Conference Committee

Hearing Date February 11, 2003

Tape Number	Side A	Side B	Meter #
2	x		1212-6055

Committee Clerk Signature Linda Gruentner

Minutes: Chairman Kelsch opened HB 1398

Rep. Sitte reviewed the amendment, LEGISLATIVE COUNCIL 30566.

Rep. Sitte moved the amendment and Rep. Meier seconded the motion.

Voice vote passed.

Discussion:

Rep. Williams See Attached Testimony, North Dakota Standard and Benchmark Content standards, Health and Texas Teaches Abstinence

I am very concerned about this bill. And I want to explain why by two advantage points. First: HB1398 has a very lofty ideal, I think it is one we are proponents of, the very first step in sex education for students. It is very much an ideal. But in this bill, teaches abstinence almost exclusively the way it is laid out, and that is not the reality of our time. We have a good number of kids in our system that will not abstain no matter what we do. It is the same thing in alcohol education, drug education, and sex education. they will want to experiment, we try to discourage them from doing that, but we never will get all of them. If we teach exclusively a curriculum of

abstinence, I strongly believe that we are leaving a great portion of our young people at risk, and we are leaving them at risk for disease and many things. I want to touch on something. (1650) Read Texas paper. (1903) We have to show the other side. I 1990 in Wahpeton High School, designed their curriculum, with Department of Public Instruction guidance, with High School students involved, school board members and community members, church organizations. We set up the curriculum based on the standard guidelines. We are on 5 year cycles on our curriculum, new benchmarks were set up by the state, we also upgraded. Look at the Standard handout. Look at who the players are, a good variety of people were involved. We are legislating a standard. I'm so afraid that we are placing students are risk. Who decided what is taught. The local school district. To legislate this in the form of a standard or a curriculum, and to go around the infrastructure of local areas with their differences, I think is assuming to much of the Legislature and not enough of the local people. I can not support this bill.

Rep. Sitte I don't think I'm putting anyone at risk. How much of a change will this be in schools. They will still teach about contraceptives. This will teach abstinence first. Refereed to Linda Johnson's article and read parts of it. 51% of the schools promote abstinence. This is not an abstinence back into the discussions of sex education.

Rep. Williams Already in the Health standards there is a benchmark on abstinence. I am concerned we are getting into the area of legislating standards and benchmarks. Department of Public Instruction offers guidance in the area and it is up to the local school boards and communities to decide these things.

Rep. Sitte Local school districts, only if they choose, it isn't a mandate at all.

Chairman Kelsch I do remember when there was talk of mandating sex education and how it was fought tooth and nail by people that were very concerned about it. The proponents said then leave it to the school district and the community to decide, because it is a a sensitive issue. As a state we listened to that. That is where several of the people who testified in opposition were coming from, leave it to the local decision.

Rep. Hunskor Is it going to work in the classroom? Those who are comfortable will those who don't are going to use it , does anyone force them to use any certain type.

Rep. Sitte If it is the state law, I would think that the parents can go to the school and ask what are you teaching in the area of abstinence, state law is that it should be taught as the first option.

Rep. Hunskor What is going to best for the kids of North Dakota?

Rep. Haas If only purpose of this bill is to say ' Abstinence should be the first priority in any type of sex education class, then we need to stop the bill after line 8 on page 1 and delete the rest of the bill. Because the rest of the bill is very restrictive. In the experience that I have had with regard to the development of curriculum at the local level, I was the vocational director in the Dickinson district when we developed the curriculum there. It took us 6-8 months to develop, meeting every two weeks. We were doing it for the family consumer science department, and the teachers were developing detailed curriculum and the references, text books, audiovisual aids, everything for that curriculum, almost down to the lesson plans, and we approved it.

Rep. Hanson Do you believe this should be taught by parents?

Rep. Sitte There are some families that grow up with poor examples and in poverty. This is a bill for the children who are not taught by the parents.

Rep. Hanson No or yes, Then we got the wrong bill to require all the parents to teach sex education.

Rep. Williams I would hope that every school teaches abstinence first, I don't know if they all do, because it will vary among the communities.

Rep. Norland moved a DO NOT PASS as amended, Rep. Hawken second the motion.

Roll vote: 11-2-1, Rep. Williams will carry the bill to the floor.

30566.0201
Title.0300

Adopted by the Education Committee
February 11, 2003

VR
2/12/03

HOUSE AMENDMENTS TO HOUSE BILL NO. 1398 HEDU 2-12-03

Page 2, line 9, replace "sacred" with "succeed"

Renumber accordingly

Date: 2/11/03
Roll Call Vote #: 1

2003 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 1398

House **HOUSE EDUCATION** Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number 30566

Action Taken ~~do~~ amendments

Motion Made By Sitte Seconded By ~~Meeb~~ Meier

Representatives	Yes	No	Representatives	Yes	No
Chairman Kelsch					
Rep. Johnson					
Rep. Nelson					
Rep. Haas					
Rep. Hawken					
Rep. Herbel					
Rep. Meier					
Rep. Norland					
Rep. Sitte					
Rep. Hanson					
Rep. Hunskor					
Rep. Mueller					
Rep. Solberg					
Rep. Williams					

Total (Yes) _____ No _____

Absent _____

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

Date: 2/11/03
Roll Call Vote #: 2

2003 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 1398

House **HOUSE EDUCATION** Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number 30566

Action Taken DNP as amended.

Motion Made By Norland Seconded By Hawken

Representatives	Yes	No	Representatives	Yes	No
Chairman Kelsch	✓				
Rep. Johnson	✓				
Rep. Nelson	✓				
Rep. Haas	✓				
Rep. Hawken	✓				
Rep. Herbel	✓				
Rep. Meier		✓			
Rep. Norland	✓				
Rep. Sitte		✓			
Rep. Hanson	✓				
Rep. Hunskor	✓				
Rep. Mueller	✓				
Rep. Solberg		AB			
Rep. Williams	✓				

Total (Yes) 11 No 2

Absent 1

Floor Assignment Williams

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE (410)
February 12, 2003 1:55 p.m.

Module No: HR-27-2423
Carrier: Williams
Insert LC: 30566.0201 Title: .0300

REPORT OF STANDING COMMITTEE

HB 1398: Education Committee (Rep. R. Kelsch, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO NOT PASS** (11 YEAS, 2 NAYS, 1 ABSENT AND NOT VOTING). HB 1398 was placed on the Sixth order on the calendar.

Page 2, line 9, replace "sacred" with "succeed"

Renumber accordingly

(2) DESK, (3) COMM

HR-27-2423

2003 TESTIMONY

HB 1398

Margaret Sitte Testimony on HB1398, January 29, 2003

Madame Chairman and Members of the Committee,

For the record, I am Margaret Sitte, Representative from District 35.

I was tempted today to bring a pack of cigarettes, some cigars, pipes, snuff, and chew to demonstrate a new Safe Tobacco campaign in schools. I would have passed those items around for each of you to handle. We would have lit them so you could become familiar with the smell because we know teens are going to smoke, so we may as well inform them how to do it safely.

Then I actually considered bringing a six pack of beer, a bottle of red and white wine, and a bottle of whiskey, with several small paper cups, to demonstrate a new Safe Drinking campaign in schools. Again, I would have had you smell, and touch the alcohol, although you couldn't taste it. After all, we know teens are going to drink liquor, so we may as well inform them how to consume it safely.

I could continue to describe a new Safe Drugs program that would expose young minds to marijuana, methamphetamine, and cocaine, but I think you get the picture.

For 30 years, schools across North Dakota and the nation have been following a flawed pattern, exposing young minds to detailed sexual discussions under the guise of "Safe Sex." In 1989, the voters of North Dakota stood up against comprehensive health standards and soundly defeated them in a statewide referendum. Yet flaunting the will of the voters, the Department of Public Instruction distributed the manuals anyway after the election.

What's wrong with the way this state has been educating our young people in sexuality? Three reasons are readily apparent:

- In every other risk-taking behavior the state standard is to teach refusal skills.
- The promotion of contraceptives among teens has led to epidemic growth of sexually transmitted diseases.
- No method of birth control is 100 percent foolproof, leading to unplanned pregnancy, out-of-wedlock children, and a series of difficulties that often require government intervention.

Let's consider the first point: teaching refusal skills. In every other risk-taking behavior, our schools teach adolescents to "Just Say No." We know that smoking, drinking alcohol and using drugs are detrimental to young people, so we have a zero tolerance policy. Yet in the risk-taking behavior of adolescent sexuality, with lifelong health consequences, we tell them sex is okay as long as they "protect themselves."

Look at DPI's current definition of abstinence taken from the glossary (p. 33) at the back of the North Dakota Standards and Benchmarks, Content Standards. Abstinence is defined as "Not engaging in a particular behavior." Is this phrasing the best we can develop to inform the youth of North Dakota about the health and psychological consequences of sexuality? Where in the

standards is there a clear cut message that abstinence from sexual relationships until marriage is the healthiest choice?

The societal results from sexuality outside of marriage have been many:

- Teen mothers are less likely to graduate from high school, more likely to live in poverty and to rely on welfare. (Annie E. Casey Foundation, 1998)
- Children of teen mothers are often born at low birth weight, experience health and developmental problems, and are frequently poor, abused, and/or neglected. (Annie E. Casey Foundation, 1998)
- Teen pregnancy poses a substantial financial burden to society, estimated at $7 billion annually in lost tax revenues, public assistance, child health care, foster care, and involvement with the criminal justice system. (Annie E. Casey Foundation, 1998)
- More than 1 million teens become pregnant annually and an additional three to four million contract a sexually transmitted disease. (Planned Parenthood, 2002)

Millions of men and women have faced serious lifelong consequences from sexual experiences outside of marriage. Sexually active youth often live with anxiety about the possibility of unwanted pregnancy or contracting an STD. Studies have documented emotional and psychological injuries ranging from regret and guilt to loss of self-esteem and depression. A study reported in the *Journal of Marriage and Family* showed that those who engage in premature sexual activity are 50 percent more likely to divorce later in life than those who do not.

In his Presidential campaign, George W. Bush pledged to "elevate abstinence education from an afterthought to an urgent priority." In reality, the federal government has changed its stance to promote abstinence, and positive results are beginning to show. Both through abstinence grants aimed at teens and through Title V TANF funding, Congress has committed more than half a billion dollars to abstinence-only programs. The eight conditions of Title V, part of the TANF welfare reform package, are attached. You will see they closely mirror this bill.

Last April Secretary of Health and Human Services Tommy Thompson praised the abstinence-only education programs. He said, "Education supporting an abstinence until marriage message is a positive development in our nation's efforts to help adolescents avoid behaviors that could jeopardize their futures. Too many stories of welfare dependence begin with the pregnancy of a young girl who felt pressured to begin a sexual relationship. Abstinence until marriage is a message that we have a responsibility to deliver to all young people, and one that most of them want to hear."

The national emphasis on abstinence is changing teen attitudes and actions. Teen sexuality and pregnancy have been declining in the past ten years. Robert Rector, a senior fellow at The Heritage Foundation, has research showing that abstinence-only programs work. "There are now at least ten evaluations—scientific evaluations—that show that authentic abstinence education reduces sexual activity." A copy of his report with the results of each program is attached.

The National School Boards Association synopsis of No Child Left Behind shows that the federal legislation prohibits the distribution of contraceptives and the development and

distribution of materials that may promote or encourage sexual activities. The school must develop new, age-appropriate sex education curriculum that emphasizes abstinence.

Our legislative intern Mark Puppe did a quick search of other state laws for abstinence and curriculum and found 47 statutes, (not states) among the 50 states that use abstinence and curriculum in the same statute.

Clearly, the nation is shifting to an abstinence standard.

Second, let's look at the risks of Sexually Transmitted Diseases (STD).

According to "Sex, Condoms and STDs: What We Now Know," there were two STDs of major concern in the 1960s—syphilis and gonorrhea—both curable with penicillin. The report shows the current widespread epidemic of STDs.

> "Today according to the Institute of Medicine, there are more than 25 STDs, many of which are viral with no cure. It is estimated that over 15 million new sexually transmitted infections occur every year in the United States. One-fourth of these new infections occur in teens, and two-thirds occur in individuals less than 25 years of age.
>
> There are approximately 70 million current STD infections in the United States. The most common of these is genital herpes, which alone infects over 20 percent of Americans age 12 or older. A recent study reported that an estimated 7.9 percent of 18 to 35 year-old residents of Baltimore, MD, have untreated gonorrhea or Chlamydia infections, or both. Another large study showed that 50 percent of sexually active women ages 18-22 were infected with human papillomavirus, the virus that causes over 93 percent of cervical cancer."

Several of the STDs such as HIV and herpes have no cure. Many of them carry permanent consequences. Chlamydia is the fastest growing cause of infertility. The Centers for Disease Control has said, "Prevention of one case of STDs can result in the prevention of many cases."

What are the medical findings about the use of condoms? The Centers for Disease Control released a report on condoms and STDs in July 2001. Among the findings are the following:

- "The surest way to avoid transmission of sexually transmitted diseases is to abstain from sexual intercourse, or to be in a long-term mutually monogamous relationship with a partner who has been tested and you know is uninfected."

- "While some epidemiologic studies have demonstrated lower rates of HPV [Human Papillomavirus] infection among condom users, most have not." (CDC, "Male Latex Condoms and Sexually Transmitted Diseases").

The current dominant model of discussing condoms under the phrase "Safe Sex" is unconscionable when medical science tells us that condoms often won't protect young people

from STDs. Schools condemn tobacco use and drug use for their obvious detrimental impacts on public health. Why then should schools continue to strongly emphasize condoms when the CDC has found that condoms are often not effective in preventing STDs?

Let's move on to the third point: Contraceptives are not 100 percent effective, thereby leading to teenage pregnancy and out-of-wedlock birth with enormous societal implications.

Remember what Tommy Thompson said? For many young women welfare dependency begins with pregnancy? As reported by the Associated Press last week, a study published in the Lancet medical journal shows that children of single parents suffer many problems: they are twice as likely to develop serious psychiatric illnesses such as severe depression or schizophrenia, to kill themselves, or to attempt suicide. They are more likely to become drug addicts and to develop alcohol-related disease.

Children in single parent homes suffer far more abuse, are more likely to be sexually promiscuous, are more likely to do poorly in school and are more likely to live in poverty than children with married parents.

The CDC reports that during 1971 to 1979 the percentage of females aged 15 to 19 years living in metropolitan areas nationwide who ever had sexual intercourse increased from 30 percent to 50 percent; During 1982-1988, the percent increased from 47 to 53 percent. Yet during 1991-2001, the percent decreased from 54 percent to 46 percent. As more young people are deciding to control their sexuality, the schools of North Dakota should reinforce their decision with a strong abstinence message.

This bill still allows schools to discuss contraception, but it shifts the focus of the education to a discussion of why abstinence is the best policy. During the last thirty years of explicit sex education, some schools have prematurely destroyed natural modesty. As a result, STDs, out-of-wedlock pregnancies, and increased government dependence have expanded dramatically.

North Dakota needs strong families, committed families, who treasure healthy sexuality in the context of marriage. One of the best ways we can help to achieve that vision is for the state to make abstinence the state standard in all sex-related education. Do we know they won't all follow our advice? Absolutely, just as we know some will choose to smoke and drink, but the point is that the advice from the state of North Dakota is a strong message of abstinence.

The state should do no harm. Our young people deserve the truth about the health, psychological and social ramifications of sexual activity. As a state, we don't want North Dakota young people to engage in any risk-taking activity, whether it be smoking, liquor, drugs, or sexuality. North Dakota schools should set a higher standard for healthy living than they currently provide. I urge a Do Pass from this committee to show that North Dakota truly cares about the physical and psychological health of its young people.

From North Dakota Standards and Benchmarks Content Standards 2000

Glossary

Abstinence - Not engaging in a particular behavior.

Advocate - To speak or write in support of something.

Dysfunctional eating - Includes irregular or chaotic eating, consistent undereating, and consistent overeating of more than the body wants or needs. It exists on a continuum between normal eating and eating disorders, and may be of mild, moderate, or severe intensity.

Eating disorders - Refers to anorexia nervosa, bulimia nervosa, and binge eating.

Health care - Care pertaining to health or care provided by a health care professional, including medical doctors as well as others.

Health triangle – A balanced sense of well being that includes physical, mental, and social.

Holistic - Relating to or concerned with wholes or with complete systems rather than analysis of, treatment, or dissection into parts. Holistic health views health in terms of physical, emotional, social, intellectual, and spiritual components.

Infomercial – A television or radio program that gives information as it tries to sell a product.

Medical care - Care pertaining to medicine or care provided by a medical doctor.

Physical activity - Any bodily movement produced by skeletal muscles that results in energy expenditure (i.e., something one does).

Physical fitness - A set of attributes that people have or achieve that relates to the ability to perform physical activity; something one acquires, a characteristic or an attribute one can achieve by being physically active.

Primary prevention - Actions designed to prevent disease from occurring, includes health promotion activities.

Secondary prevention - Early diagnosis and prompt treatment, includes activities such as screening for diseases (e.g., vision, hearing, etc.).

Sexually transmitted infections (STIs) – more commonly referred to as sexually transmitted diseases which are diseases that can be transmitted through various forms of sexual contact. HIV is an example of a disease that is transmitted primarily through sexual intercourse.

Spiritual - Pertaining to a person's beliefs that promote a positive attitude and caring concern for others.

Standardized Presidential/Cooper – types of fitness assessments. The Standardized Presidential is a fitness assessment given under specified conditions and based on guidelines set by the President's Council on Physical Fitness and Sports. The Cooper assessment was developed by the Cooper Clinic, a cardiovascular fitness aerobic research and testing center located in Dallas, Texas. Results of their 1989 study on mortality/fitness indicated that the higher the level of physical fitness the lower the all-cause mortality rate. This result is most likely due to lowered rates of cardiovascular disease and cancer.

Tertiary prevention - Treatment, care, and rehabilitation of people to prevent further progression of a disease.

** Indicates word or phrase is defined in Glossary*

Frequently Asked Questions About the Title V Abstinence Education Program
November 1997

NCAE
National Coalition for Abstinence Education

Introduction
There is considerable confusion about the federally funded Abstinence Education Program being implemented beginning in 1997. Unfortunately, certain groups that are opposed to the program are actively distributing misinformation in an attempt to undermine the program.

The purposes of this document are to answer the most commonly asked questions about the Title V Abstinence Education Program and to address the misinformation campaign being conducted by the program's opposition.

What is the Title V Abstinence Education Program?
As part of the welfare-reform act of 1996, Congress authorized $50 million of federal funds annually for five years to be provided to the states in the form of block grants to promote abstinence until marriage. When combined with required state matching funds of $3 for every $4 federal dollars, $437 million will be available to support the abstinence message during the duration of the program.

Doesn't the matching funds requirement place an undue burden on the states?
This argument is not factual. It is not unusual for federal programs to require state matching funds. Additionally, in many states not a single penny of state money will be used to meet the matching requirement. In some states, organizations such as curriculum providers will be required to find their own match. In other states, the match will be met with in-kind donations. In yet others, existing abstinence programs will qualify to satisfy the match. In fact, very few states are using actual state dollars to meet the matching requirements–and those states are doing so out of the conviction that abstinence education is greatly needed.

However, it is entirely fair to expect all states to provide at least a portion of the matching funds. After all, states provide funds to promote the comprehensive safe-sex message. Doesn't it make sense for states to support adolescents who have made a healthy choice for abstinence as well?

Doesn't the Title V abstinence money come with too many strings attached?
No more than usual conditions are placed on all block grants provided to the states. For example, highway funds may carry restrictions on speed limits, construction techniques, materials and so on.

The Title V program requires the states to fund education that:

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 human 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 increases vulnerability to sexual advances; and
(H) teaches the importance of attaining self-sufficiency before engaging in sexual activity.

These eight conditions are entirely realistic and based on fact. As long as these conditions are satisfied, states are given great latitude in the implementation of abstinence programs.

But aren't the majority of students sexually active? Won't they have sex no matter what they're taught?
Wrong. Not everybody is doing it. In fact, in 1995 the federal Centers for Disease Control found that nearly half of high school students (48 percent of girls, 46 percent of boys) had never had a sexual experience. In addition, a large percentage of students who have had sex, wish they had remained virgins–and would like to acquire the skills to become abstinent.

Intern 7 NDLA
01/20/2003 12:57 PM

To: maitte@state.nd.us
cc:
Subject: Abstinence

Rep. Sitte,

I am writing to inform you that I was wrong when I told you earlier today that only 5 states use the word "abstinence" in their statutes. I have found that there are 47 state statutes (not states) among the 50 states that use "abstinence" & "curriculum" in the same statute. I'm sorry for my error and hope it does not happen again.

Sorry,
Mark Puppe

Mark Puppe
Legal Intern
Natural Resources & Education Committees, Pioneer Room
House of Representatives
701.328.4975

Sex Education Programs and Curriculum

1. School district leadership will inform, in writing, district curriculum specialists, those who teach sex education, school nurses, and other school staff of new restrictions and prohibitions regarding the distribution of contraceptives and the development and distribution of materials that may promote or encourage sexual activities. All professional development activities and materials for teachers and other school staff should be revised to reflect these new guidelines.

2. School districts will target federal funds toward the development or purchase of new, age-appropriate sex education curriculum that emphasizes abstinence if such curriculum is not currently being used in the district.

HB 1398
Pioneer Room 8:30 AM
Madam Chairman _Kelsch__, Members of the committee:
My name is Joan Lee. I am wife, mother, and nurse and have worked with abstinence resources

I stand in support of HB 1398 and urge you to pass it. Why?

1. It is the right thing to do. Abstinence is the most normal lifestyle for adolescents. Adolescents who abstain avoid the related physical, psychological, emotional, social and economic consequences of premature sexual contact and are more likely to achieve their life goals for education, career, stable marriage and family.

Besides pregnancy, physical consequences to the teen include: infection, fatal disease, infertility, and disease--or even death-- to her newborn. Three million teens contract sexually transmitted diseases, annually. It is wrong to gamble when the stakes are so high.

There are basically two philosophies of sexual education (and you have to be careful because they define words like abstinence and responsibility differently).
The two are: Abstinence until marriage and Comprehensive Health Education.
Abstinence until Marriage is not just say no--as you can see by the definition in the bill; it equips students with information and good reasons to wait. The hallmarks of Comprehensive health are (they even use the word abstinence now) abstinence until you are "ready" and contraceptive use.

2. To teach contraception to teens it would seem prudent to be sure that the "protection" is actually able to keep them from harm. IT ISN"T. Contraception is fraught with problems. Among the various methods of contraceptives only the condom offers any protection at all from sexually transmitted disease. That's a tall order because condom use is much more likely to be effective in theory than in practice.

Therefore two methods of contraception are advocated for use at the same time. For example: the pill (or Depo) and the condom. The question to ask yourself is: if condoms are so effective in preventing STDs what's the pill for? The answer is preventing pregnancy. But, if the condom is not effective at preventing pregnancy, how on earth do they prevent STD"s? Should we continue to stake our children's lives on them?

(Let me Call attention to the Article: "To Tell the Truth About Condoms") by gynecologist Joe McIlhaney

Other reasons to support abstinence education are:
3. Schools should not undermine parents that are teaching their children to abstain nor should we confuse students with mixed messages about what is appropriate or responsible behavior.

4. Regret. Studies have reported that of those who are sexually active 4/10 boys and 6/10 wish they had waited. (SEICUS web site acknowledges)

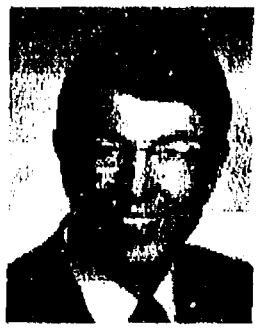
5. If we care about kids in ND, we must teach abstinence and that marriage is the appropriate context for sexual intercourse. By all kinds of measures children and women and men and society all benefit from the institution of marriage.

The legislature would do well to recognize and uphold marriage in the interest of public health.

I ask you to vote in favor of abstinence education for our school children.

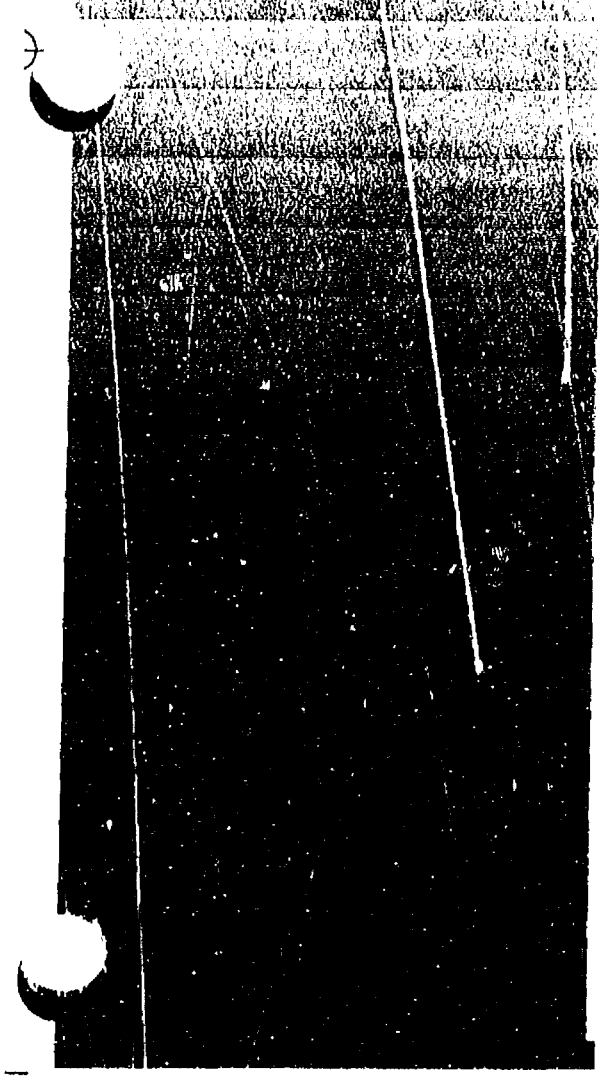
HB 1398 - Abstinence

In My Opinion



By Joe S. McIlhaney, Jr., M.D.

To Tell the Truth About Condoms



The classic television game show, *To Tell the Truth*, is back. Could we ask the producers to dedicate one episode to condoms? Yes, condoms. Because it seems that we just don't seem capable of telling the truth about condoms.

If we did, at least then young people would have all the facts they need to decide whether to become sexually active. And their parents would have a true measure of the risks involved.

Unfortunately, too many experts seem to obfuscate, to create a confusing haze around the reality of condoms. The facts though, are rather clear. The National Institutes of Health last year convened a panel to explore the scientific evidence determining whether male latex columns are effective in preventing sexually transmitted diseases (STDs) – the report has just been released. Experts from around the world presented research to the panel. What the panelists heard paints a much less reassuring picture about condoms than the message kids and parents generally hear.

The panel found that condoms can reduce the risk of HIV by approximately 87 percent if they are used 100 percent of the time. Condoms can reduce the risk of gonorrhea in men, and may or may not reduce the risk of chlamydia in men. (Chlamydia is an STD that is a common cause of infertility in women and is common in sexually active adolescents.) The studies reviewed consistently reported that condoms had no impact on the risk of sexual transmission of human papillomavirus (HPV) infection in women, which is responsible for more than 98 percent of cervical cancers. Finally, they learned that there is no clear evidence that condoms reduce the risk of any other STD, including gonorrhea and chlamydia in women and HPV infection in men.

The other truth is that America is experiencing an epidemic of STDs. Sixty percent of co-eds at Rutgers University, for example, were found to be infected with HPV at some time during a three-year study. A study of herpes infection showed that 45.9 percent of all African-Americans over the age of 11 in this country is infected. And there has been a 500 percent increase in the prevalence of genital herpes in white adolescents over the past 25 years.

And condoms do nothing to protect the emotional health of young people engaged in activities they don't really understand.

All of this being the case, you wouldn't think we would have any difficulty telling the truth about condoms. Yet, much of the public health community, committed as they are to promoting an intervention strategy relying almost solely on condom use, would end up with the booby prize on *To Tell the Truth*.

Indeed, an honest look at the research leads to only one conclusion: the only realistic way for a young person to eliminate their risks of STDs and nonmarital pregnancy is to remain sexually abstinent until marriage. But, despite the fact that *more* teenagers are grasping this fact and *fewer* teenagers are having sex than just nine years ago, public health advocates continue to promote condom use over abstinence.

Leslie Kantor, spokesperson for the Othmer Institute at Planned Parenthood of New York, recently said, "The United States currently spends close to $100 million annually on abstinence-only-until-marriage programs, which prohibit discussion of key topics, such as contraception." She's referring to Title V funding for abstinence education, which is just a drop in the bucket compared to federal funding for contraception and family planning. But she's also not telling the truth. Title V does allow discussion about contraceptives as long as it's in the context of emphasizing abstinence.

And James Wagoner of Advocates for Youth said, "American young people are contracting HIV at the rate of two per hour, yet Congress continues to dump taxpayer dollars into ineffective programs that deny young people information about contraception that could protect their health and save their lives." Besides being inaccurate about abstinence education programs, Wagoner ignores the fact that only rare contraception-based education programs have been shown to decrease pregnancy rates and then only a little. None have reduced STD rates.

Kantor and Wagoner are far from the only public health figures who would find *To Tell the Truth* a challenging game show. And that's a terrible shame because this isn't a game. This really can be life or death.

Dear Madam and Chair members of the Committee:

My name is Jessica Shaw and I am here in support of HB 1398 relating to abstinence in sex education because I support the education of the only sure way to prevent the damage that sex before marriage can cause.

I made the definite choice to remain abstinent when I was a teenager not because of but in spite of what I was taught in school. I remember the mention of abstinence as a possible way to prevent pregnancy, diseases, etc... but it was followed by the many other forms of contraception that could but not absolutely prevent just a few of the problems that sex before marriage may cause.

I remember not only being a minority but being ridiculed by my peers for being a virgin. Some of my friends made the choice to have sex. I remember the turmoil they had to go through having to sneak around and get pregnancy tests then some of them having to tell their parents that they were pregnant putting undo strain on their parents. And that in turn putting strain on their relationship with them. A couple of close friends acquired STD's that they couldn't tell anyone about because they were so embarrassed. They would come to me crying and wondering what they were going to tell the one that they did decide to marry someday. I heard about the worry, the anxiety, and the confusion. Wouldn't you rather help teens avoid the chance of having horrible experiences like that? Help them not worry about whether they had an incurable disease or whether they would have to drop out of school to take care of a baby

they didn't expect to have and can't afford to keep without government assistance?

Those that I have kept in contact with and those who I have chatted with in passing, have expressed respect for my lifestyle. They can see by example that it's not impossible to say no even when you want to say yes. In learning to control my actions and not letting my feelings lead the way I have been able to make realistic and practical decisions on who I choose to be involved with. Not base them on my emotions only. Solid long-lasting relationships are not based on sex. I don't have to be concerned with having to tell him that I've been with any other man. I won't do him the injustice of comparing him with anyone else. Or what diseases I got from whom. I don't have to get rid of the emotional baggage carried by sharing myself with anyone else before him. I will have all of me to give to my husband.

I support not just the mention of abstinence, but the promotion and education of remaining abstinent until marriage. Why prioritize the education of safe sex when safe sex isn't completely safeguarding them in the first place. In doing that, are we really prioritizing their safety? Shouldn't we care about them more than to encourage something that is less than 100% safe?

What is the harm in teaching kids about self-control? What is the harm in teaching them to think things through beyond what their emotions and hormones want them to do? They have a whole life to live beyond high school and hormones.

And what they learn in school shapes them for life.

House Bill 1398

Good morning Chair Kelsch and members of the House Education Committee. My name is Jean King, I am a resident of Bismarck, and I am here to speak in opposition to House Bill 1398.

While I agree with the goals of sexual abstinence until marriage and fidelity within marriage, especially when it comes to myself and my children, I have to say that my life experiences tell me that expecting this level of behavior from all teens in North Dakota is not only unrealistic, it is ludicrous. Not every teen comes from a two-parent family with lots of disposable income and a strong religious or moral background. In North Dakota, too many of our young people come from alcoholic, drug-addicted, poverty-stricken families with little time or emotional energy to invest in their children. It is sad but true that many of these young people come from the reservations, our state's tragic centers of poverty and despair.

To require that our state refuse to teach these young people about proper use of contraceptives, including condoms, and furthermore that we refuse to accept Title X monies from the government (HB 1467) that provide contraceptive services for those who cannot otherwise afford them is negligent and criminal. If they try to tell you that it is irresponsible to teach condom use because inexperienced users of condoms experience a 50% failure rate, I will tell you that that is still half the number of teen mothers and babies that our state has to try to pay for on the welfare roles for the next 16 years until that baby becomes the next generation of teen mothers or fathers – because statistics show that POVERTY is the leading correlate of teen pregnancy, NOT sex education. If they try to tell you that teen sexual activity, pregnancy and abortion rates are rising because of sex education in schools, I will ask you to look at the statistics I bring to this committee that show declines in those rates over the last 30 years. The only time those rates have risen is in the late 1980's and I will tell you that it is an remarkable coincidence that those rates rose shortly after Ronald Reagan slashed the Title X family planning budgets in the first year of his administration; and

they began to fall again in the 1990's shortly after President Clinton began to restore funding.

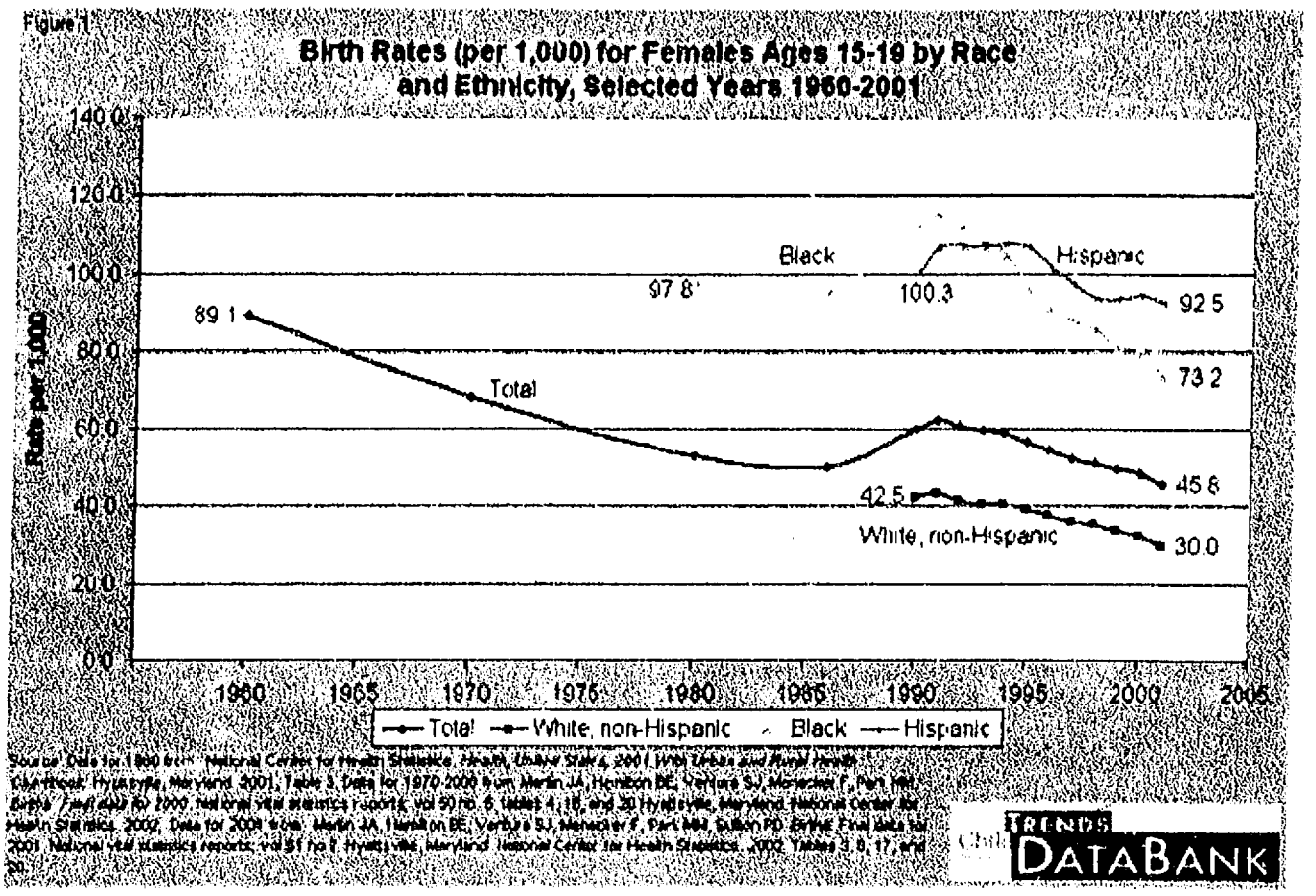
It would be a wonderful world if we could successfully encourage all young people to make healthy choices for themselves. But we know that is not a reasonable expectation. Some teens WILL drink, some will drive when they drink, some will take drugs, some will drop out of school, and some will engage in risky sexual behaviors. The state has an interest in preventing teen STD's, pregnancies, and abortions. It is in the state's best interest to provide teens with information not only about abstinence, but about contraceptives and their uses, STD's and their prevention and cure rates, teen pregnancies, abortions and their consequences. We provide teens with information about alcohol and drugs to prevent their abuse. Why would we refuse to give them accurate and complete information about sex, contraception, pregnancy and STD's?

Please vote do NOT pass on this well-intentioned but mis-guided bill.

Thank you,

Jean King
737 Munich Drive
Bismarck
258-7579
jking@westriv.com

Figure 1



Source: Data for 1960 from National Center for Health Statistics. *Health, United States, 2001 With Urban and Rural Health*. Hyattsville, Maryland, 2001, Table 3. Data for 1970-2000 from Martin JA, Hamilton BE, Ventura SJ, Menacker F, Park MM. *Births: Final data for 2000*. National vital statistics reports; vol 50 no. 5. Tables 4, 18, and 20. Hyattsville, Maryland: National Center for Health Statistics. 2002. Data for 2001 from Martin JA, Hamilton BE, Ventura SJ, Menacker F, Park MM, Sutton PD. *Births: Final data for 2001*. National vital statistics reports; vol 51 no 2. Hyattsville, Maryland: National Center for Health Statistics. 2002. Tables 3, 8, 17, and 20.

http://www.childtrendsdatabank.org/figures/13-figure-1.gif 1/29/03

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Teen Pregnancy

View as PDF (Best for Printing)

Headline

Pregnancy rates are declining among adolescent females of all ages. (See Figure 1)

Importance

Teen pregnancy has negative consequences for both the mother and child. The vast majority of teen pregnancies (78 percent) are unintended.[1] Data from the mid-1990s indicate that 43 percent of pregnancies to teens aged 15-19 end in unintended births and another 35 percent end in abortions.[2] These percentages are even higher for younger teens. Mothers who do have a teen birth are more disadvantaged, on average, than are other teens and have children who face negative health, cognitive, and behavioral outcomes.[3]

Trends

In 1997, the teen pregnancy rate reached the lowest recorded rate since 1976. Though the pregnancy rate has fallen since 1991, the decline was preceded by an increase in rates between 1986 and 1991. Among female teens 15-19, the rate declined from 116.5 per 1,000 in 1991 to 94.3 in 1997, the most recent year for which national data are available. Teens 15-17 experienced a decline from 80.3 in 1990 to 63.7 in 1997. The rates for teens 18-19 also declined between 1991 (167.2) and 1997 (141.7). (See Figure 1)

Differences by Race and Ethnicity

Although non-Hispanic white teens have lower teen pregnancy rates (65.1 and 1.1 per 1,000 for teens in 1997, ages 15-19 and under 15, respectively) than either non-Hispanic black teens (170.4, 7.7) or Hispanic teens (148.7, 3.9), each racial/ethnic subgroup has experienced declining rates in the 1990s. Non-Hispanic white and non-Hispanic black teens aged 15-19 experienced steady declines between 1991 and 1997. Teenage pregnancy rates for Hispanic teens did not begin declining until 1995. (See Figure 2)

Differences by Age

Younger teens have lower pregnancy rates than older teens. Teens under age 15 have very low pregnancy rates (2.6 per 1,000 in 1997). In 1997, teens 15-17 had a pregnancy rate of 63.7 per 1,000 teens compared to 141.7 among teens 18-19. (See Table 1)

Related Indicators

Sexually Active Teens, Sexually Experienced Teens, Condom Use, Birth Control Pill Use, Teen Births, Teen Abortion

State and Local Estimates

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Teen Births

View as PDF (Best for Printing)

Headline

The 2001 birth rate among teens 15-19 years old is the lowest rate ever reported in the United States. (See Figure 1)

Importance

Teenage parents are more disadvantaged than other teens, and they are generally unprepared for the financial responsibilities and the emotional and psychological challenges of early childbearing. A recent study of the consequences of teen childbearing suggests that the effects of teen motherhood are borne primarily by the children of teen mothers, followed by the mothers themselves, and by government and taxpayers.[1] Children born to adolescent mothers are more likely to be born prematurely, to have a low birth weight, and to die as infants.[2] The children generally have less stimulating home environments and poorer academic and behavioral outcomes then children born to older mothers[3] and are more likely themselves to initiate sex at an early age and to have a teen birth.[4]

Trends

After an increase in the teen birth rate in the late 1980s, the birth rate for adolescent females of all ages has declined steadily since 1991. The 2001 rate of 45.8 births per 1,000 females ages 15-19 is a record low and substantially lower than the 1991 rate of 62.1 (See Figure 1). However, because the decline in the teen birth rate in the 1990s was preceded by an increase between 1986 and 1991, the teen birth rate in 2001 is only slightly lower than the rate in 1986 (50.2 per 1,000 females 15-19). Declines since 1991 are evident for both younger (15-17) and older (18-19) teen females. (See Table 1)

Differences by Gender

Adolescent males are less likely than females to have a child, due in part to the fact that females generally have older partners than males, as well as to under-reporting among males. For example, the teen birth rate for males ages 15-19 in 2001 (18.7 per 1,000 males 15-19) is less than half the rate for female teens (45.8 per 1,000 females 15-19). The trend in birth rates in the late 1990s is declining for both adolescent males and females. The adolescent male birth rate, however, began declining a few years after the adolescent female birth rate. (See Table 1)

Differences by Race and Ethnicity

In the past, black teens had the highest female teen birth rates. However, rates among Hispanic teens began declining later in the 1990s than rates among black or white teens, and Hispanic teens currently have the highest teen birth rates. Rates per 1,000 ages 15-19 among female Hispanic teens (92.5) and black teens (73.2) were higher than rates among American Indian teens (66.0), non-Hispanic white teens (30.0), and Asian teens (20.4) in

Teen Abortion

View as PDF (Best for Printing)

Headline

The abortion rate among teens ages 15 to 17 has declined by more than a third since 1994, to 15 abortions per 1,000 in 2000 (See Figure 2). Overall, teen abortion rates have been declining since the late 1980s.

Importance

A little more than half of adults interviewed in 1998 felt that abortion was acceptable (9 percent "always" and 42 percent "in some situations but not in others").[1] More than one-third of all teenage pregnancies in the U.S. end in abortion.[2] The vast majority of teenage pregnancies are unintended, and close to half of those unintended pregnancies (45 percent) end in an abortion. Teens often choose to have an abortion because they have concerns about how a baby would change their lives, they worry about financial problems, or they feel that they are not mature enough to become a parent.[3] Abortion levels would be reduced if the high rate of unintended pregnancies was reduced or if more pregnant teens carried their pregnancy to term.

Trends

Government estimates indicate that teen abortion rates increased during the 1970s, stabilized during the 1980s at around 43 per 1,000 females ages 15-19, then decreased steadily to 27.5 per 1,000 by 1997 (See Figure 1 and Table 1). More recent estimates produced by the Alan Guttmacher Institute (See Table 2) and not directly comparable to government figures also show a decline from 34 per 1,000 in 1994 to 25 per 1,000 in 2000. Recent declines have been especially large among teens ages 15-17 (See Figure 2).

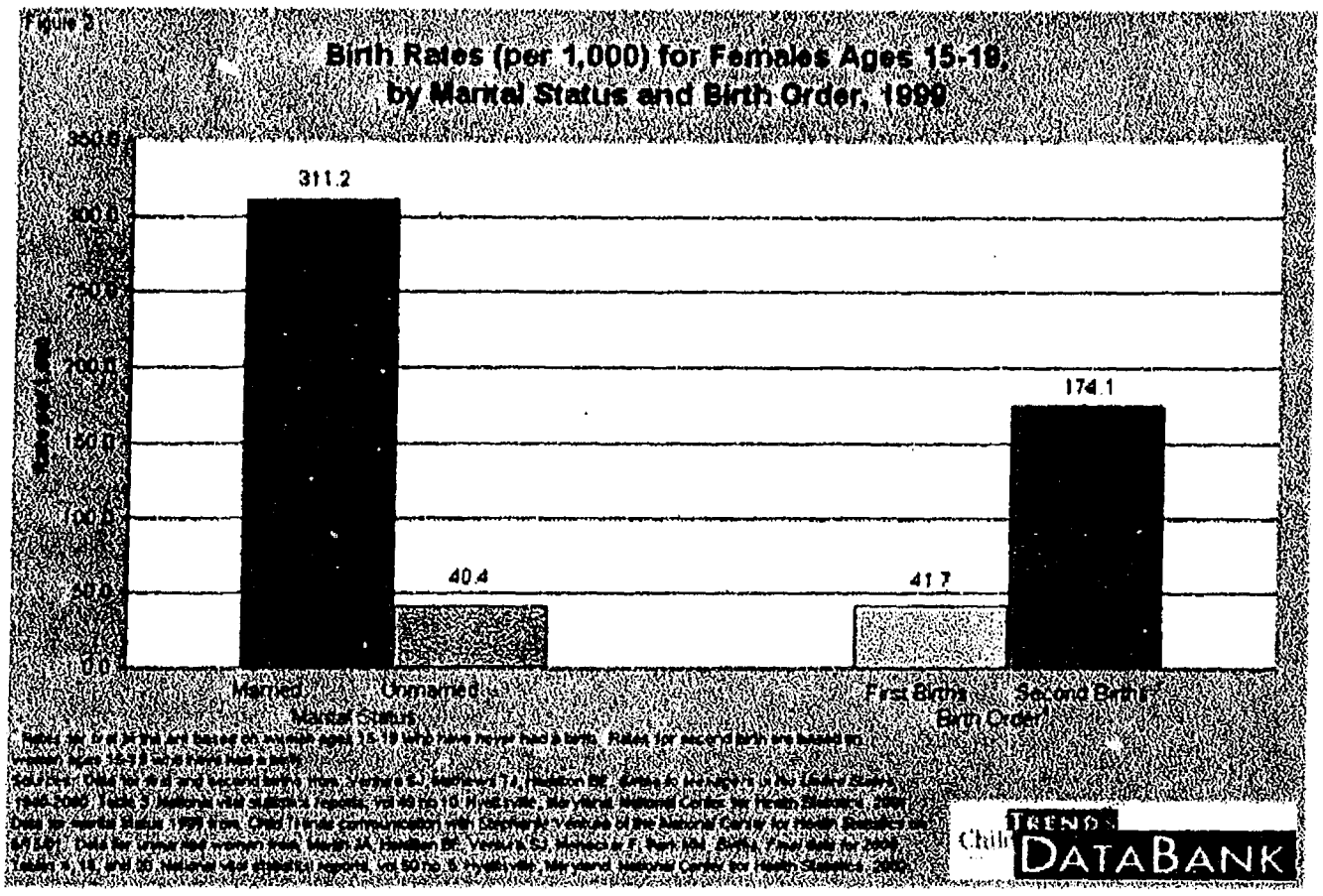
Differences by Age

Younger teens have fewer abortions than older teens. In 2000, teens ages 15-17 had an abortion rate of 15 per 1,000 compared to 39 per 1,000 among teens ages 18-19. (See Figure 2)

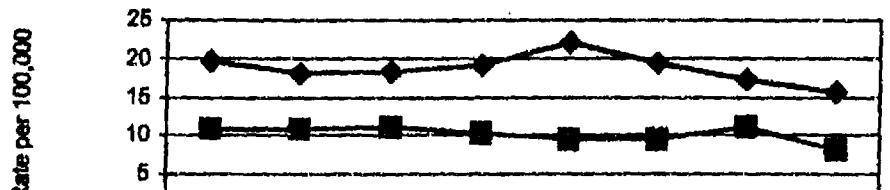
Differences by Race and Ethnicity

Non-Hispanic black teens have much higher abortion rates than Hispanic and non-Hispanic white teens. In 1997, that latest year for which race-specific estimates are available, there were 18.2 abortions per 1,000 non-Hispanic white adolescent females ages 15-19, compared to 62.7 among non-Hispanic black and 35.4 among Hispanic adolescent females. Since 1990, rates for non-Hispanic white and non-Hispanic black females have fallen substantially. (See Figure 1)

> Back to Top



Graph 35: Suicide Mortality Rate
Adolescents Ages 15 - 19
North Dakota and United States, 1992 - 1999
(Three-Year Averages)



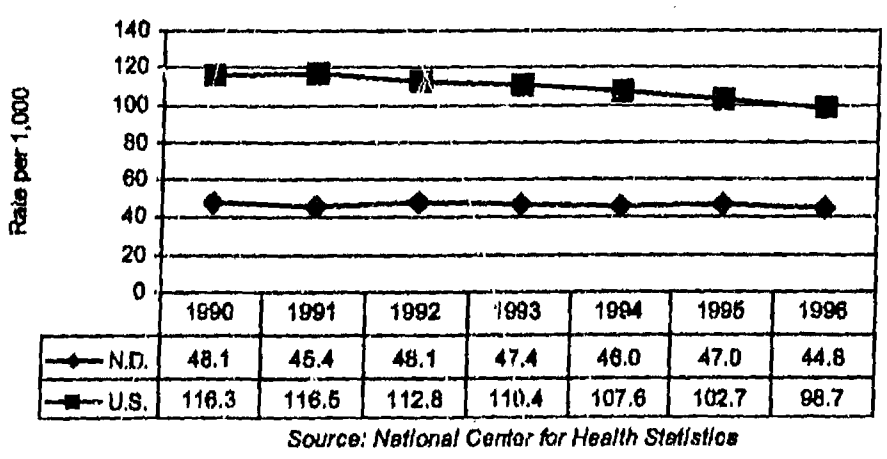
	1992	1993	1994	1995	1996	1997	1998	1999
N.D.	19.6	18.1	18.4	19.2	22	19.4	17.2	15.7
U.S.	10.8	10.9	11.1	10.5	9.7	9.5	11.1	8.2

Source: Centers for Disease Control and Prevention

Teen Pregnancies

Both the United States and North Dakota pregnancy rates for teens ages 15 through 19 declined slightly between 1990 and 1996. In 1996, the state rate was less than one-half the national rate. (Graph 36) The number of teen pregnancies and teen pregnancy rates by North Dakota county can be found in tables 36 and 37.

Graph 36: Teen (Ages 15 - 19) Pregnancy Rates
North Dakota and United States, 1990 - 1996



	1990	1991	1992	1993	1994	1995	1996
N.D.	48.1	45.4	48.1	47.4	46.0	47.0	44.8
U.S.	116.3	116.5	112.8	110.4	107.6	102.7	98.7

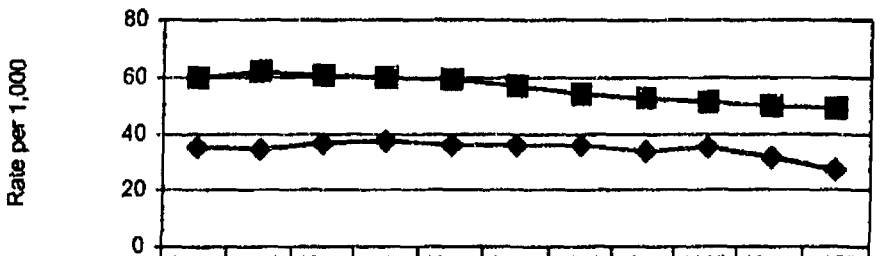
Source: National Center for Health Statistics

Teen Births

The number of births to North Dakota teens ages 15 through 19 decreased from 810 in 1995 to 707 in 2000.

Between 1990 and 2000, the United States birth rate for teens ages 15 through 19 decreased slightly; at the same time, the North Dakota teen birth rate remained about the same until 1999, when the rate began a dramatic decline. The national teen birth rate remains considerably higher than the state rate. (Graph 37) The number of teen births and teen birth rates by county is in Tables 38 and 39.

Graph 37: Teen (Ages 15 - 19) Birth Rates
North Dakota and United States, 1990 - 2000



	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000
N.D.	35.6	34.8	36.7	37.3	35.7	36.3	35.8	34.0	35.0	31.9	27.3
U.S.	59.9	62.1	60.7	59.6	58.9	56.8	54.4	52.3	51.1	49.6	48.7

Source: National Center for Health Statistics

Alcohol and Tobacco Use During Pregnancy

Teen mothers were slightly more likely to use alcohol and more than twice as likely to use tobacco during their pregnancies than were North Dakota mothers ages 20 and older. (Charts 22 and 23)

Chart 22: Births With Maternal Alcohol Use, by Age of Mother, 1994 through 2000

Age of Mother	1994	1995	1996	1997	1998	1999	2000
Younger than 20	1.8%	2.2%	2.0%	1.6%	1.7%	1.5%	3.7%
20 or older	1.6%	1.3%	1.5%	1.1%	1.1%	1.1%	1.0%

Source: NDDoH, Division of Vital Records

Chart 23: Births With Maternal Tobacco Use, by Age of Mother, 1994 through 2000

Age of Mother	1994	1995	1996	1997	1998	1999	2000
Younger than 20	30.3%	27.9%	32.7%	37.0%	33.4%	36.6%	33.5%
20 or older	18.2%	16.7%	16.8%	18.2%	17.8%	17.3%	13.0%

Source: NDDoH, Division of Vital Records

Facts in Brief

Teen Sex and Pregnancy

Revised 9/1999

SEXUAL ACTIVITY

• Most very young teens have not had intercourse: 8 in 10 girls and 7 in 10 boys are sexually inexperienced at age 15. [1]

• The likelihood of teenagers' having intercourse increases steadily with age; however, about 1 in 5 young people do not have intercourse while teenagers.[2]

• Most young people begin having sex in their mid-to-late teens, about 8 years before they marry; more than half of 17-year-olds have had intercourse.[3]

• While 83% of teenage women report that their first intercourse was voluntary, one-quarter of these young women report that it was unwanted.[4]

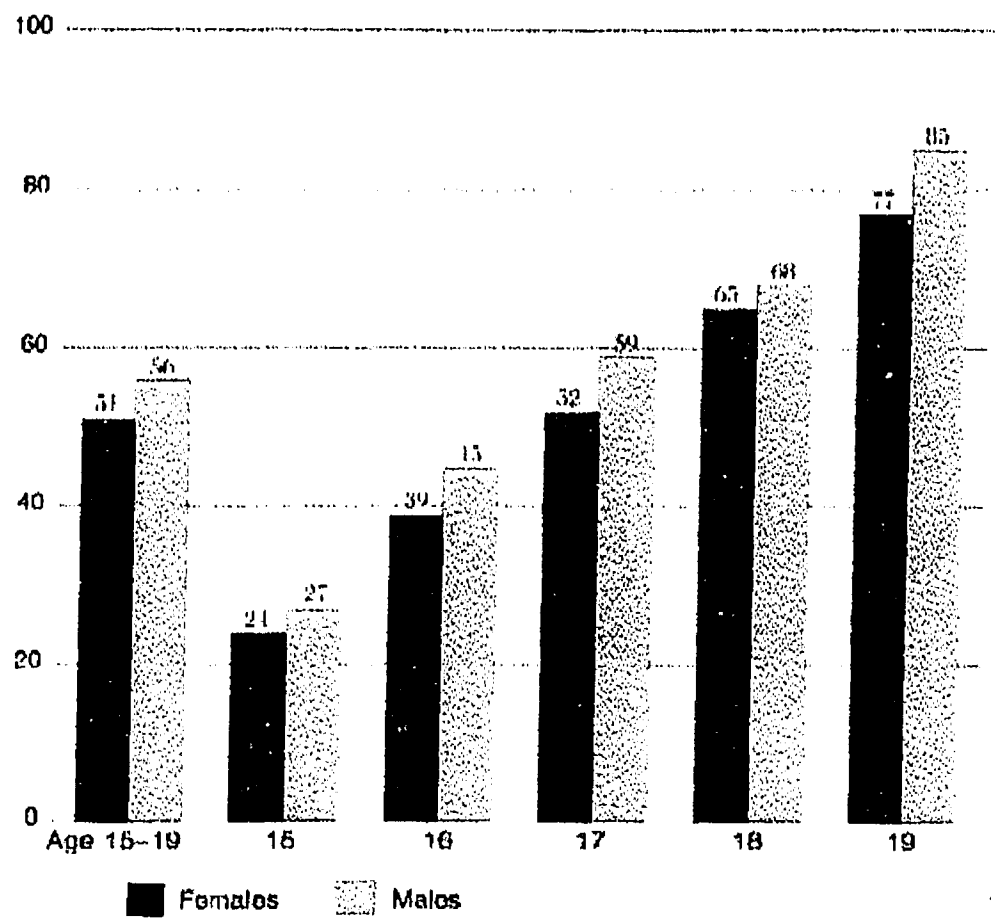
• The younger women are when they first have intercourse, the more likely they are to have had unwanted or nonvoluntary first sex--7 in 10 of those who had sex before age 13, for example.[5]

• Nearly two-thirds (64%) of sexually active 15-17-year-old women have partners who are within two years of their age; 29% have sexual partners who are 3-5 years older, and 7% have partners who are six or more years older.[6]

• Most sexually active young men have female partners close to their age: 76% of the partners of 19-year-old men are either 17 (33%) or 18 (43%); 13% are 16, and 11% are aged 13-15.[7]

Sex is rare among very young teenagers, but common in the later teenage years.[40]

% who have had sexual intercourse at different ages, 1995



Sources: 1995 National Survey of Family Growth and 1995 National Survey of Adolescent Males.

CONTRACEPTIVE USE

• A sexually active teenager who does not use contraceptives has a 90% chance of becoming pregnant within one year. [8]

• Teenage women's contraceptive use at first intercourse rose from 48% to 65% during the 1980s, almost entirely because of a doubling in condom use. By 1995, use at first intercourse reached 78%, with 2/3 of it condom use.[9]

• 9 in 10 sexually active women and their partners use a contraceptive method, although not always consistently or correctly.[10]

• About 1 in 6 teenage women practicing contraception combine two methods, primarily the condom and another method.[11]

• The method teenage women most frequently use is the pill (44%), followed by the condom (38%). About 10% rely on the injectable, 4% on withdrawal and 3% on the implant.[12]

• Teenagers are less likely than older women to practice contraception without interruption over the course of a year, and more likely to practice contraception sporadically or not at all.[13]

SEXUALLY TRANSMITTED DISEASES (STDs)

• Every year 3 million teens--about 1 in 4 sexually experienced teens--acquire an STD.[14]

• In a single act of unprotected sex with an infected partner, a teenage woman has a 1% risk of acquiring HIV, a 30% risk of getting genital herpes and a 50% chance of contracting gonorrhea.[15]

• Chlamydia is more common among teens than among older men and women; in some

settings, 10-29% of sexually active teenage women and 10% of teenage men tested for STDs have been found to have chlamydia.[16]

• Teens have higher rates of gonorrhea than do sexually active men and women aged 20-44.[17]

• In some studies, up to 15% of sexually active teenage women have been found to be infected with the human papillomavirus, many with a strain of the virus linked to cervical cancer.[18]

• Teenage women have a higher hospitalization rate than older women for acute pelvic inflammatory disease (PID), which is most often caused by untreated gonorrhea or chlamydia. PID can lead to infertility and ectopic pregnancy.[19]

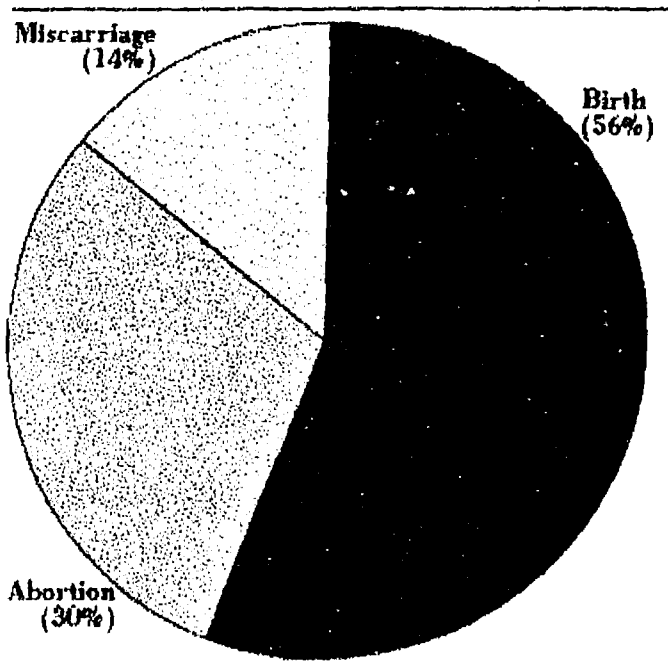
TEEN PREGNANCY

• Each year, almost 1 million teenage women--10% of all women aged 15-19 and 19% of those who have had sexual intercourse--become pregnant.[20]

• The overall U.S. teenage pregnancy rate declined 17% between 1990 and 1996, from 117 pregnancies per 1,000 women aged 15-19 to 97 per 1,000.[21]

• 78% of teen pregnancies are unplanned, accounting for about 1/4 of all accidental pregnancies annually.[22]

Teen Pregnancy Outcomes[41]



More than half (56%) of the 905,000 teenage pregnancies in 1996 ended in births (2/3 of which were unplanned).

• 6 in 10 teen pregnancies occur among 18-19 year-olds.[23]

• Teen pregnancy rates are much higher in the United States than in many other developed countries--twice as high as in England and Wales or Canada, and nine times as high as in the Netherlands or Japan.[24]

• Steep decreases in the pregnancy rate among sexually experienced teenagers accounted for most of the drop in the overall teenage pregnancy rate in the early-to-mid 1990s. While 20% of the decline is because of decreased sexual activity, 80% is due to more effective contraceptive practice.[25]

CHILDBEARING

• 13% of all U.S. births are to teens.[26]

• The fathers of babies born to teenage mothers are likely to be older than the women: About 1 in 5 infants born to unmarried minors are fathered by men 5 or more years older than the mother.[27]

• 78% of births to teens occur outside of marriage.[28]

• Teens now account for 31% of all nonmarital births, down from 50% in 1970.[29]

• 1/4 of teenage mothers have a second child within 2 years of their first.[30]

TEEN MOTHERS AND THEIR CHILDREN

• Teens who give birth are much more likely to come from poor or low-income families (83%) than are teens who have abortions (61%) or teens in general (38%).[31]

• 7 in 10 teen mothers complete high school, but they are less likely than women who delay childbearing to go on to college.[32]

• In part because most teen mothers come from disadvantaged backgrounds, 28% of them are poor while in their 20s and early 30s; only 7% of women who first give birth after adolescence are poor at those ages.[33]

• 1/3 of pregnant teens receive inadequate prenatal care; babies born to young mothers are more likely to be low-birth-weight, to have childhood health problems and to be hospitalized than are those born to older mothers.[34]

ABORTION

• Nearly 4 in 10 teen pregnancies (*excluding those ending in miscarriages*) are terminated by abortion. There were about 274,000 abortions among teens in 1996.[35]

• Since 1980, abortion rates among sexually experienced teens have declined steadily, because fewer teens are becoming pregnant, and in recent years, fewer pregnant teens have chosen to have an abortion.[36]

• The reasons most often given by teens for choosing to have an abortion are being concerned about how having a baby would change their lives, feeling that they are not mature enough to have a child and having financial problems.[37]

• 29 states currently have mandatory parental involvement laws in effect for a minor seeking an abortion: AL, AR, DE, GA, ID, IN, IO, KS, KY, LA, MD, MA, MI, MN, MS, MO, NE, NC, ND, OH, PA, RI, SC, SD, UT, VA, WV, WI and WY.[38]

• 61% of minors who have abortions do so with at least one parent's knowledge; 45% of parents are told by their daughter. The great majority of parents support their daughter's decision to have an abortion.[39]

Sources

The data in this fact sheet are the most current available. Most of the data are from research conducted by The Alan Guttmacher Institute (AGI) or published in the peer-reviewed journal *Family Planning Perspectives* and the 1994 AGI report *Sex and America's Teenagers*. Additional sources include the Centers for Disease Control and Prevention and the National Center for Health Statistics.

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Teen Mothers And Their Children

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40. CHART 1--Sources: reference 1.

41. CHART 2--Source: Henshaw SK, (reference 20), Table 1.

SIECUS sexuality information and education council of the united states

BACK TO FOR POLICY MAKERS & ADVOCATES

Policy Update - October 2002

Previous Updates

In this issue:

Growing Trend by the Bush Administration Puts Ideology Over Science

The Bush Administration has indicated its intention to appoint Dr. W. David Hager to the Advisory Committee for Reproductive Health Drugs at the Food and Drug Administration (FDA). This committee makes recommendations to the FDA commissioner on the safety and effectiveness of reproductive drugs.

Dr. Hager is the author of *As Jesus Cared for Women:*

Groups Distort Truth about Medical Accuracy

A new breed of "medically accurate" abstinence-only-until-marriage programs that distort facts and employ scare tactics is

emerging. Texas-based "Worth the Wait" is one such program. While it presents medically accurate information, it does not present complete information.

For example, while "Worth the Wait" mentions condoms, it does so only in the context of failure rates, thereby using a fear-based tactic to scare young who may be sexually active.

Using a latex condom to prevent transmission of HIV is 10,000 times safer than not using a condom, but "Worth the Wait" teaches instead that condoms are not 100 percent effective and that failure rates are higher for adolescents than for adults.

Advocates of comprehensive sexuality education worry that information like this may discourage condom use for young people who are choosing to be sexually active, thereby exposing them to increased risk of disease and pregnancy.

Another example of this scare tactic is in providing some, but not all, information. For example, according to R.A. Hatcher's *Contraceptive Technology*, mentioned in MISH's report as an "authoritative resource," condoms are 98 percent effective in preventing unintended pregnancy when used consistently and correctly.

However, MISH's report chooses instead to highlight the fact that "the typical first year failure rate for couples using condoms is 14 percent." While this is not incorrect, it is

Restoring Women Then and Now. According to a Time magazine article, he refuses to prescribe contraceptives to unmarried women. It has also been reported that he suggests reading scripture to ease the pain of premenstrual syndrome. Dr. Hager has made it clear that he is opposed to mifepristone, also known as RU-486, a drug that induces abortion. Mifepristone was determined safe and was approved by the FDA more than two years ago.

Dr. Hager's possible appointment is indicative of the disturbing trend to utilize ideology over science in health care. Eighty-two Members of Congress signed an October 16 letter to President Bush

misleading. MISH also does not choose to inform its readers that failure rate is reduced by 50 percent in the second year of condom use.

These claims of inflated condom failure rates and medical accuracy by proponents of abstinence-only-until-marriage programs create new policy challenges for advocates of comprehensive sexuality education. However, the research, the medical community, and the public soundly support the idea that young people need and deserve medically accurate, age-appropriate sexuality education that teaches them about both abstinence and contraception.

For more information on "Worth the Wait".

MTV Runs Local Youth Forums Focusing on Sexual Health

SIECUS and other national organizations have partnered with MTV to conduct a series of sexual health youth forums across the United States as part of *MTV's Fight for Your Rights: Protect Yourself* campaign. They are working with local advocacy and public health groups to organize the forums.

Lubbock, TX, was the site for the first forum on October 15. The Lubbock Youth Commission and the City of Lubbock's Department of Health joined with MTV and SIECUS to gather over 60 young people for the forum. Youth in Lubbock have been engaged in an ongoing battle to replace their local abstinence-only-until-marriage

expressing their concern about Dr. Hager assuming the committee post.

In addition, two separate letters were sent from Members of Congress to U.S. Secretary of Health and Human Services Tommy Thompson regarding Dr. Hager's appointment. The most recent letter, sent by 12 Democrats on October 21, expresses concern that "scientific decision making is being subverted by ideology" at HHS agencies.

For more information on the FDA's Advisory Committee for Reproductive Health Drugs.

program with comprehensive sexuality education.

Commenting on the forum, Corey Nichols, mayor of the Lubbock City Youth Commission said, "That's exactly what we wanted. We wanted them to ask questions they didn't have the information on so they could get the information."

Lubbock currently has one of the highest rates of sexually transmitted diseases (STDs) and pregnancy among youth in Texas.

In a second forum, more than 100 young people gathered in Tucson, AZ, on October 24. Tucson Metropolitan Education Commission's Youth Advisory Council/ Tucson Teen Conference hosted the event. Planned Parenthood of Southern Arizona, Kino Teen Center, the Pima County Health Department, Luz Social Services, and Pima Prevention Partnership were local advocacy partners.

Tucson United School District uses an abstinence-only-until-marriage program funded through Title V, the abstinence-only-until-marriage program created under 1996's welfare law. Arizona has seen a sharp rise in syphilis infections and now leads the nation in per capita syphilis cases.

The next forum is scheduled for Seattle, WA, in November.

For more information, see *MTV's Fight for*

Your Rights: Protect Yourself web site.

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Best viewed at 800 x 600 screen resolution

Web Master: cmeade@siecus.org

NORTH DAKOTA HEALTH STANDARDS

Use of the Document

This document serves as a **guide** for local districts in developing standards. Use of the standards in this document is **encouraged,** but districts **are not required** to adopt these standards **nor are students required to meet them.** It is **strongly recommended** that a **district team** be convened **to model local standards** from these state standards, considering **local values,** developmental level of students, and educational goals.

TESTIMONY ON HB 1398

HOUSE EDUCATION COMMITTEE
January 29, 2003
by Linda L. Johnson, Director of School Health Programs
(701) 328-4138
Department of Public Instruction

Madam Chair Kelsch and members of the committee:

My name is Linda Johnson and I am the Director of School Health Programs including the agreement with Centers for Disease Control for HIV/AIDS education. I am here to speak in opposition to HB 1398 and provide information regarding the current status of sex education in North Dakota schools.

Although there are many good ideas in this bill, defining curriculum in North Dakota in any content area, is left to the local school districts. NDCC 15.1-21-01 lists the courses students should receive. "Health, including physiology, hygiene, disease control, and the nature and effects of alcohol, tobacco, and narcotics" is as specific as the law gets in prescribing content.

NDCC 15.1-02-04 gives the State Superintendent the responsibility of developing course content standards. Standards are a framework on which curriculum is built at the district level to meet the local needs. North Dakota Health Standards were developed in 1999 and 2000 by a group of our state's teachers and are available for district use.

Our state health standards are based on common ground ideology with districts deciding their views on these sensitive subjects. (Attachment 1) The Standards are abstinence-based, emphasizing the benefits of abstinence and including information about contraception or disease prevention methods. The standards document states, "It is strongly recommended that a district team be convened to model local standards from these state standards, considering local values, developmental level of students and educational goals." We currently have districts choosing a variety of paths to meet their community mores, even varying between school sites in a district. The School Health Education Profile, data collected biannually from school principals and lead health

teachers, denotes the variety of subjects addressed. (Attachment 2) Also attached is a portion of the results of the Youth Risk Behavior Survey. (Attachment 3)

Other states' requirements on sex education vary greatly. Currently 22 states require that students receive sex education while 30 states require school districts that offer sex education to teach about abstinence. (Attachment 4) North Dakota requires HIV/AIDS education through NDCC 23-07-16.1 and Rules 33-06-05. It states schools shall adopt policy on the management and education of significant contagious disease.

Youth have a better chance of making responsible decisions for themselves when given accurate information. Parents and schools working together need to make accurate information available so students don't need to go hunting for information "underground".

Are there any questions?

Attachment 1

CONSERVATIVE POSITION	COMMON GROUND	LIBERAL POSITION
1. Family: Uphold traditional marriage and family structures	Uphold family love, care, protection, commitment, responsibility for each other.	Any household configuration counts as a family, incl. gay couples.
2. Sexuality: Assume heterosexuality; do not portray homosexuality as normal.	Identify and discourage behaviors which spread HIV, rather than targeting sexual orientation.	Bi/homosexual orientations are to be celebrated as diversity; also a human rights issue.
3. Abstinence: Present as the only option until marriage; no drug use.	Uphold abstinence as most protective/effective; postpone sexual involvement; no drug use.	Most teens are sexually active; abstinence is not an option; multiple partners common; clean your drug needles or do not share; use condoms.
4. Age-appropriateness: Do not discuss sex in elementary school; limit in upper grades to penis-vagina activity.	Acknowledge heterosex in upper elementary school; acknowledge other sexual behaviors in upper grades if elicited; no "how to do it"; use gender-neutral language.	Describe all possible forms of sexual contact from upper elementary on; uphold homosexual contacts, relations.
5. Condoms. Condoms fail; data is suspect; not an alternative; do not discuss as it sends a mixed message.	Less desirable alternative to abstinence; failure rate probably higher than 0-2% due to teen user error; discuss consistent, correct use with high risk teens	98-100% effective; reasonable alternative to abstinence; present to all upper grades; be playful and enjoy!

Prepared by Kim Robert Clark, DrPH, for AIDS on the Front Line Conference 3/14/95; modified for WCH 2000 4/22/95.

CONSERVATIVE POSITION	COMMON GROUND	LIBERAL POSITION
6. Scientific information from US Govt is narrow and biased; introduce outside sources.	Use government data; acknowledge inconclusive outside findings; emphasize common recurrent peer-reviewed data, core themes.	Report/defend only most favorable data; discount cautious concerns.
7. Parent involvement in all aspects of curriculum planning and presentation; prevent curriculum from being taught to anyone; disavow majority rule.	Representative parental involvement in planning and adoption, periodic review; right to withdraw child from instruction.	Be wary of local participation; maximize state/national regulation.
8. Parent/family's values must be reflected in classroom curriculum.	Be directive in instruction favoring abstinence, protection of self and others; refer to family/cultural/religious traditions; home assignments	Attempt "value free" instruction; allow everyone to draw his/her own conclusions; do not "hear" conservative concerns or adapt curriculum.
9. Teacher qualifications must demonstrate congruence with content, high moral character; parent presence in classroom advocated.	Knowledgable and skilled presenter able to model and recommend protective behaviors incl. abstinence, personal responsibility	Open and comfortable with their own sexuality, all terms and behaviors; non-directive; self-disclosure.
10. Instructional strategies: information only, no role-play, no decision-making, no measure of attitudes; no outcome-based ed.	Social skill-building to diminish risk behaviors; use of third person; use of conservative normative influence.	Use open-ended discussions and role-play; teach in first & second person; non-directive.

Prepared by Kim Robert Clark, DrPH, for AIDS on the Front Line Conference 3/14/95; modified for WCH 2000 4/22/95.

Attachment 2

SCHOOL HEALTH EDUCATION PROFILE
HEALTH EDUCATION
2002

Ways In Which Teachers Tried to Increase Student Knowledge in a Required Health Education Course

	1998	2000	2002
Tobacco use prevention	99%	100%	99%
Alcohol and other drug use prevention	100%	100%	99%
Pregnancy prevention	76%	74%	70%
Human sexuality	82%	85%	82%
STD prevention	89%	90%	82%
HIV(Human immunodeficiency virus) prevention	94%	97%	91%
Physical activity and fitness	97%	94%	99%
Dietary behaviors and nutrition	97%	94%	99%

Issues Addressed in Policy on Students and/or Staff With HIV/AIDS

	2002
Worksite safety/universal precautions	96%
Maintaining confidentiality of infected students and staff	94%
Procedures to protect infected students and staff from discrimination	93%
Communication of the policy to students, staff and parents	89%
Attendance of students with HIV/AIDS for school staff	87%
Adequate training about HIV/AIDS for school staff	86%

Procedures for implementing the policy	84%
Confidential counseling for infected students	78%

Courses Which Include HIV/AIDS Units or Lessons

	2002
Family life education/life skills	40%
Science	38%
Family and consumer science	38%
Physical education	23%
Special education	10%

---

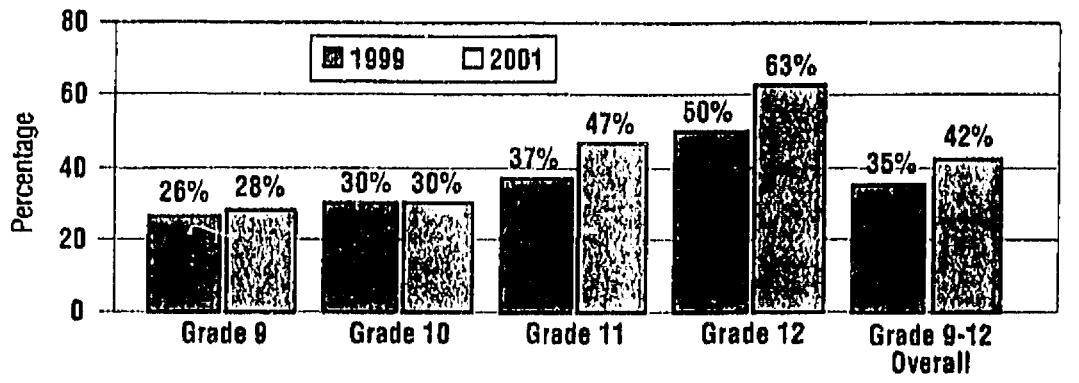
pics Included in HIV/AIDS Education

	2002
How HIV is transmitted	88%
Abstinence as the most effective method to avoid HIV infection	88%
How HIV affects the human body	87%
Compassion and support for people living with HIV/AIDS	76%
How to find valid information or services related to HIV or HIV testing	66%
Condom efficiency/how well condoms work	51%
Correct use of condoms	23%

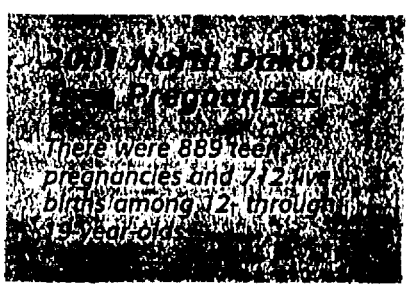
Attachment 3

Sexual Behavior

Percentage of North Dakota students in grades nine through 12 reporting intercourse during their lifetime



Sexual abstinence is at least an important priority to 52 percent of North Dakota students in grades nine through 12.



North Dakota in 2001...

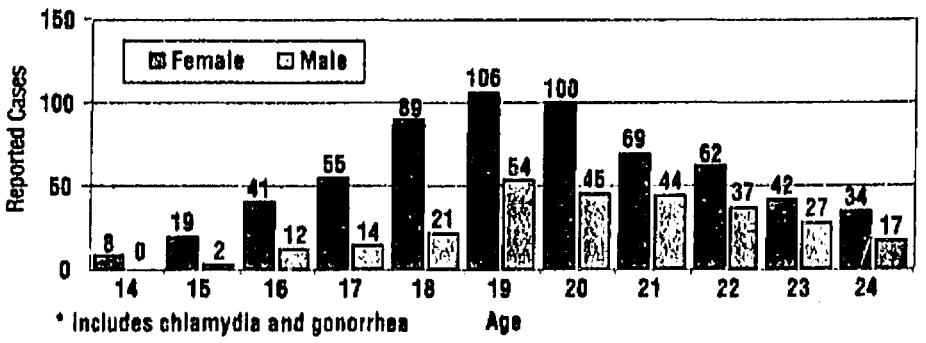
Thirty-four percent of students in grades nine through 12 reported drinking alcohol or using drugs before last sexual intercourse; this compares to 26 percent nationally.

Almost 60 percent of high school students who have ever had sex indicated they had used a condom the last time they had sexual intercourse.

For those students reporting sexual activity, 25 percent were age 15 or younger when they had sexual intercourse for the first time.

Sexually Transmitted Diseases/Infections

Number of STDs* by Age and Sex – North Dakota 2001



* Includes chlamydia and gonorrhea

In North Dakota 37 percent of all sexually transmitted diseases occur in 15- through 19-year-olds.

Number of sexually transmitted diseases/ infections reported in 15- to 19-year-olds[6]

	Chlamydia	Gonorrhea
1995	320	16
1996	304	11
1997	276	26
1998	349	25
1999	307	30
2000	329	23
2001	397	15

HIV/AIDS

North Dakota in 2001...

Eighty-nine percent of high school students reported having been taught about HIV/AIDS in school.

Forty-one percent of high school students reported talking to their parents or another adult about HIV/AIDS.

Individuals age 15 through 24 accounted for 72 percent of gonorrhea and chlamydia cases respectively. This indicates that unprotected sexual activity, which is also a risk behavior for acquiring HIV, is occurring to a large degree among this age group.[7]

2001 North Dakota Youth Risk Behaviors

A PATCHWORK OF STATE POLICIES

Like the federal government, many states have multiple policies governing the teaching of sex education. These policies create an overall picture that is fairly complex. For example, states that require sex education programs may vary considerably in terms of what, if any, curriculum they specify. And, a state that has no specific policy on sex education may still recommend that educators take a particular course of action or even specify that a school district opting to offer sex education must adhere to a particular curriculum. Even within an individual state, there may be differing policies governing mandates for education about contraception or abstinence and instruction on HIV/AIDS and other STDs. In fact, more states require schools to offer specific HIV or STD education than require general sex education. It also is common for states to have different requirements for students at different grade levels. These policy distinctions often are lost in the larger debate about sex education.

As of September 2002, 22 states require that students receive sex education and 39 states require that students receive instruction about HIV/STDs:[13]

- Twenty-two states require schools to provide sex education as well as instruction on HIV/STDs: AK, DE, FL, GA, HI, IL, IA, KS, KY, MD, ME, MN, NV, NJ, NC, RI, SC, TN, UT, VT, WV, WY.
- Seventeen states require instruction about HIV/STDs but not sex education: AL, CA, CT, ID, IN, MI, MS, NH, NM, NY, ND, OH, OK, OR, PA, WA, WI.
- One state (ME) requires sex education but not STD instruction.

Specific requirements about *what* should be taught also are on the books in a number of states. Thirty states require school districts that offer sex education to teach about abstinence. Eight (CT, DE, FL, GA, KY, MI, VT, VA) require that it be covered, and 22 (AL, AZ, AK, CA, HI, IL, IN, LA, MD, ME, MS, MO, NC, NJ, OK, OR, RI, SC, TN, TX, UT, WV) require that it be stressed. In addition, 13 states (AL, CA, DE, HI, MD, MO, NJ, OR, RI, SC, VT, VA, WV) require school districts that do offer sex education to provide information about contraception. However, no state requires that birth control information be emphasized.

Thirty-four states (AL, AZ, CA, CT, FL, GA, ID, IL, IA, KS, LA, MD, MA, ME, MI, MN, MS, MO, MT, NJ, NY, NC, OK, OR, PA, RI, SC, TN, TX, VT, VA, WA, WV, WI) give parents some choice as to whether or not their children receive sex education or STD instruction.[14] Most of these states give parents the option of withdrawing their children from the courses. Three of these states (AZ, NV, UT) say that parents must actively consent before the instruction begins. One (AZ) has an opt-out policy for STD education and requires parental consent for sex education. Of the states with opt-out policies, five require that it be due to a family's religious or moral beliefs.

State policies on sex education leave significant latitude and oversight to local school districts.[15] A national survey of school superintendents conducted in 1998 by the Alan Guttmacher Institute found that the teaching of sex education is required in more than two-thirds (69 percent) of U.S. school districts.[16] The remaining 31 percent leave the decisions about whether to teach such a curriculum to individual schools. However, a disproportionate number of students reside in the districts with policies that require sex education.

Among districts with such a policy, 14 percent say the policy takes a comprehensive approach, teaching abstinence as one possible option for adolescents; 51 percent promote abstinence-plus—that is, abstinence as the preferred option with discussion of contraception as an effective way to protect against pregnancy and disease; and the remaining 35 percent have an abstinence-only policy.

Some 48 percent of superintendents say state directives are the single most important factor influencing district policy. They cite special committees and school boards about equally (18 percent and 17 percent, respectively).

In the coming year, federal, state, and local lawmakers will look at spending for sex education programs in the context of shrinking budgets. The debate about federal funding initiatives such as the abstinence only program has already begun. The outcome will have a ripple effect on both state and local policy, as well as on the information young people receive in sex education classes across the country.

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13. State information listed in this section is taken from *State Policies in Brief: State Sexuality Education Policy*, The Alan Guttmacher Institute, 1 December 2002, and R. B. Gold and E. Nash, "Special Analysis: State-Level Policies on Sexuality, STD Education," *The Guttmacher Report on Public Policy*, August 2001.
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January 29, 2003

Madame/Mister Chairman and Committee Members,

I oppose HB 1398 because it would allow religious sexual education programs into the school and allow an instructor's personal moral and religious beliefs to be taught in a sex education class.

Section 1, paragraph 2 has the words "any type of instruction or program". Could the instructor of a sex education class bring his or her church program on sex education into the classroom? If the answer is yes then the line between the separation of church and state has just been crossed.

Section 1, paragraph 2, line F uses the words "skills and attitudes needed to make marriage sacred". The children in our schools are a captive audience coming with a variety of religious beliefs. Are the "skills and attitudes " going to be different with each instructor? Will "skills and attitude" include, as in some religious institutions in Bismarck, that the proper "attitude" of a female is to be submissive to the male and he is the final decision maker in a marriage? If this is what an instructor chooses to believe that is their right but they do not have the right to expose a student to these religious beliefs in the school setting.

There are programs on what makes a marriage work and on sex education that already exist in the individual churches in our community. The program a parent chooses to support is in their choice of the church they attend and closely aligns with their personal moral belief. The views instructors hold on sex and marriage are closely tied to their personal moral belief. This will be devisive when the parent and instructor's personal moral beliefs are not the same.

This legislation is a thinly veiled attempt to introduce certain religious beliefs on sex and marriage into the school system. Leave it to the parent to instruct their child on morality and to the school to present only the facts on contraceptives. The parent decides what moral and religious instruction they want for their child by the choice of the church they attend and the teachings they give at home. Whether an instructor agrees with a parent's moral or religious teachings on sex or marriage is immaterial and best left out of school instruction. The instructor's job is to provide facts.

Teaching abstinence as part of a comprehensive sex education program reinforces a teenagers choice if they chose to be abstinate. Teaching the facts on the reliability of contraceptives and how contraceptives are properly used promotes responsible behavior in those that do not abstain. Responsible behavior is preferred to the consequences associated with ignorance. Better choices are made when you have all the facts.

Teenagers are having sex. Abstinence is the ideal but we do not live in an ideal world.

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Teenage Births in the United States: State Trends, 1991–2000, an Update

by Stephanie J. Ventura, M.A., T.J. Mathews, M.S., and Brady E. Hamilton, Ph.D.,
Division of Vital Statistics

Abstract

Objectives—This report provides State-specific birth rates for teenagers for 1991 and 2000, and the percent change between the time periods.

Methods—Tabular and graphical description of trends in teenage birth rates by age group for each State and territory.

Results—Birth rates for teenagers 15–19 years declined significantly in all States, the Virgin Islands and Guam, between 1991 and 2000. Declines by State ranged from 12 to 39 percent. Rates also fell significantly for teenage subgroups 15–17 and 18–19 years.

Keywords: teenage fertility • State-specific birth rates

Highlights

The birth rate for U.S. teenagers declined steadily throughout the 1990s, falling from 62.1 births per 1,000 teenagers 15–19 years in 1991 to 48.5 in 2000, a reduction of 22 percent (table 1). Rates for teenage subgroups fell as well. The rate for young teenagers 15–17 years dropped 29 percent, from 38.7 to 27.4 per 1,000, and the rate for older teenagers 18–19 years declined 16 percent, from 94.4 to 79.2 per 1,000. The rates for ages 15–19 and 15–17 years in 2000 were at all-time lows.

Teenage birth rates vary substantially by State (table 1 and figure 1). In 2000 rates for teenagers 15–19 ranged from 23.4 per 1,000 in New Hampshire to 72.0 in Mississippi. Although not directly comparable, because it is a city, the highest rate was for the District of Columbia, 80.7. The rates for teenage subgroups also vary considerably. Among teenagers 15–17 years, the rates ranged from 9.8 in New Hampshire to 45.0 in Mississippi. Rates were higher for the District of Columbia, 60.7; Guam, 55.0; and Puerto Rico, 49.1. Among older teenagers 18–19 years, the rates ranged from 44.5 in Vermont to 114.1 in Arkansas.

Birth rates in 2000 for ages 15–19 years were significantly lower than in 1991 in every State, the District of Columbia, the Virgin Islands, and Guam, with overall declines ranging from 12 (Nebraska) to 39 percent (Vermont) (table 1 and figure 2). Generally, the year-to-year declines in the State-specific rates echoed the national declines, but there was considerable variability in the State declines (1). Among young teenagers 15–17 years, birth rates dropped in all States, the District of Columbia, and the Virgin Islands. Statistically significant declines ranging from 15 percent (Texas) to 50 percent (Vermont) were reported. Rates for older teenagers, 18–19 years, declined in the Virgin Islands, Guam, the District of Columbia, and all but four States. Statistically significant declines ranged from 6 percent (Georgia) to 38 percent (Alaska).

This summary updates a recently issued report, "Births to Teenagers in the United States, 1940–2000," by providing State-specific data for 2000, and supplements information provided in "Births: Final Data for 2000," published earlier this year (1,2). These previous reports provide additional detail on the trends and variations for population subgroups, and also describe the factors associated with the recent trends in childbearing among U.S. teenagers. Information on the population denominators used for this report is available in "Births: Final Data for 2000" (2).

Acknowledgments

This report was prepared in the Reproductive Statistics Branch of the Division of Vital Statistics. This report was edited by Thelma Sanders, typeset by Jacqueline M. Davis, and graphics produced by Jarmila Ogburn of the Publications Branch, Division of Data Services.

Table 1. Birth rates for teenagers aged 15–19 years, by age group and State and territory, and percent change by age: United States, 1991 and 2000

State	1991			2000			Percent change between 1991 and 2000		
	15–19 years	15–17 years	18–19 years	15–19 years	15–17 years	18–19 years	15–19 years	15–17 years	18–19 years
United States[1]	62.1	38.7	94.4	48.5	27.4	79.2	–21.9	–29.2	–16.1
Alabama	73.9	47.7	109.5	62.9	37.9	97.3	–14.9	–20.5	–11.1
Alaska	65.4	35.3	111.7	42.4	23.6	69.4	–35.2	–33.1	–37.9
Arizona	80.7	51.4	122.6	69.1	41.1	111.3	–14.4	–20.0	–9.2
Arkansas	79.8	49.4	122.8	68.5	36.7	114.1	–14.2	–25.7	–7.1
California	74.7	46.9	113.6	48.5	28.6	75.6	–35.1	–39.0	–33.5
Colorado	58.2	35.3	91.4	49.2	28.6	79.8	–15.5	–19.0	–12.7
Connecticut	40.4	26.3	59.4	31.9	16.9	56.3	–21.0	–35.7	**–5.2
Delaware	61.1	40.3	87.1	51.6	30.5	80.2	–15.5	–24.3	**–7.9
District of Columbia	114.4	102.8	125.5	80.7	60.7	101.8	–29.5	–41.0	–18.9
Florida	68.8	44.0	102.9	52.6	29.7	88.0	–23.5	–32.5	–14.5
Georgia	76.3	50.6	110.9	64.2	36.8	104.3	–15.9	–27.3	–6.0
Hawaii	58.7	34.7	91.5	45.1	24.7	70.5	–23.2	–28.8	–23.0
Idaho	53.9	29.3	90.8	43.1	21.3	72.8	–20.0	–27.3	–19.8
Illinois	64.8	40.6	99.1	49.5	28.5	81.1	–23.6	–29.8	–18.2
Indiana	60.5	35.2	95.2	50.3	26.2	85.9	–16.9	–25.6	–9.8
Iowa	42.6	22.8	71.5	34.7	17.4	60.3	–18.5	–23.7	–15.7
Kansas	55.4	29.4	94.1	45.3	22.4	78.5	–18.2	–23.8	–16.6
Kentucky	68.9	42.6	105.5	55.3	29.2	92.2	–19.7	–31.5	–12.6
Louisiana	76.1	51.1	111.4	62.1	36.3	97.1	–18.4	–29.0	–12.8
Maine	43.5	23.8	70.1	28.7	13.4	52.8	–34.0	–43.7	–24.7
Maryland	54.3	35.2	79.8	41.8	23.8	68.8	–23.4	–32.4	–13.8
Massachusetts	37.8	25.2	52.9	27.1	15.0	44.9	–28.3	–40.5	–15.1
Michigan	59.0	35.5	91.1	39.2	21.3	66.3	–33.6	–40.0	–27.2
Minnesota	37.3	20.7	61.4	29.6	15.6	51.0	–20.6	–24.8	–16.9
Mississippi	85.6	60.1	120.4	72.0	45.0	109.9	–15.9	–25.1	–8.7
Missouri	64.5	38.7	100.7	48.8	26.5	82.2	–24.3	–31.5	–18.4
Montana	46.7	23.6	83.0	35.8	19.1	60.8	–23.3	–19.1	–26.7
Nebraska	42.4	23.6	69.2	37.2	19.3	62.7	–12.3	–18.2	–9.4
Nevada	75.3	43.9	119.1	62.2	34.2	106.7	–17.4	–22.1	–10.4
New Hampshire	33.3	17.1	53.6	23.4	9.8	45.4	–29.7	–42.7	–15.6
New Jersey	41.6	26.3	62.9	31.7	17.0	54.9	–23.8	–35.4	–12.7
New Mexico	79.8	50.0	124.4	66.2	40.2	105.1	–17.0	–19.6	–15.5
New York	46.0	29.1	69.0	35.6	20.1	58.1	–22.6	–30.9	–15.8
North Carolina	70.5	46.2	101.7	59.9	32.8	101.4	–15.0	–29.0	**–0.3
North Dakota	35.6	18.1	62.4	28.2	12.5	51.4	–20.8	–30.9	–17.6
Ohio	60.5	36.2	93.8	45.6	24.1	77.2	–24.6	–33.4	–17.7
Oklahoma	72.1	41.7	115.6	60.1	32.9	99.8	–16.6	–21.1	–13.7
Oregon	54.9	31.3	90.7	43.2	23.5	72.8	–21.3	–24.9	–19.7
Pennsylvania	46.9	29.2	70.5	35.2	19.6	58.8	–24.9	–32.9	–16.6
Rhode Island	45.4	30.1	63.6	38.4	21.3	64.0	–15.4	–29.2	**0.6
South Carolina	72.9	48.0	105.4	60.6	36.7	92.9	–16.9	–23.5	–11.9
South Dakota	47.5	26.3	79.2	37.2	19.4	62.2	–21.7	–26.2	–21.5
Tennessee	75.2	47.8	112.1	61.5	34.2	101.8	–18.2	–28.5	–9.4
Texas	78.9	50.4	119.3	69.2	42.7	107.1	–12.3	–15.3	–10.2
Utah	48.2	27.0	79.8	40.0	22.0	62.7	–17.0	–18.5	–21.4
Vermont	39.2	21.3	62.0	24.1	10.6	44.5	–38.5	–50.2	–28.2
Virginia	53.5	31.8	81.2	40.8	21.7	66.9	–23.7	–31.8	–17.6
Washington	53.7	31.0	86.5	38.2	20.3	64.5	–28.9	–34.5	–25.4
West Virginia	57.6	32.4	93.2	46.4	22.8	79.8	–19.7	–29.6	–14.4
Wisconsin	43.7	24.8	71.2	34.5	18.3	58.8	–21.1	–26.2	–17.4
Wyoming	54.2	26.4	98.6	40.8	19.0	73.4	–24.7	–28.0	–25.6
Puerto Rico	72.4	50.8	105.9	71.5	49.1	103.8	**–1.2	**–3.3	**–2.0
Virgin Islands	77.9	48.6	124.0	51.9	29.2	86.6	–33.4	–39.9	–30.2
Guam	95.7	55.0	156.1	80.3	55.0	120.5	–16.0	**0.0	–22.8
American Samoa	...	...	...	44.8	20.4	83.8	...	...	...
Northern Marianas	...	...	...	54.0	40.8	70.9	...	...	...

... Data not available.
** Not significant at $p < 0.05$.
[1]Excludes data for the territories.

NOTE: Birth rates by State shown in this table are based on population estimates provided by the U.S. Bureau of the Census, projected from the 1990 census; see reference 2. Therefore, the rates shown here may differ from rates computed on the basis of other population estimates.

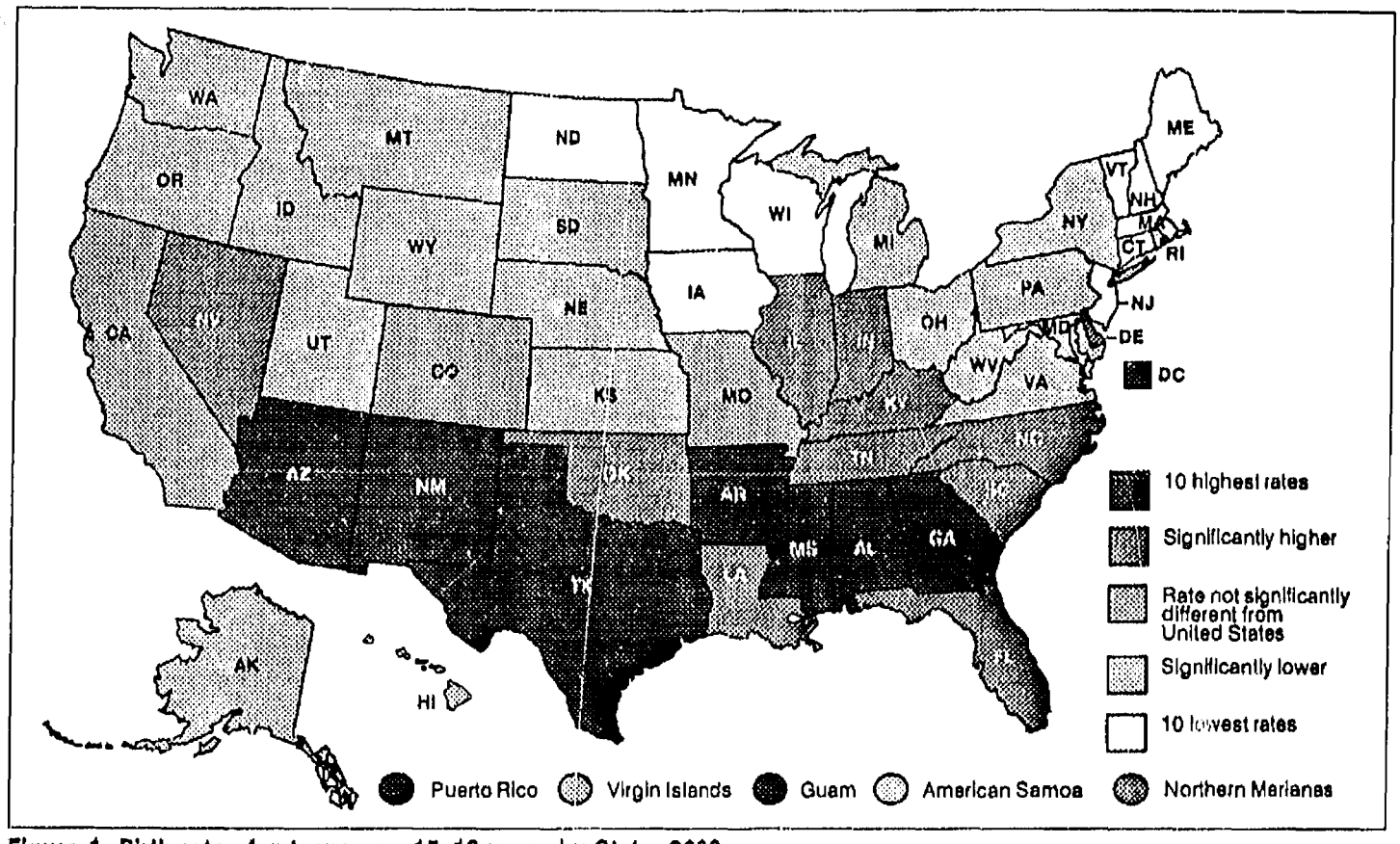

Figure 1. Birth rates for teenagers 15–19 years by State, 2000

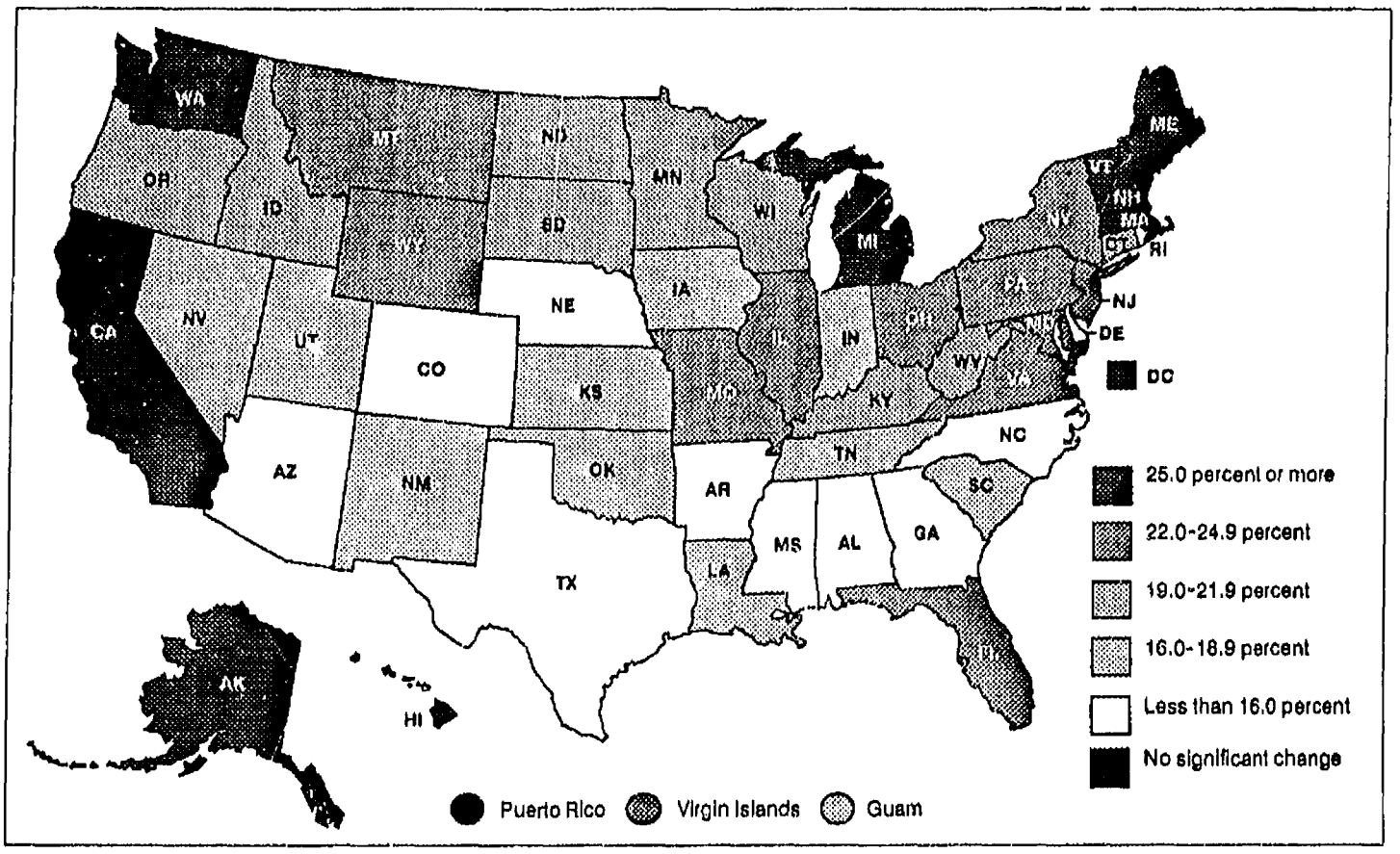

Figure 2. Percent decline in birth rates for teenagers 15–19 by State, between 1991 and 2000

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Contents

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Child TRENDS

TABLE 2: BIRTH RATES FOR FEMALES 15-19 IN 1970, 1980, 1985, 1990-1997, AND FEMALES 15-17 AND 18-19 IN 1997; AND PREGNANCY AND ABORTION RATES FOR FEMALES 15-19, 1996, BY STATE

	Birth Rates (Births per 1,000) to Females Aged 15-19											Birth Rates 1997		Pregnancy Rates Age 15-19	Abortion Rates Age 15-19	Percent Pregnancy Ending Abortio
STATE	1970	1980	1985	1990	1991	1992	1993	1994	1995	1996	1997	Age 15-17	Age 18-19	1996	1996	1996
Alabama	89	68	64	71	74	73	71	72	70	69	67	43	100	106	22	20%
Alaska	87	64	56	65	65	64	57	55	50	46	45	25	74	75	18	24%
Arizona	77	66	67	76	81	82	80	79	75	74	70	44	111	118	27	23%
Arkansas	91	75	73	80	80	76	74	76	74	75	73	43	119	108	16	15%
California	65	53	53	71	75	74	73	71	68	63	57	36	91	125	45	36%
Colorado	64	50	48	55	58	58	55	54	51	50	48	30	77	90	26	31%
Connecticut	43	31	31	39	40	39	39	40	39	37	36	23	58	86	37	43%
Delaware	72	51	51	55	61	60	60	60	57	57	56	37	83	95	24	25%
Florida	85	59	58	69	69	66	65	64	62	59	58	35	94	115	40	35%
Georgia	98	72	66	76	76	75	73	72	71	68	67	44	103	109	25	23%
Hawaii	60	51	48	61	59	54	53	54	48	48	44	25	70	101	39	39%
Idaho	65	60	47	51	54	52	51	47	49	47	43	23	73	70	12	17%
Illinois	66	56	51	63	65	64	63	63	60	57	55	34	88	106	34	32%
Indiana	73	58	52	59	61	59	59	58	58	56	54	32	86	86	19	22%
Iowa	52	43	35	41	43	41	41	40	39	38	36	22	60	58	12	21%
Kansas	61	57	52	56	55	56	56	54	52	50	49	28	82	79	18	23%
Kentucky	86	72	63	68	69	66	64	65	63	62	60	35	95	89	14	16%
Louisiana	85	76	72	74	76	77	76	75	70	67	66	42	101	97	15	15%
Maine	65	47	42	43	44	40	37	36	34	31	32	15	58	57	18	32%
Maryland	68	43	46	53	54	51	50	50	48	46	44	28	69	106	46	43%
Massachusetts	36	28	29	35	38	39	38	37	34	32	32	19	51	79	37	47%
Michigan	66	45	43	59	59	57	53	52	49	47	44	25	72	87	29	33%
Minnesota	42	35	31	36	37	36	35	34	32	32	32	18	55	56	16	29%
Mississippi	102	84	76	81	86	84	83	83	81	76	74	50	109	108	16	15%
Missouri	71	58	54	63	65	63	60	59	56	54	52	30	86	86	19	22%
Montana	58	49	44	48	47	46	46	41	42	39	38	20	65	65	17	26%
Nebraska	52	45	40	42	42	41	41	43	38	39	37	21	62	62	14	23%
Nevada	90	59	55	73	75	71	73	74	73	70	68	42	109	140	51	36%
New Hampshire	55	34	32	33	33	31	31	30	31	29	29	14	53	57	20	35%
New Jersey	48	35	34	41	42	39	38	39	38	35	35	21	57	97	50	52%
New Mexico	77	72	73	78	80	80	81	77	74	71	68	44	106	110	22	20%
New York	49	35	36	44	46	45	46	46	44	42	39	23	62	108	53	49%
North Carolina	86	58	57	68	71	70	67	66	64	64	61	38	97	105	26	25%
North Dakota	43	42	36	35	36	37	37	35	34	32	30	14	55	50	10	20%
Ohio	63	53	50	58	61	58	57	55	53	50	50	29	83	81	18	22%
Oklahoma	81	75	69	67	72	70	69	66	64	63	64	37	107	90	13	14%
Oregon	56	51	43	55	55	53	51	51	51	51	47	27	78	90	26	29%
Pennsylvania	52	41	40	45	47	45	44	44	42	39	37	22	61	70	20	29%
Rhode Island	45	33	36	44	45	46	50	48	43	43	43	28	66	87	32	37%
South Carolina	89	65	63	71	73	70	68	67	65	63	61	40	93	98	20	20%
South Dakota	50	53	46	47	48	46	44	43	41	40	40	22	66	59	10	17%
Tennessee	87	64	61	72	75	71	70	71	68	66	65	39	104	100	18	18%
Texas	84	74	72	75	79	79	78	78	76	74	72	47	110	113	23	20%
Utah	54	65	50	49	48	46	45	43	42	43	43	24	68	60	8	13%

Members of the House Education Committee:

I am here as a private citizen and a mother to testify on House Bill No. 1398. As a member of Mrs. Sitte's Legislative district, I am here to tell you that she is not representing me with this bill. In my professional life, I have worked with young people for almost 30 years and have raised two children to adulthood. One of the things I learned in both capacities is that our children and youth want to know more about sexual activity than abstinence. Abstinence is just one of the things we need to teach them, not the only thing.

As an HIV/AIDS educator, I have presented workshops in over 20 states including North Dakota. We taught young people to say 'Just Wait' when it came to sexual activity. Drugs are illegal and we teach our children to say "NO" to them. There is a legal age for purchasing alcohol and tobacco and we tell our children to say "NO" until they reach the legal age. We also told young people to *wait* until they were mature and in a meaningful relationship before having sex. However, in order to teach them to make healthy and meaningful decisions in their lives, we had to teach them what sexual activity is about. Many parents do not teach their children about sex or even want to talk about it in the home. If this does not happen, then the schools need to teach more than abstinence in their curriculum. If the schools fail to teach it and the parents fail to teach it, children and youth will get the wrong ideas and information from their friends and peers. It is not the right way for them to find out about sex.

As a mother, I had friends of my both my daughter and son's come and ask me simple biological questions their own mother's should have answered. They didn't tell their children such simple things because they were embarrassed. Because I was not

embarrassed, young people asked me these questions. This has happened to me both personally and professionally. I know from my own life experiences that we need to teach our children more than just one way of looking at sexual activity.

The United States has a higher teen pregnancy rate than countries like Sweden and Holland where sex education is thorough and comprehensive. The prohibitions we have put around sexual activity in the U.S. and its education are one of the causes of our teen pregnancy rate. We need to look honestly at what causes teen pregnancy and move towards a comprehensive sex education program. This program should teach abstinence as one of the choices a person can make. However, it should also teach young people about sexual intercourse in a mature way that allows a discussion of birth control as a method to prevent pregnancy and for disease protection as well. Our children are worth it. They need this kind of information presented to them accurately. Let's not take that out of their education.

Please vote No on House Bill 1398.

Linda Garding

1110 N. 4th Street

Bismarck, ND 58501

701-223-2213

28-Jan-03

Madame Chair and members of the House Education Committee:

Please accept this written testimony in support of HB 1398. I offer this testimony as a parent, as a former health teacher, and as a high school principal in a public school in North Dakota.

Abstinence education is no longer an issue simply about morality. There is a great deal of scientific evidence supporting the success of abstinence education to reduce unwanted pregnancies and the transmittion of sexually transmitted diseases.

It's time to put an end to the notion that condom use will result in safe sex. The failure rate of condoms as a preventative to conception is far to high to be considered safe. Condoms certainly do not prevent STDs transmitted by skin to skin contact.

A resource available to schools for teaching sex education and condom use listed 18 steps required for safe and proper condom use. Please stop and consider for one moment, what teenager in a moment of passion is going to stop and consider 18 steps to the safe and proper use of a condom.

There is one last failure of the old notion of teaching safe sex you should consider, that of protecting the emotional well being of our youth. Literally and figuratively, one cannot put a condom on the heart.

Respectfully submitted,
Matt Herman
Ellendale ND

January 29, 2003
Testimony of Christina Kindel
For North Dakota Family Alliance
House Education Committee
H.B. 1398

Madam Chairman and Committee Members:

My name is Christina Kindel. I'm appearing today on behalf of the North Dakota Family Alliance. We support this bill.

The North Dakota Family Alliance believes that sex outside of marriage is harmful to individuals, to families, and to society. Current sex-education programs often emphasize "safe-sex" by the promotion of condom and other contraceptive use. The concern we have with this approach is that it carries no guarantee of safety for North Dakota's young people, given the risks and failure rates of condoms in particular.

Based on the ongoing research of the North Dakota Family Alliance in regards to sex education programs, the "safe-sex" message is not adequately protecting our young people, nor is it protecting them from potentially harmful and even deadly diseases. For your information, I have attached a report published by The Heritage Foundation, entitled "The Effectiveness of Abstinence Education Programs in Reducing Sexual Activity Among Youth," which cites many credible and nationally recognized sources on the effectiveness of teaching sexual abstinence until marriage.

The North Dakota Family Alliance believes, as do the members of this committee and this entire legislative body, that the future of our state rests with our young people. As citizens of our state, I know we all pride ourselves on the heritage we are working hard to pass on to our future leaders, such as our work ethic, our safe communities, and our levels of academic achievement. However, we continue to teach our young people that it's okay to have sex outside of marriage, as long as they use "protection," even though research clearly points out that the "protection" we are encouraging them to use is full of risks and failure rates. By continuing to promote the "safe-sex" message, we are communicating to our young people that we believe they are not capable of abstaining from sexual activity until marriage, and instead are encouraging them to engage in an activity that we know may cause them harm, disease, and even difficulty in forming stable relationships later in life. Any of these consequences will have a significant impact on the quality of life our young people will live to experience, and may even compromise their ability to fulfill their dreams as adults.

I urge the members of this committee to give North Dakota's youth your vote of confidence in their ability to achieve their full potential without compromising their health or quality of life, by supporting this bill.

Thank you for your time and consideration.

The Heritage Foundation
Backgrounder
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No. 1533 April 5, 2002

THE EFFECTIVENESS OF ABSTINENCE EDUCATION PROGRAMS IN REDUCING SEXUAL ACTIVITY AMONG YOUTH

ROBERT RECTOR

Teenage sexual activity is a major problem confronting the nation and has led to a rising incidence of sexually transmitted diseases (STDs), emotional and psychological injuries, and out-of-wedlock childbearing. Abstinence education programs for youth have been proven to be effective in reducing early sexual activity. Abstinence programs also can provide the foundation for personal responsibility and enduring marital commitment. Therefore, they are vitally important to efforts aimed at reducing out-of-wedlock childbearing among young adult women, improving child well-being, and increasing adult happiness over the long term.

Washington policymakers should be aware of the consequences of early sexual activity, the undesirable contents of conventional "safe sex" education programs, and the findings of the professional literature concerning the effectiveness of genuine abstinence programs. In particular, policymakers should understand that:

- **Sexually transmitted diseases (STDs), including incurable viral infections, have reached epidemic proportions.** Annually, 3 million teenagers contract STDs; STDs afflict roughly one in four teens who are sexually active.
- **Early sexual activity has multiple negative consequences for young people.** Research shows that young people who become sexually active are not only vulnerable to STDs, but also likely to experience emotional and psychological injuries, subsequent marital difficulties, and involvement in other high-risk behaviors.
- **Conventional "safe sex" programs (sometimes erroneously called "abstinence plus" programs) place little or no emphasis on encouraging young people to abstain from early sexual activity.** Instead, such programs strongly promote condom use and implicitly condone sexual activity among teens. Nearly all such programs contain

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material and messages that would be alarming and offensive to the overwhelming majority of parents.

- **Despite claims to the contrary, there are 10 scientific evaluations showing that real abstinence programs can be highly effective in reducing early sexual activity.** Moreover, real abstinence education is a fairly young field; thus, the number of evaluations of abstinence programs at present is somewhat limited. In the near future, many additional evaluations that demonstrate the effectiveness of abstinence education will become available.

CONSEQUENCES OF EARLY SEXUAL ACTIVITY

Young people who become sexually active enter an arena of high-risk behavior that leads to physical and emotional damage. Each year, influenced by a combination of a youthful assumption of invincibility and a lack of guidance (or misguidance and misleading information) millions of teens ignore those risks and suffer the consequences.

Sexually Transmitted Diseases

The nation is experiencing an epidemic of sexually transmitted diseases that is steadily expanding. In the 1960s, the beginning of the "sexual revolution," the dominant diseases related to sexual activity were syphilis and gonorrhea. Today, there are more than 20 widespread STDs, infecting an average of more than 15 million individuals each year.[1] Two-thirds of all STDs occur in people who are 25 years of age or younger.[2] Each year, 3 million teens contract an STD; overall, one-fourth of sexually active teens have been afflicted.[3]

There is no cure for sexually transmitted viral diseases such as the human immunodeficiency virus (HIV) and herpes, which take their toll on people throughout life. Other common viral STDs are the Human Papillomavirus (HPV)—the leading viral STD, with 5.5 million cases reported each year,[4] and the cause of nearly all cases of cervical cancer that kill approximately 4,800 women per year[5]—and *Chlamydia trachomatis*, which is associated with pelvic inflammatory disease that scars the fallopian tubes and is the fastest growing cause of infertility.

Significantly, research shows that condom use offers relatively little protection (from "zero" to "some") for herpes and no protection from the deadly HPV. A review of the scientific literature reveals that, on average, condoms failed to prevent the transmission of the HIV virus—which causes the immune deficiency syndrome known as AIDS—between 15 percent and 31 percent of the time.[6] It should not be surprising, therefore, that while condom use has increased over the past 25 years, the spread of STDs has likewise continued to rise.[7]

Emotional and Psychological Injury

Young people who become sexually active are vulnerable to emotional and psychological injury as well as to physical diseases. Many young girls report experiencing regret or guilt after their initial sexual experience. In the words of one psychiatrist who recalls the effects of her own sexual experimentation in her teens, "The longest-standing,

1. Shepherd Smith and Joe S. McIlhaney, M.D., "Statement of Dissent on *The Surgeon General's Call to Action to Promote Sexual Health and Responsible Sexual Behavior*," issued by the Medical Institute of Sexual Health, Austin, Texas, June 28, 2001, and American Social Health Association, Research Triangle Park, N.C., "STD Statistics," at *http://www.ashastd.org/stdfaqs/statistics.html*.
2. American Social Health Association, at *http://www.ashastd.org/stdfaqs/statistics.html*.
3. Alan Guttmacher Institute, *Sex and America's Teenagers* (New York: Alan Guttmacher Institute, 1994), pp. 19–20.
4. American Social Health Association, "STD Statistics."
5. American Cancer Society, *Cancer Facts and Figures*, 1998, at *http://www.cancer.org*.
6. Dr. Susan Weller, "A Meta-Analysis of Condom Effectiveness in Reducing Sexually Transmitted HIV," *Social Science and Medicine*, Vol. 36, No. 12 (1993). See also National Institute of Allergy and Infectious Diseases, National Institutes of Health, Department of Health and Human Services, "Summary," *Scientific Evidence on Condom Effectiveness for Sexually Transmitted Disease (STD) Prevention*, July 20, 2001, at *http://www.niaid.nih.gov/dmid/stds/condomreport.pdf*.
7. Centers for Disease Control and Prevention, *Tracking the Hidden Epidemics 2000: Trends in STDs in the United States*, 2000, *at http://www.cdc.gov/nchstp/od/news/RevBrochure1pdftoc.htm*.

deepest wound I gave myself was heartfelt; that sick, used feeling of having given a precious part of myself—my soul—to so many and for nothing, still aches. I never imagined I'd pay so dearly and for so long."[8]

Sexually active youth often live with anxiety about the possibility of an unwanted pregnancy or contracting a devastating STD. Those who do become infected with a disease suffer emotional as well as physical effects. Fears regarding the course the disease are coupled with a loss of self-esteem and self-confidence. In a survey by the Medical Institute for Sexual Health, 80 percent of those who had herpes said that they felt "less confident" and "less desirable sexually."[9]

In addition, early sexual activity can negatively affect the ability of young people to form stable and healthy relationships in a later marriage. Sexual relationships among teenagers are fleeting and unstable, and broken intimate relationships can have serious long-term developmental effects. A series of broken intimate relationships can undermine an individual's capacity to enter into a committed, loving marital relationship. In general, individuals who engage in premarital sexual activity are 50 percent more likely to divorce later in life than those who do not.[10] Divorce, in turn, leads to sharp reductions in adult happiness and child well-being.

Marital relationships that follow early sexual activity can also suffer from the emotional impact of infertility resulting from an STD infection, ranging from a sense of guilt to depression. In the words of one gynecologist and fertility specialist, "Infertility is so devastating, it often disorients my patients to life itself. This is more than shock or even depression. It impacts every level of their lives, including their marriage."[11]

Correlation Between Sexual Activity and Other High-Risk Behaviors

Research from a variety of sources indicates a correlation between sexual activity among adolescents and teens and the likelihood of engaging in other high-risk behaviors, such as tobacco, alcohol, and illicit drug use.

A study reported in *Pediatrics* magazine found that sexually active boys aged 12 through 16 are four times more likely to smoke and six times more likely to use alcohol than are those who describe themselves as virgins. Among girls in this same age cohort, those who are sexually active are seven times more likely to smoke and 10 times more likely to use marijuana than are those who are virgins.[12] The report describes sexual activity as a "significant associate of other health-endangering behaviors" and notes an increasing recognition of the interrelation of risk behaviors. Research by the Alan Guttmacher Institute likewise finds a correlation between risk behaviors among adolescents and sexual activity; for example, teenagers who use alcohol, tobacco, and/or marijuana regularly are more likely to be sexually active.[13]

Out-of-Wedlock Childbearing

Today, it is widely reported that one child in three is born out of wedlock. Only 14 percent of these births occur to women under the age of 18. Most occur to women in their early twenties.[14] Thus, giving birth control to teens in high school through safe-sex programs will have little effect on out-of-wedlock childbearing.

8. Tom and Judy Lickona, with William Boudreau, M.D., *Sex, Love and You* (Notre Dame, Ind.: Ave Maria Press, 1994), p. 70.
9. Medical Institute for Sexual Health, "Safe Sex," lecture with slide show, Austin, Texas, 1992.
10. Joan R. Kahn and Kathryn A. London, "Premarital Sex and the Risk of Divorce," *Journal of Marriage and the Family*, November 1991, pp. 845–855.
11. Joe S. McIlhaney, M.D., *Why Condoms Aren't Safe* (Colorado Springs, Colo.: Focus on the Family, 1993).
12. D. P. Orr, M. Beiter, and G. Ingersoll, "Premature Sexual Activity as an Indicator of Psychosocial Risk," *Pediatrics*, Vol. 87, No. 2 (February 1, 1991), pp. 141–147. See also Kimberly Erickson, "Interconnections: Emerging Patterns in Youth Risk Behavior," Institute for Youth Development, Washington, D.C., June 1, 1998.
13. Alan Guttmacher Institute, *Sex and America's Teenagers*.
14. See, for example, U.S. Department of Health and Human Services, National Center for Health Statistics, "National Vital Statistics Report," 2001.

Nearly half of the mothers who give birth outside marriage are cohabiting with the child's father at the time of birth.[15] These fathers, like the mothers, are typically in their early twenties. Out-of-wedlock childbearing is, thus, not the result of teenagers' lack of knowledge about birth control or a lack of availability of birth control. Rather, it is part of a crisis in the relationships of young adult men and women. Out-of-wedlock childbearing, in most cases, occurs because young adult men and women are unable to develop committed, loving marital relationships. Abstinence programs, therefore, which focus on developing loving and enduring relationships and preparation for successful marriages, are an essential first step in reducing future levels of out-of-wedlock births.

THE SILENT SCANDAL: PROMOTING TEEN SEX

With millions of dollars in sex-education programs at stake, it is not surprising that the groups that have previously dominated the arena have taken action to block the growing movement to abstinence-only education. Such organizations, including the Sexuality Information and Education Council of the United States (SEICUS), Planned Parenthood, and the National Abortion and Reproductive Rights Action League (NARAL), have been prime supporters of "safe-sex" programs for youth, which entail guidance on the use of condoms and other means of contraception while giving a condescending nod to abstinence. Clearly, the caveat that says "and if you do engage in sex, this is how you should do it" substantially weakens an admonition against early non-marital sexual activity.

Not only do such programs, by their very nature, minimize the abstinence component of sex education, but many of these programs also effectively promote sexual activity among the youths they teach. Guidelines developed by SEICUS, for example, include teaching children aged five through eight about masturbation and teaching youths aged 9 through 12 about alternative sexual activities such as mutual masturbation, "outercourse," and oral sex.[16] In addition, the SEICUS guidelines suggest informing youths aged 16 through 18 that sexual activity can include bathing or showering together as well as oral, vaginal, or anal intercourse, and that they can use erotic photographs, movies, or literature to enhance their sexual fantasies when alone or with a partner. Not only do such activities carry their own risks for youth, but they are also likely to increase the incidence of sexual intercourse.

In recent years, parental support for real abstinence education has grown. Because of this, many traditional safe-sex programs now take to calling themselves "abstinence plus" or "abstinence-based" education. In reality, there is little abstinence training in "abstinence-based" education. Instead, these programs are thinly disguised efforts to promote condom use. The actual content of most "abstinence plus" curricula would be alarming to most parents. For example, such programs typically have condom use exercises in which middle school students practice unrolling condoms on cucumbers or dildoes.[17]

EFFECTIVE ABSTINENCE PROGRAMS

Critics of abstinence education often assert that while abstinence education that exclusively promotes abstaining from premarital sex is a good idea in theory, there is no evidence that such education can actually reduce sexual activity among young people. Such criticism is erroneous. There are currently 10 scientific evaluations (described below) that demonstrate the effectiveness of abstinence programs in altering sexual behavior.[18] Each of the programs evaluated is a real abstinence (or what is conventionally termed an "abstinence only") program; that is, the program does not provide contraceptives or encourage their use.

The abstinence programs and their evaluations are as follows:

15. Irwin Garfinkle and Sara McLanahan, *The Fragile Families and Child Wellbeing Study*, baseline report, at *http://crcw.princeton.edu/fragilefamilies/nationalreport.pdf*.
16. SIECUS National Guidelines for Comprehensive Sexuality Education Kindergarten—12th Grade, and National Guidelines Task Force, The Sexuality Information and Education Council of the United States (SEICUS), 1992.
17. Major programs with this type of activity include "Focus on Kids," "Becoming a Responsible Teen," and "Be Proud! Be Responsible!"

1. **Virginity Pledge Programs.** An article in the *Journal of the American Medical Association* by Dr. Michael Resnick and others entitled "Protecting Adolescents From Harm: Findings from the National Longitudinal Study on Adolescent Health" shows that "abstinence pledge" programs are dramatically effective in reducing sexual activity among teenagers in grades 7 through 12.[19] Based on a large national sample of adolescents, the study concludes that "Adolescents who reported having taken a pledge to remain a virgin were at significantly lower risk of early age of sexual debut."[20]

   In fact, the study found that participating in an abstinence program and taking a formal pledge of virginity were by far the most significant factors in a youth's delaying early sexual activity. The study compared students who had taken a formal pledge of virginity with students who had not taken a pledge but were otherwise identical in terms of race, income, school performance, degree of religiousness, and other social and demographic factors. Based on this analysis, the authors discovered that the level of sexual activity among students who had taken a formal pledge of virginity was one-fourth the level of that of their counterparts who had not taken a pledge. Overall, nearly 16 percent of girls and 10 percent of boys were found to have taken a virginity pledge.

2. **Not Me, Not Now.** Not Me, Not Now is a community-wide abstinence intervention targeted to 9- to 14-year-olds in Monroe County, New York, which includes the city of Rochester. The Not Me, Not Now program devised a mass communications strategy to promote the abstinence message through paid TV and radio advertising, billboards, posters distributed in schools, educational materials for parents, an interactive Web site, and educational sessions in school and community settings. The program sought to communicate five themes: raising awareness of the problem of teen pregnancy, increasing an understanding of the negative consequences of teen pregnancy, developing resistance to peer pressure, promoting parent–child communication, and promoting abstinence among teens.

   Not Me, Not Now was effective in reaching early teen listeners, with some 95 percent of the target audience within the county reporting that they had seen a Not Me, Not Now ad. During the intervention period, the program achieved a statistically significant positive shift in attitudes among pre-teens and early teens in the county. The sexual activity rate of 15-year-olds across the county (as reported in the Youth Risk Behavior Survey[21]) dropped by a statistically significant amount from 46.6 percent to 31.6 percent during the intervention period. Finally, the pregnancy rate for girls aged 15 through 17 in Monroe County fell by a statistically significant amount, from 63.4 pregnancies per 1,000 girls to 49.5 pregnancies per 1,000. The teen pregnancy rate fell more rapidly in Monroe County than in comparison counties and in

18. Most of the programs in this section show reductions in sexual activity that are statistically significant at the 95 percent confidence level and above. The significance of these studies is indisputable. In addition, a few studies show programs with positive effects in reducing sexual activity, but with statistical significance levels in the 90 percent to 94 percent confidence range. Because they fall short of the 95 percent confidence level, each of these studies viewed in isolation might be dismissed as inconclusive. Yet, viewed in conjunction with each other, the existence of multiple studies based on small samples, each showing the positive effects of abstinence programs in reducing sexual activity with tests of statistical significance slightly below the 95 percent confidence level, offers evidence reinforcing the case for the overall effectiveness of abstinence education.
19. Michael Resnick, M.D., *et al.*, "Protecting Adolescents from Harm: Findings from the National Longitudinal Study on Adolescent Health," *Journal of the American Medical Association*, Vol. 278 (September 10, 1997). The effects of a virginity pledge in reducing sexual activity were statistically significant at the 99.9 percent confidence level.
20. *Ibid.*, p. 830.
21. L. Kahn *et al.*, "Youth Risk Behavior Survey—United States 1997," *Morbidity and Mortality Weekly Reports*, Vol. 47 (SS–3), 1998, pp. 1–89.

upstate New York in general, and the difference in the rate of decrease was statistically significant.[22]

3. **Operation Keepsake.** Operation Keepsake is an abstinence program for 12- and 13-year-old children in Cleveland, Ohio. Some 77 percent of the children in the program were black or Hispanic. An evaluation of the program in 2001, involving a sample of over 800 students, found that "Operation Keepsake had a clear and sustainable impact on...abstinence beliefs." The evaluation showed that the program reduced the rate of onset of sexual activity (loss of virginity) by roughly two-thirds relative to comparable students in control schools who did not participate in the program. In addition, the program reduced by about one-fifth the rate of current sexual activity among those with prior sexual experience.[23]

4. **Abstinence by Choice.** Abstinence by Choice operates in 20 schools in the Little Rock area of Arkansas. The program targets 7th, 8th, and 9th grade students and reaches about 4,000 youths each year. A recent evaluation, involving a sample of nearly 1,000 students, shows that the program has been highly effective in changing the attitudes that are directly linked to early sexual activity. Moreover, the program reduced the sexual activity rates of girls by approximately 40 percent (from 10.2 percent to 5.9 percent) and the rate for boys by approximately 30 percent (from 22.8 percent to 15.8 percent) when compared with similar students who had not been exposed to the program. (The sexual activity rate of students in the program was compared with the rate of sexual activity among control students in the same grade in the same schools prior to the commencement of the program.)[24]

5. **Virginity Pledge Movement.** A 2001 evaluation of the effectiveness of virginity pledge movement using data from the National Longitudinal Study of Adolescent Health finds that virginity pledge programs are highly effective in helping adolescents to delay sexual activity. According to the authors of the study:

> Adolescents who pledge, controlling for all of the usual characteristics of adolescents and their social contexts that are associated with the transition to sex, are much *less* likely than adolescents who do not pledge, to have intercourse. The delay effect is substantial and robust. Pledging delays intercourse for a long time.[25]

The study, based on a sample of more than 5,000 students, concludes that taking a virginity pledge reduces by one-third the probability that an adolescent will begin sexual activity compared with other adolescents of the same gender and age, after controlling for a host of other factors linked to sexual activity rates such

22. Andrew S. Doniger, "Impact Evaluation of the 'Not Me, Not Now' Abstinence-Oriented, Adolescent Pregnancy Prevention Communications Program, Monroe County, New York," *Journal of Health Communications*, Vol. 6 (2001), pp. 45–60. Both the shifts in attitudes and the decline in sexual activity rate over the intervention period were statistically significant at the 95 percent confidence level. The difference in the rate of decline in adolescent pregnancy in Monroe County, when compared to other geographic areas, was statistically significant at the 95 percent to 99 percent confidence levels.
23. Elaine Borawski *et al.*, *Evaluation of the Teen Pregnancy Prevention Programs Funded through the Wellness Block Grant (1999–2000)*, Center for Health Promotion Research, Department of Epidemiology and Biostatistics, Case Western Reserve University, School of Medicine, March 23, 2001. The program effects on sexual activity were significant at the 93 percent confidence level.
24. Stan E. Weed, *Title V Abstinence Education Programs: Phase I Interim Evaluation Report to Arkansas Department of Health*, Institute for Research and Evaluation, October 15, 2001. The effects of the program in reducing the onset of sexual activity were statistically significant at the 98 percent confidence level. (Data on statistical significance are not currently included in the written report but were provided separately to the author by the evaluator, Dr. Stan Weed.)
25. Peter S. Bearman and Hanna Bruckner, "Promising the Future: Virginity Pledges and First Intercourse," *American Journal of Sociology*, Vol. 106, No. 4 (January 2001), pp. 861, 862. The effects of a virginity pledge were shown to be statistically significant at the 95 percent confidence level.

as physical maturity, parental disapproval of sexual activity, school achievement, and race. When taking a virginity pledge is combined with strong parental disapproval of sexual activity, the probability of initiation of sexual activity is reduced by 75 percent or more.

6. **Teen Aid and Sex Respect.** An evaluation of the Teen Aid and Sex Respect abstinence programs in three school districts in Utah showed that both programs were effective among the students who were at the greatest risk of initiating sexual activity. Approximately 7,000 high school and middle school students participated in the evaluation. To determine the effects of the programs, students in schools with the abstinence programs were compared with students in similar control schools within the same school district. Statistical adjustments were applied to further control for any initial differences between program participants and control students. The programs together were shown to reduce the rate of initiation of sexual activity among at-risk high school students by over a third when compared with a control group of similar students who were not exposed to the program.[26] Statistically significant changes in behavior were not found among junior high students.

   When high school and junior high school students were examined together, Sex Respect was shown to reduce the rate of initiation of sexual activity among at-risk students by 25 percent when compared with a control group of similar students who were not exposed to the program. Teen Aid was found to reduce the initiation of sex activity by some 17 percent. A third non-abstinence program, Values and Choices, which offered non-directive or value-free instruction in sex education and decision-making, was found to have no impact on sexual behavior.

7. **Family Accountability Communicating Teen Sexuality (FACTS).** An evaluation performed for the national Title XX abstinence program examined the effectiveness of the Family Accountability Communicating Teen Sexuality abstinence program in reducing teen sexual activity. The evaluation assessed the FACTS program by comparing a sample of students who participated in the program with a group of comparable students in separate control schools who did not participate in the program. The experimental and control students together comprised a sample of 308 students. The evaluation found the FACTS program to be highly effective in delaying the onset of sexual activity. Students who participated in the program were 30 percent to 50 percent less likely to commence sexual activity than were those who did not participate.[27]

8. **Postponing Sexual Involvement (PSI).** Postponing Sexual Involvement was an abstinence program developed by Grady Memorial Hospital in Atlanta, Georgia, and provided to low-income 8th grade students. A study published in *Family Planning Perspectives*, based on a sample of 536 low-income students, showed that the PSI program was effective in altering sexual behavior.[28] A comparison of the program participants with a control population of comparable low-income minority students who did not participate showed that PSI reduced the rate of initiation of sexual activity during the 8th grade by some 60 percent for boys and over 95 percent for girls.[29] As the study explained:

   The program had a pronounced effect on the

26. Stan E. Weed, *Predicting and Changing Teen Sexual Activity Rates: A Comparison of Three Title XX Programs*, report submitted to the Office of Adolescent Pregnancy Programs, U.S. Department of Health and Human Services, December 1992. The effects the programs on at-risk high school students were significant at the 99 percent confidence level.
27. Stan E. Weed, *FACTS Project: Year End Evaluation Report, 1993–1994*, prepared for the Office of Adolescent Pregnancy Prevention Programs.
28. Marion Howard and Judith Blarney McCabe, "Helping Teenagers Postpone Sexual Involvement," *Family Planning Perspectives*, January/February 1990, pp. 21–26.
29. These effects were statistically significant at the 99 percent confidence level.

> behavior of both boys and girls who had not been sexually involved before the program.... By the end of eighth grade, boys who had not had the program were more than three times as likely to have begun having sex as were boys who had the program.... Girls who had not had the program were as much as 15 times more likely to have begun having sex as were girls who had had the program.[30]

The effects of the program lasted into the next school year even though no additional sessions were provided. By the end of the 9th grade, boys and girls who had participated in PSI were still some 35 percent less likely to have commenced sexual activity than were those who had not participated in the abstinence program.[31]

9. **Project Taking Charge.** Project Taking Charge is a six-week abstinence curriculum delivered in home economics classes during the school year. It was designed for use in low-income communities with high rates of teen pregnancy. The curriculum contains these elements: self-development; basic information about sexual biology (anatomy, physiology, and pregnancy); vocational goal-setting; family communication; and values instruction on the importance of delaying sexual activity until marriage. The effect of the program has been evaluated in two sites: Wilmington, Delaware, and West Point, Mississippi. The evaluation was based on a small sample of 91 adolescents. Control and experimental groups were created by randomly assigning classrooms to either receive or not receive the program. The students were assessed immediately before and after the program and through a six-month follow-up.

   In the six-month follow-up, Project Taking Charge was shown to have had a statistically significant effect in increasing adolescents' knowledge of the problems associated with teen pregnancy, the problems of sexually transmitted diseases, and reproductive biology. The program was also shown to reduce the rate of onset of sexual activity by 50 percent relative to the students in the control group, although the authors urge caution in the interpretation of these numbers due to the small size of the evaluation sample.[32]

10. **Teen Aid Family Life Education Project.** The Teen Aid Family Life Education Project is a widely used abstinence education program for high school and junior high students. An evaluation of the effectiveness of Teen Aid, involving a sample of over 1,300 students, was performed in 21 schools in California, Idaho, Oregon, Mississippi, Utah, and Washington. The Teen Aid program was shown to have a statistically significant effect in reducing the rate of initiation of sexual activity (loss of virginity) among high-risk high school students, compared with similar students in control schools. Among at-risk high school students who participated in the program, the rate of initiation of sexual activity was cut by more than one-fourth, from 37 percent to 27 percent. A similar pattern of reduction was found among at-risk junior high school students, but the effects did not achieve statistical significance. The program did not have statistically significant effects among lower-risk students.[33]

30. Howard and McCabe, "Helping Teenagers Postpone Sexual Involvement," p. 24.
31. These effects were statistically significant at the 95 percent confidence level.
32. Stephen R. Jorgensen, Vicki Potts, and Brian Camp, "Project Taking Charge: Six-Month Follow-Up of a Pregnancy Prevention Program for Early Adolescents," *Family Relations*, October 1993, pp. 401–406. The effects of the program in reducing the rate of onset of sexual activity were statistically significant at the 94.9 percent confidence level. The effects of the program on specific areas of knowledge were significant at the 95 percent confidence level and above.
33. Stan E. Weed, Jerry Prigmore, and Raja Tanas, *The Teen Aid Family Life Education Project: Fifth Year Evaluation Report*, Institute for Research and Evaluation, 1992. The effect of the program on the sexual activity of high-risk high school students was statistically significant at the 99 percent confidence level.

CONCLUSION

Real abstinence education is essential to reducing out-of-wedlock childbearing, preventing sexually transmitted diseases, and improving emotional and physical well-being among the nation's youth. True abstinence education programs help young people to develop an understanding of commitment, fidelity, and intimacy that will serve them well as the foundations of healthy marital life in the future.

Abstinence education programs have repeatedly been shown to be effective in reducing sexual activity among their participants. However, funding for the evaluation of abstinence education programs until very recently has ranged from meager to nonexistent. Currently, the number of adequately funded evaluations of abstinence education is increasing. At present, there are several promising new evaluations nearing completion. As each year passes, it can be expected that the number of evaluations showing that abstinence education does significantly reduce sexual activity will grow steadily.

Abstinence education is a nascent and developing field. Substantial funding for abstinence education became available only within the past few years. As abstinence programs develop and become more broadly available, future evaluations will enable the programs to hone and increase their effectiveness.

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Re: HB 1398 Relating to abstinence in sex education

Hau mitakuyapi, Madam Chair and members of the Committee, for the record my name is Carol Two Eagles. I wish to speak in opposition to parts of HB 1398.

As a parent and grandparent, and as a Pipe Carrier, I do a great deal of counseling of people of all ages. Abstinence is a fine idea – I agree with it. I practice it. I counsel its practice. I urge its practice to my many children and grandchildren. I tell people, "I have a ton of boy friends; I have no bed friends. I have a lot of responsibilities to deal with before I can indulge in bed sports; and then it ***has*** to be with a ***suitable*** man. Not just someone male." Abstinence ***as part of*** a comprehensive sex education program is a good approach. I strenuously object to abstinence education at the expense of comprehensive sex education, however.

Most cultures of the world take the position that sexual activity outside of a committed relationship is taboo to one degree or another, and they always have. I am living proof that the term 'legally married' does not automatically mean 'committed relationship'. We such are legion.

My Grandmother Pearl was a very smart woman, and wise about such things as this matter of sexual behavior. She graduated from high school at a time when women born in 1898 were lucky to get any education. She put her 8 brothers and sisters through high school, as well. She did it working as a domestic, scrubbing floors on her hands and knees. She had a ton of boy friends. She had one bed friend for 23 years; and for reasons of her own, she refused to marry him legally.

She taught me such things as, "Any dummy can push a baby buggy or get venereal disease, my girl. It takes a smart girl to have a good time and no one be the wiser." And, " An aspirin held firmly between the knees prevents pregnancy and venereal disease; and if that looks like it isn't going to work, long walks always do." Pearl was pithy, but she always hit the nail on the thumb. It was her attitude that she taught me about this subject that made me realize as a youngster that when some guy said, "What are you savin' it for, honey?", the answer was, "So I will continue to have my self-respect; because the only person in the world who has to live with me, is me."

My many uncles who helped raise me taught me, "Males may enjoy panting with a female, but they don't take such women home to their relatives; and they don't recognize them on the street when they are with their relatives." I was one of three known virgins in my high school graduating class. I took a huge amount of flack about it; we all did. But we had goals, and we achieved them. Marriage wasn't on the radar screen; achievement was.

By the way, before the advent of "christian'-run boarding schools and white-washing 'educational' efforts by the majority culture on us 'poor ignorant Ind'ns", a loose woman was referred to 'everybody's woman', and if gentle reminders didn't work, she was handed over to the warriors 'to play with' until she learned to straighten up and not be a discredit to her relatives. The warriors lived the hardest of lives; they played very roughly. Only the tiniest number of 'everybody's woman(s)' ever needed a refresher course.

Adopting self-respect-preserving attitudes has gotten me great rewards. It helped get me a college degree "plus", so I wouldn't have to live in a burned-out car like some of my relatives. It enabled me to start several businesses and help support my grandmothers and various other relatives. It has gotten me friendships with business and government leaders of several countries. It has gotten me the trust of their women. It's a great thing when women trust you with their husbands or boyfriends; not because they think you don't like men, but because they know I will enjoy their men like works of art, not just objects of some performance standard in the field of bedsports.

On the surface, much of this bill sounds acceptable, until we reach lines 14 and 15, and references to marriage on lines 21 and 22 on page 1; and lines 2 through 5 and line 9 on page 2.

In Traditional Native cultures, all children are wanted, and bastardy is an unknown concept. It is only in the Euro-American cultures that bastardy – both parents of a child not married to each other – carries a problematic

stigma. Stigmatizing children for something adults did is child abuse, since the child in no way controls any part of the situation from the beginning. It punishes children for something they had no part in, and produces adults who are less productive or un-productive, who grow up feeling they have something terrible to hide and that they are somehow second-rate. This is a terrible thing to do to a person. This bill does nothing to eliminate that. If anything, the language points it out.

I am legally a bastard, and I feel no stigma whatsoever about it, and I never have, despite the efforts of non-Indians – mostly teachers – to try to make me feel somehow second-rate because of the activities of two adults I had no control over. I/We were not even there, after all, when it all began. I can thank my grandmothers and my many uncles, who raised me, for my positive attitude. Serious modification of bills like this one help this process occur for others.

I know that: my birth father is an Indian man because of DNA tests proving that the birth certificate father is not my blood relative and that I have ample Native blood; that my birth mother lied on paper and verbally about it because my grandmothers told me the truth and she confirmed it.

Not only did my grandmothers catch them in bed, "making each other and me", as Pearl put it; the man the birth mother listed on the birth certificate was 2000 miles away for 2 months prior to and 3.5 months after conception. She did not qualify as the 'smart girl' my grandmother spoke of, and I suffered greatly for it as a child. How stupid. Hardly the mark of a 'superior' culture.

The birth mother said her 'reason' for listing the man she was married to instead of the truth was, "Because racism is a fact of life in this country, girl, and a white man could support us better than an Indian man could, and I refused to raise my children on welfare." Later, she also said, "And I didn't want you to carry the stigma of bastardy that exists in this (ie, Euro-American) culture."

She was completely unsuccessful in protecting me from the stupidity of the majority culture's attitude to something I didn't do. I still think her behavior regarding the man on the birth certificate is among the 3 filthiest things I will ever hear – to sentence someone to 18 years of involuntary slavery to support children not of his making – because of a culture that promotes 'legalities' over people's best development into productive citizens. This also certainly puts to rest the argument that legal marriage somehow insures commitment or fidelity, and I am hardly the lone example.

Aboriginal cultures of this Turtle Island and of Australia have a much more sensible approach. All children are welcomed at birth. Period. The Aboriginals of Australia have a custom of welcoming each child by everyone saying, "I support you completely on your journey." This is their approach to every aspect of life, including contraception and abortion. Even if they object to a woman's decision to have an abortion, they have ceremonies to make peace between her soul and the removal of housing for another soul to come here. In Traditional Native cultures, the soul is not attached until the child has been here for some length of time (which varies with the culture). Euro-American cultures would do well to adopt this philosophy and approach instead of the current one.

Lines 14 & 15 of page 1 refer to 'the consequences that bearing children out of wedlock and abortion are likely to produce'. There are no such consequences if the culture doesn't insist on dumping them on the mother and the child. None in the case of abortion, if a person keeps their person business to themselves, and has a peaceful soul about their reasons. Again, Traditionally, Indigenous cultures don't have these stigmas.

Since the mother takes every iota of responsibility for what happens to any child she is carrying while she is pregnant, and she is presumed to be intelligent enough to raise her children to productive adulthood, she automatically has the right – not the privilege – to decide whether or not to remain pregnant. The risks associated with pregnancy and birth are hers alone, the right to choose and any spiritual risks associated with that are hers automatically. While people might disagree with her choice, everyone realizes that they might be in a similar situation some day and have to make a similar choice, so we don't castigate her for choosing abortion if she does. It's a matter of right-to-privacy, and ***showing*** respect.

Line 2, page 2, refers to the "abortifacient characteristics" of contraceptives. I've used many different contraceptives in my life, and I have a degree in chemistry "plus", and I cannot remember any contraceptive having "abortifacient characteristics". I have searched the medical records, and can find no legitimate study indicating that contraceptives have such characteristics. Their very name, contra-ceptives, says they prevent

conception, thus, there is nothing to abort. The term "abortifacient characteristics" as applied to contraceptives is definitely misleading and not true. Contraception beats abortion. The language of this part of the bill is dishonest about what contraceptives and contraception are about and should be removed.

My four favorite questions are: why; why not; what's really going on here; and who's thinking for you in this matter. Young people need to know "why" and "why not" in dealing with controversial matters such as this. Anything with a lot of peer or cultural pressure attached is by definition controversial. Confusing. Just saying "don't" has never cut much ice anywhere. We are supposed to be a reasoning animal. Young people need to know why/why not in terms of the costs of raising babies; the misery of poverty; the misery and even devastation of venereal diseases. The dangers that go with birthing, not just the dangers associated with abortion, which are far lower in the first trimester than in giving birth. "Morality" has nothing to do with this; self-esteem and productivity do. When I face these pressures, even now as an adult, and some guy asks me 'why not" or says "what do you mean, no?"; I respond in the first case, "because I don't want to and it's my right not my privilege and I don't have to explain it to anyone"; and in the second case, I give him a look and leave. The last thing he hears is, "No means no. It doesn't mean maybe."

With over 37,000 ***species eminently facing extinction*** right this minute, we need more contraception, not more deception about it. The Superior Intellect that makes all of those other species and puts them here on the earth with us says, simply by making them, that they have an equal right to exist and that humans do not have a right to extinct them in favor of more humans.

I make no secret of the fact that when I agreed to take on the Sun Dance Prayer called The Four Winds, I did it with the full realization that it was more on behalf of the non-human species of the earth than the one human specie. Healing the Sacred Hoop of the world means bringing it back into balance. The gross excess of human population on the earth make for a very unbalanced situation, overall. Promoting thinking and self-confidence and self-protection, instead of indulging, in terms of sexual activity, and contraception, not ignorance or delusion, helps promote balance. This is the responsible approach to take.

Knowledge is power, that's why all cultures educate children. Only in the majority culture is there an effort to institutionalize limits on information, instead of promoting free access to it, under the guise of 'education', and that's what this bill seems to promote. These efforts to censor seem always to come under an umbrella promoting some ostensibly religious view. Humans have more potential for constructive or destructive effects than other species do. This bill is one example of destructiveness, unless it is changed to make abstinence education part of a comprehensive sex education program, so young people can make intelligent choices and confident in refusing.

Lines 8 and 9 have nothing whatsoever to do with education about pregnancy prevention, responsible sexual behavior, and the like, and should be struck from this bill. This wording makes this a Separation of Church and state bill, and it violates the concept with lines 8 & 9 of page 2. Again, I note that I think the term "marriage" should be replaced with some wording speaking of "committed long-term relationship". I recommend this wording instead, for these lines: "Teaches the health and societal benefits of committed, long-term relationships; the meaning of commitment; and the skill and attitudes needed to make such relationships last and succeed."

Thank you for hearing me in a good way now. I am always available to answer any questions the Committee may have. Many blessings.

Texas Teaches Abstinence, With Mixed Grades

By Cecl Connolly
Washington Post Staff Writer
Tuesday, January 21, 2003; Page A01

LUBBOCK, Tex. -- The day's guest instructor had spiked blond hair, tight black jeans and a propensity for street slang.

"You have been lied to, lied to by the media, lied to by celebrities," Ed Ainsworth told the 120 squirming eighth-graders at Smylie Wilson Junior High School. "Will this condom protect your heart?" he asked, flashing a glossy Trojan ad on a giant screen. "Will this condom protect your reputation? Go ahead and use a condom. You'll still be known as a slut."

This is sex education, Texas-style, where the only safe sex taught since 1995 is no sex outside marriage. That is when George W. Bush, who was then governor, signed a law making Texas the third state requiring schools to follow an abstinence-only sex education curriculum.

Now President Bush is promoting abstinence-until-marriage programs nationwide, a shift in health policy that has sparked an emotional debate over how to keep young people healthy.

Abstinence-only proponents say that teaching young people about birth control is simply inviting them to have sex; advocates for comprehensive sex education say that withholding detailed information leads to dire medical consequences. Lubbock's situation illustrates the limitations of abstinence-only programs.

In the seven years since their schools began teaching abstinence-only, young people here have been anything but abstinent. Teen pregnancy rates in the state remain above the national average, and Lubbock County consistently has one of the highest rates in the state. In addition, the number of Texas youths with sexually transmitted diseases has risen steadily.

At the same time, many parents lack the time or expertise to provide adequate guidance. Teachers complain that even if the law did not limit what they could teach, the school day already is packed. And young people are living in a culture that features both regular church attendance and provocative music videos.

Now, a small group of students is revolting against the abstinence-only curriculum.

"The current policies are obviously ineffective," said Corey Nichols, 17, who, as mayor of the Lubbock Youth Commission, is leading a push for a more comprehensive program. "I think abstinence is wonderful; as a commission we back abstinence. But when you look at the numbers, you see the abstinence curriculum fails."

Risk and Routine

Lubbock is a flat, dusty farming community on the western edge of the Bible Belt, where liquor is prohibited and high school football is worshipped. Bush received his largest winning percentage in Lubbock's congressional district in the 2000 presidential election, and local lore holds that the city has more churches per capita than any other in the nation.

It would seem fertile ground for abstinence-only education.

"I really believe that's the way to go," said Cindy Wright, the mother of two girls. "The Bible says you are supposed to get married before you consummate a relationship. That may not be very popular, but I don't think teaching anything other than abstinence is right."

Since the abstinence-only curriculum began in 1995, teen pregnancy rates have fallen in Texas generally -- and Lubbock County specifically -- but not as dramatically as for the nation as a whole. Meanwhile, rates of sexually transmitted diseases have soared.

In 1996, the last year for which national figures are available, the U.S. teen pregnancy rate was 38 out of every 1,000 girls; Texas's rate was 40 per 1,000 and Lubbock County's was 43. In subsequent years, as the national and state rates inched steadily downward, Lubbock's figures fluctuated.

By 2000, the statewide teen pregnancy rate had dropped to 33 per 1,000; Lubbock County reported a rate of 42.4, said Jane Tustin, health services coordinator for the Lubbock Independent School District.

Over the last decade, as rates for gonorrhea and chlamydia have fallen nationally, Lubbock County has confronted an epidemic. In 2000, fewer than 150 cases of gonorrhea were reported nationally for every 100,000 people. Lubbock County reported double that, with the highest number of cases in people between the ages of 15 and 20.

But Lubbock has struggled with teenage sex for generations.

In 1973, the city developed a separate high school program for pregnant girls and young mothers, but it did not slow the pace of teen pregnancies. Two decades later, local officials appointed a teen pregnancy task force that met over two years, said Tustin, a task force member.

"We developed all sorts of recommendations," she said. The group urged a community-wide effort targeting high-risk behavior, such as smoking, gang membership, substance abuse and sexual activity, by providing more activities and mentors for Lubbock's young people. None of the recommendations was adopted, largely for reasons of cost.

What has persisted, Lubbock residents say, is a culture of teen sexual activity.

"We've got a lot of kids for whom the norm is to be a high school dropout and pregnant well before she is 18," said Eric Benson, who coordinates HIV programs in the Lubbock area for the Texas Department of Health. "We have instances where a girl has her first child at 15, becomes a grandmother by the time she is 30 and a great-grandmother at age 45."

Benson's observations are based partly on experience: Fifteen years ago, at age 19, he fathered a child. "I got my sex ed from three sources -- my peers, the media and my own research," he said.

Many teenagers said that with the limits on teaching, and with parents who are uncomfortable discussing sex in detail, they learn much of what they know from experience. Some young women here, under the mistaken belief that they can get pregnant through oral sex, refer to their children as "spit babies."

"I learned the hard way," said Jennifer Villarreal, 19, who gave birth two years ago. "You can continue to talk about abstinence, but kids are curious and they will experiment."

Even teenagers who have taken a virginity pledge see a community in which sexual activity -- often risky, promiscuous behavior -- is a routine part of growing up.

"Why so much sex in Lubbock?" said Shelby Knox, 16, who initiated the student effort to change the Lubbock curriculum. "There's nothing to do. You can only go to the movies so many times on Friday night."

Point of Agreement

Facing the eighth-graders at Smylie Wilson, Ainsworth asked how many knew someone age 15 or younger who was pregnant or had a child. Close to 90 percent of the hands shot up.

"Which one of you girls wants to go and have sex with a yo-yo who doesn't take care of you?" he asked. "Are you willing to trade your entire destiny for six seconds of pleasure?"

Ainsworth's make-the-adults-blush rap reflects the Bush administration's new tack on teen sexuality. He is a youth pastor, but he makes the case for abstinence not on religious grounds, but by highlighting the consequences of casual sex at a young age.

Sex outside marriage is Russian roulette, he told the students. Contracting the AIDS virus, he warned, means "a long, slow process of death" with medical care costing as much as $80,000 a year. Genital herpes "is the gift that keeps on giving," because sores on the mouth, buttocks, thigh and genitals come and go "for the rest of your life."

Joseph McIlhaney, founder of the Medical Institute for Sexual Health, said it is too early to evaluate the effectiveness of abstinence-only programs, but he has seen instances in which teen sexual activity declined after an aggressive education effort on condom failure rates and the dangers of sexually transmitted diseases.

"We feel there is very clear data that show that sexual activity is probably more risky behavior for an adolescent than smoking," said McIlhaney, who will run an educational session with Lubbock teachers and nurses Monday. "I don't think parents want their young people to become sexually active."

Abstinence educators aim to instill greater self-esteem in adolescents so they will have the courage and creativity to reject negative peer pressure. The easiest way to keep out of trouble, Ainsworth told the girls, is to "stay off your knees, stay off your back and keep your clothes on." And there is nothing cool about a young man in college preying on a 14-year-old girl, he added.

In large measure, medical professionals agree with Ainsworth. "Abstinence is the 100 percent effective way of not getting an STD or pregnant," said Vilka Scott, a disease intervention specialist at the Lubbock Health Department. "I strongly encourage abstinence."

But it would be irresponsible to stop the lesson there, she said. Abstinence may be the gold standard, but she also tells young people that delaying the onset of sexual activity, reducing the number of partners and using a condom greatly reduce risk.

"Telling people, 'Don't drink and drive,' doesn't make them go out and get drunk," she said. "I don't think information leads to bad decisions. I think it empowers individuals to make their own responsible decisions."

Like Scott, Tustin suggested that the abstinence-only approach does not give teenagers credit for being able to digest nuanced messages.

"Parents underestimate the knowledge kids have and the pressure they are under," she said. "They would be horrified if they knew what their kids know about drugs and sex."

One thing Ainsworth and Tustin agree on: Adults have failed the children of Lubbock.

"If parents think their kids are exposed to too much sexuality, they shouldn't have Britney Spears come to town," said Tustin, who was flabbergasted that tickets for the young sexpot's concert there sold out in 70 minutes. "You can't say to kids 'Don't have sex' and then let 12-year-olds stay out at a teen dance club until 11 at night."

The small band of rebels on the youth commission began to push for changes in the school curriculum more than a year ago. Last summer, several commission members took a Red Cross course on sexuality in the hope that they could do some teaching on their own outside school. In October, they organized a community forum sponsored by MTV that filled the city council chambers.

The session began with a short video in which pop star Tweet describes "nine things you need to know before you're good to go." The tips include getting regular checkups, learning about sexually transmitted diseases, using a condom and speaking candidly with sexual partners.

Some parents and students voiced dismay. "It was like a promotional video: Here are fun ways to do it," said Blake Williamson, 15. "The video made it sound like everybody's doing it -- you just need this information."

John Norris, the MTV correspondent moderating the forum, said a recent poll showed that 84 percent of teenagers wanted a comprehensive sex education curriculum and that 63 percent were not getting information they say they need. The students' questions seemed to illustrate his point.

Could a virgin conceive, one asked. Another asked: If a mother has AIDS, will the baby also contract the virus? Is the HIV virus spread by kissing? What about chlamydia? Would a girl with genital herpes infect her child during delivery? Can a woman get pregnant having sex with her clothes on? Do two condoms work better than one?

For youth commission member Maranda Buchanan, the forum was further proof that the abstinence-only curriculum had failed many of her peers.

"I knew this many people were having sex, but I didn't know so many were getting sick and pregnant," said Buchanan, 17. "Lubbock is in need of sex education."

HB 1398

National Conference of State Legislatures

LEGISBRIEF

Briefing Papers on the Important Issues of the Day

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Sex Education

By Carla K. Curran

For the most part, states leave sex education up to local school districts.

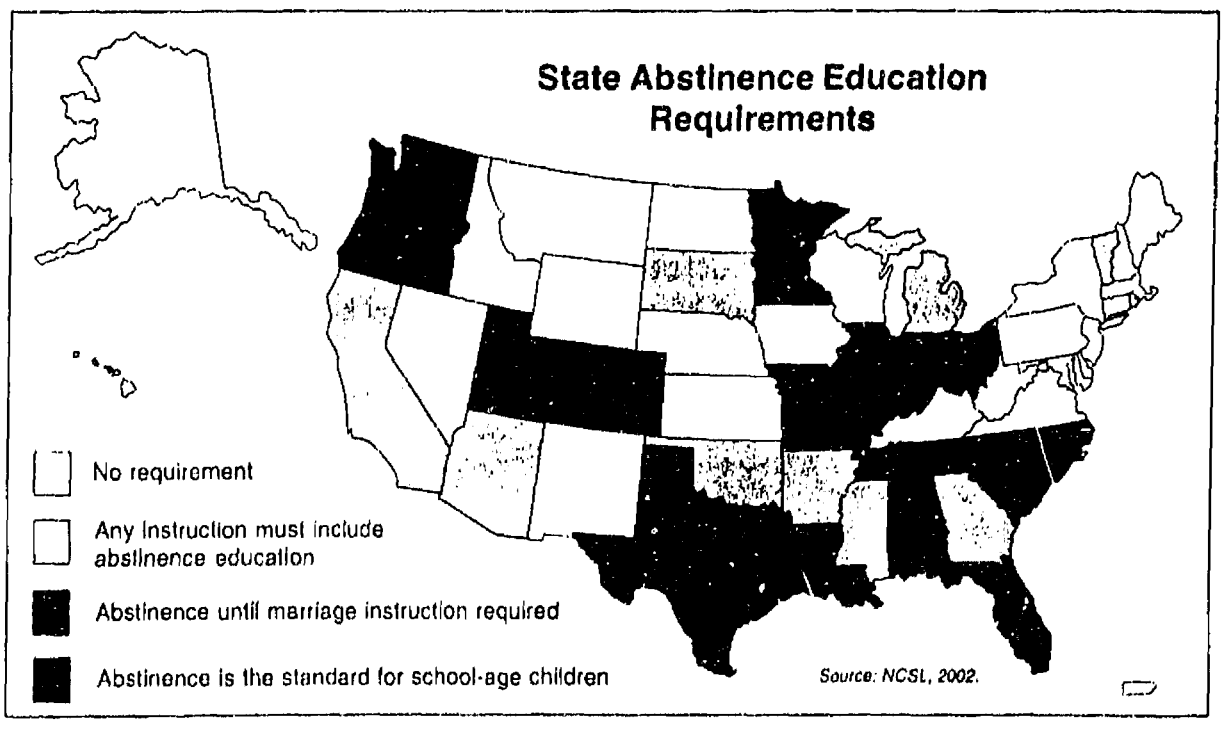
For the most part, states have chosen to leave sex education up to local school districts. The states that have laws requiring some level of sex education leave approval of the curriculum to local officials. In some states with no laws requiring sex education, there may be laws that say that if sex education is taught, it must include abstinence education.

State Action

Almost half the states have no laws on sex education and have no content requirements.

Almost half the states have no laws on sex education and have no requirements regarding content if it is taught. Some states have no laws requiring sex or HIV education, but do require that if taught it has to promote or stress abstinence education. There are several ways that states require abstinence education. Some mandate that abstinence until marriage be taught to all students; some specify that abstinence be taught as the standard for all school-age children; and others only say abstinence must be stressed or emphasized. Seventeen states require varying levels of HIV/AIDS education.

State Examples. In Alabama, any public school program must emphasize that abstinence is the only completely effective protection against pregnancy, sexually transmitted diseases and HIV, and that abstinence from sexual intercourse is the accepted standard for school-age children.



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In California, HIV prevention instruction must be given to all students in grades seven through 12. Classes must emphasize and include statistics on failure and success rates of condoms and other contraceptives in preventing sexual transmission of HIV.

Connecticut also requires HIV instruction, but leaves the content to the local and regional school boards.

Georgia requires each local board to offer a course in sex education and HIV prevention that includes abstinence education.

Federal Action

The Abstinence Education Formula Block Grant Program was created in 1996 through welfare reform legislation. The program has had an appropriation of $50 million for the last three fiscal years. The U.S. Department of Health and Human Services announced in July 2001 an additional $17.1 million in new grants for abstinence-only education programs in 49 communities. This new money has no state match requirement. These funds are administered by the federal Health Resources Services Administration.

The Abstinence Education Formula Block Grant Program was created in 1996 through welfare reform legislation.

The abstinence-only grants can be used for programs that teach:

- The benefits of abstaining from sexual activity.
- That abstinence is the only certain way to avoid out-of-wedlock pregnancy.
- The dangers of sexually transmitted diseases and other health problems.
- That monogamous, mutually faithful relationships in the context of marriage are the expected standard of human sexual activity.
- That sex outside of marriage is likely to have harmful psychological and physical effects.
- That having children outside of marriage is likely to have harmful consequences for the child, the parents and society.

These courses also teach young people how to reject sexual advances, how alcohol and drug use increases vulnerability, and the importance of attaining self-sufficiency before engaging in sex.

Federal welfare reform legislation requires all states to develop ways to reduce out-of-wedlock births. The Department of Health and Human Services awards bonuses to states achieving the largest reductions. The District of Columbia, Alabama and Michigan received awards in 2001 that totaled $75 million.

Federal welfare reform legislation requires all states to develop ways to reduce out-of-wedlock births.

Selected References

Centers for Disease Control's Division of Adolescent and School Health (DASH)—Resources and Tools, http://www.cdc.gov/nccdphp/dash/resources.htm

Department of Health and Human Services, Office of Population Affairs, information on abstinence education demonstration projects, http://opa.osophs.dhhs.gov/titlexx/afl-grantees-ae.html

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FALL 2001

SEXUAL HEALTH UPDATE

VOLUME 3

A QUARTERLY PUBLICATION

MEDICALLY SPEAKING

TWENTY YEARS WITH HIV/AIDS

A refresher on what you need to know about this highly publicized disease.

Last May many of the major newsmagazines highlighted the 20th anniversary of HIV/AIDS. For a few the deadly disease has become just another obstacle to overcome in our sexually permissive society, for others it's a disease they live with everyday. However, others are still trying to understand more about the implications of this complicated disease by sorting out fact and fiction.

WHAT IS HIV?

Human immunodeficiency virus (HIV) is a virus that infects certain white blood cells. When the virus infects these cells (called T-helper cells or CD4 cells), the virus takes over the cell's ability to reproduce. These "compromised" cells start making new copies of the virus. The infected cells die, releasing new copies of the virus that infect new white blood cells. This destruction of white blood cells damages the infected person's immune system and compromises his/her ability to fight off infections and other immune system challenges.

In the United States, HIV infection is relatively uncommon, but in terms of morbidity (illness and suffering) and mortality (death), the toll is substantial. Outside the U.S.— and particularly in developing countries—the rates of new HIV infections are rising and the numbers of currently infected people are incredibly large. In some sub-Saharan countries in Africa, HIV prevalence among young adults is 15 percent or higher. Focusing on HIV as a sexually transmitted disease, then, is both timely and appropriate.

THE HISTORY OF HIV

In 1981, news of a strange syndrome of immune suppression and death in young, otherwise healthy, homosexual males began to appear in the medical literature and news media. This condition was initially called Gay Related Immune Disorder (GRID); but in 1982, the name was changed to Acquired Immune Deficiency Syndrome (AIDS) as individuals other than homosexual men were noted to have this same condition. Efforts were begun to identify the cause of the condition and the manner in which the condition was spread. Epidemiologic investigations determined that an infectious agent transmitted by

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THOUGHTS AND TRENDS

Three polls conducted by the National Campaign to Prevent Teen Pregnancy reveal that youth believe it's best for teens and young adults to remain abstinent.

The first poll was a nationally representative survey conducted among 12 to 17 year-olds during February and April 2000. The poll's findings are contained in a report titled, "The Cautious Generation." Of the 1025 young people surveyed:

- Fifty-eight percent said sexual activity for high school-age teens is not acceptable, even if precautions are taken against pregnancy and sexually transmitted diseases.
- Sixty-four percent of girls and 53 percent of boys reported sex was unacceptable for high school-age teens.
- Sixty-nine percent of 12 to 14 year olds said sex was unacceptable, while 48 percent of 15 to 17 year olds said it was unacceptable.
- Ninety-three percent said it was somewhat important (22%) or very important (71%) for teens to be given a strong message from society that they should abstain from sex until they are at least out of high school."
- Sixty-three percent said they had had a helpful conversation with their parents about sex.
- Fifty percent stated that the main reason teens don't have sex is fear of STDs and/or pregnancy. Fifty percent stated the main reason was because of religion, morals and values.

The second survey was conducted on a nationally representative sample of 501

THOUGHTS AND TRENDS

cont. from page 1

adolescents from 12 to 17 years old during June 2000. Findings of this survey are contained in a report titled, "Not Just Another Thing to Do." The findings include:

- Forty-one percent of those surveyed reported having ever had sexual intercourse. Of these, 63 percent reported wishing they had waited longer before having sex.
- Thirty-seven percent of adolescents surveyed reported that their parents were most influential in their decisions about sex. Thirty percent named their friends as the most important influence, 11 percent named their religious community and 11 percent named the media.
- Twenty-four percent of those surveyed said teens should not be sexually active and should not have access to birth control. Fifty-four percent stated that teens should not be sexually active, but teens who are should have access to birth control. Only 21 percent said it is "okay" for teens to be sexually active, as long as they have access to birth control.
- When asked what advice they would give to a younger brother, sister or friend, 25 percent responded, "Don't have sex until you are at least out of high school" and 64 percent responded, "Don't have sex until you are at least out of high school, but, if you do, be certain to protect yourself against STDs and pregnancy." Only 7 percent responded, "Sex is okay as long as you love the girl or guy" and 1 percent responded, "Sex is fun; enjoy yourself."

The third poll was conducted in January and February of 2001. 1,002 young people from 12 to 19 years of age and 1,024 adults age 20 or older were included in the nationally representative poll. The results were published in a report titled, "With One Voice: America's Adults and Teens Sound Off About Teen Pregnancy." Findings of this report include:

- Ninety-three percent of adults and 88 percent of adolescents believe that the number of teen pregnancies in the United States is a "serious problem."
- Seventy-eight percent of adults and 66 percent of adolescents surveyed believed it is "very important" for teens to be given a strong message from society that they should abstain from sex until they are at least out of high school.
- Thirty-eight percent of adolescents stated that parents were the most influential factor in their sexual decision-making.
- Eighty-eight percent of adults agreed strongly or agreed somewhat when asked, "Parents believe they should talk to their kids about sex but often don't know what to say, how to say it, or when to start."

WHAT DOES ALL THIS INFORMATION MEAN?

This information provides new insight into how adolescents view sex and sexual activity. The results are much more "conservative" than most people—and even, most parents—believe. Adults who grew up in the "free love" generation often believe it is unreasonable to expect adolescents to delay or avoid sexual activity. However, these polls indicate that the majority of adolescents believe that young people should not be having sex and that society should be sending a strong message encouraging them to abstain from sex.

Coupled with recent declines in the proportion of high school students who have had sexual intercourse, these results are encouraging. Our youth are hearing and understanding the abstinence message, perhaps even more than we realize. It is important that we continue our efforts to find effective ways to help adolescents avoid sexual activity. The health and future of our young people depend on it.

For more information about these studies click on www.teenpregnancy.org/poll

JUST A CLICK AWAY!

The Medical Institute's newest resource makes researching issues surrounding the impact of sexually transmitted diseases and nonmarital pregnancy easier than ever. Visit www.medinstitute.org for a summary of current journal articles that can help you articulate your message clearer than ever.

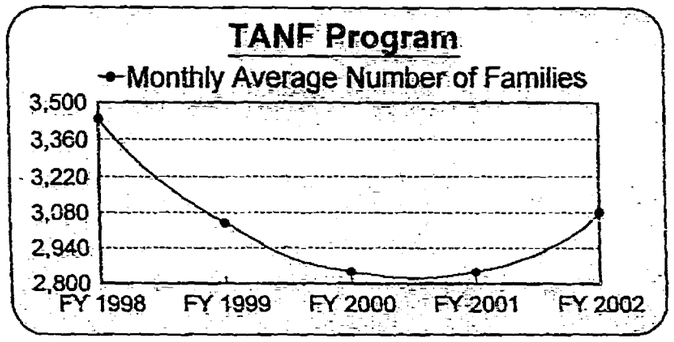
Our newest reference tool can be found in the Medical Updates section of our website (www.medinstitute.org), the Topical Reference Library will allow users to quickly and easily find summaries of credible journal articles and reports on a variety of topics, including STDs, condoms/contraception, marriage/cohabitation, STDs and pregnancy prevention programs, and risk behavior. New article summaries will be added continually to the website, so visit it often for current, up-to-date information.

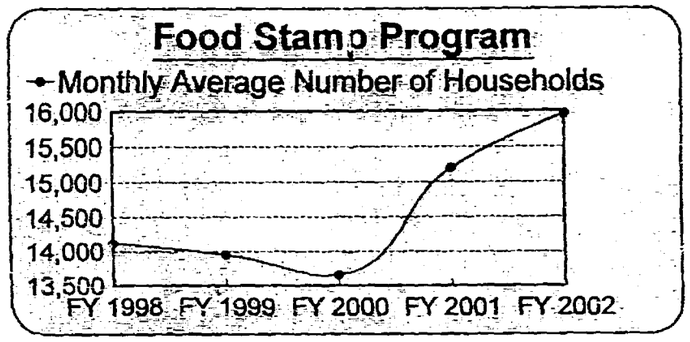
WHAT'S UP?

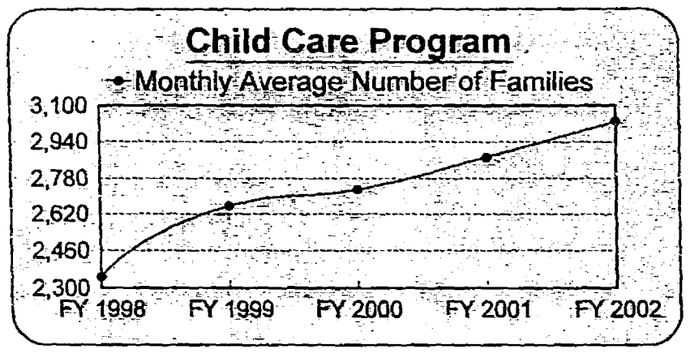
The Medical Institute's year 2000 annual report is now available. If you would like to review the report visit www.medinstitute.org. If you would like to receive a copy of the report call us at 512-328-6268.

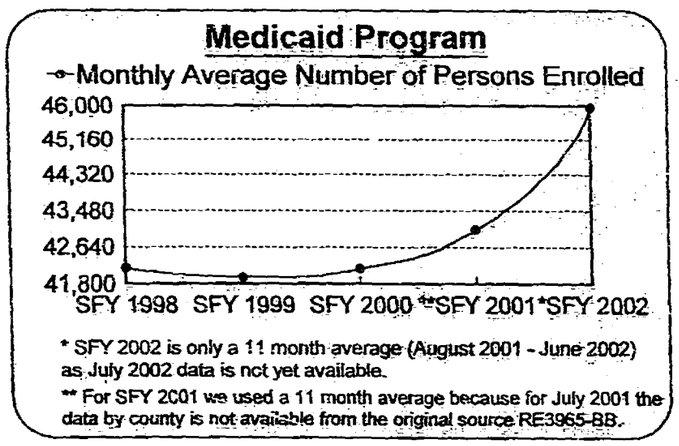
North Dakota Department of Human Services

Statewide Averages for TANF, Food Stamps, Child Care, Medicaid, & Healthy Steps
Trend Data



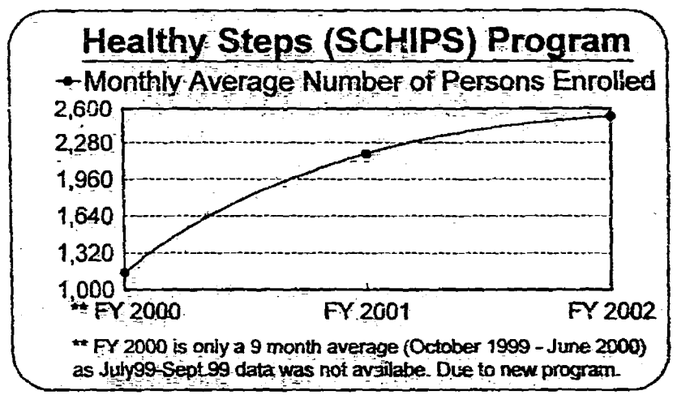






* SFY 2002 is only a 11 month average (August 2001 - June 2002) as July 2002 data is not yet available.

** For SFY 2001 we used a 11 month average because for July 2001 the data by county is not available from the original source RE3965-BB.



** FY 2000 is only a 9 month average (October 1999 - June 2000) as July99-Sept 99 data was not available. Due to new program.

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North Dakota
Standards and Benchmarks

Content Standards

Health

2000

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Table of Contents

Components of the Document

Content Standards – general statements that describe what students should know and the skills they should have in a specific content area.

Benchmarks – statements of knowledge and skill that define a standard at a given developmental level (e.g., 4th grade, 8th grade, 12th grade).

Examples of Specific Knowledge – facts, vocabulary, principles, generalizations, relationships, concepts, step-by-step procedures, strategies, or processes that describe the specific information or skills that students should acquire to meet a standard.

Examples of Activities – instructional activities that students could do to acquire the knowledge and skills described in the standard and benchmarks.

** Indicates word or phrase is defined in Glossary*

Introduction

No knowledge is more crucial than knowledge about health. Without it, no other life goal can be successfully achieved. (E. L. Boyer)

"Health [class] has made people think about what's right to do and what's wrong. And every day when I'm faced with a decision, I think." (High school girl, age 15)

Development of the Document
The North Dakota Health Standards were developed to improve overall academic achievement of students since healthy students are more likely to learn at an optimal level. They were written through a cooperative effort of health experts, public health nurses, North Dakota educators, the North Dakota Department of Public Instruction, and the Carnegie BRIDGES Middle School Project. The writing team built its work on past North Dakota health frameworks documents and consulted national and other states' health standards documents.

Organization of the Document
The standards and benchmarks in this document address the six dimensions of health (i.e., physical, mental, emotional, social, spiritual*, and intellectual) and serve as a guide to districts in developing their health curriculum. They are written in a format that indicates the type of knowledge (i.e., information/ideas or skills/processes) that the standard requires.

Information/ideas (i.e., facts, details, vocabulary, principles, generalizations, and concepts) standards are indicated by the word "know" or "understand" at the beginning of the standard (e.g., "Students know how public health policies and government regulations impact health-related issues.") Standards that address skill/process type of knowledge usually begin with a verb that describes the use of the skill or process. In this document, the verbs are often preceded by the phrase "know how to" or "demonstrate the ability to." These words were chosen to indicate that, although the skills and procedures will be taught and students will be assessed on them in class, students' application of these skills outside the classroom can not be determined.

In addition to statements of the content standards, the document includes benchmarks for what students should know and be able to do in the area of health education by the end of grades 4, 8, and 12. Local districts may choose to write grade-specific benchmarks and objectives. The benchmarks are written at a general level. More specifics are included in the section labeled "Examples of Specific Knowledge that Support the Standard and Benchmarks." The sample activities also provide more specifics about the benchmarks and suggest ways in which students can acquire the desired level of understanding or skill. These activities are merely suggestions to assist teachers in their planning. They are not mandates nor are they assessments. Further, the examples of specific knowledge and sample activities are illustrative, not exhaustive.

Use of the Document
This document serves as a guide for local districts in developing standards. Use of the standards in this document is encouraged, but districts are not required to adopt these standards nor are students required to meet them. It is strongly recommended that a district team be convened to model local standards from these state standards, considering local values, developmental level of students, and educational goals. A 1990 document, *Curriculum Development Strategies for Health Education in the State of North Dakota*, developed by the Department of Public Instruction, may be helpful in selecting such a committee, sharing information with the community, building consensus, addressing sensitive issues, and adopting and implementing a new health curriculum.

We hope that this document will help districts provide students with health education curriculum that gives them information and skills for healthy living now and throughout their lives.

** Indicates word or phrase is defined in Glossary*

North Dakota Health Content Standards

Standard 1: GROWTH AND DEVELOPMENT
Students understand the fundamental concepts of growth and development.

Standard 2: HEALTH PROMOTION AND DISEASE PREVENTION
Students understand concepts related to health promotion and disease prevention.

Standard 3: ENVIRONMENTAL AND COMMUNITY HEALTH
Students understand the effects of environmental and external factors on personal, family, and community health.

Standard 4: HEALTH-ENHANCING SKILLS
Students demonstrate the ability to use problem-solving, decision-making, communication, and goal-setting skills to enhance health.

Standard 5: BEHAVIORS AND RISK
Students demonstrate the ability to practice health-enhancing behaviors and reduce health risks.

Standard 6: HEALTH – RELATED INFORMATION
Students demonstrate the ability to access and evaluate health-related information, products, and services.

Standard 7: HEALTH ADVOCACY
Students demonstrate the ability to advocate* for personal, family, and community health.

** Indicates word or phrase is defined in Glossary*

Summary Of Grades K-4 Benchmarks

Standard 1: GROWTH AND DEVELOPMENT

Students understand the fundamental concepts of growth and development.

4.1.1 Know the cycle of growth and development in humans from infancy to older adult.
4.1.2 Understand how individuals differ in their rates of growth and development.
4.1.3 Know basic structure and functions of the human body systems.
4.1.4 Know the importance of intellectual, emotional, social, spiritual*, and physical health during childhood.

Standard 2: HEALTH PROMOTION AND DISEASE PREVENTION

Students understand concepts related to health promotion and disease prevention.

4.2.1 Understand relationships between personal health behaviors and individual well being.
4.2.2 Know how the family influences personal health.
4.2.3 Understand how childhood injuries and illnesses can be prevented or treated.
4.2.4 Understand the importance of personal hygiene.

Standard 3: ENVIRONMENTAL AND COMMUNITY HEALTH

Students understand the effects of environmental and external factors on personal, family, and community health.

4.3.1 Know how media influence thoughts, feelings, and health behaviors.
4.3.2 Know how elements of the environment affect personal health.
4.3.3 Know how positive health behaviors contribute to a healthy environment.

Standard 4: HEALTH – ENHANCING SKILLS

Students demonstrate the ability to use problem-solving, decision-making, communication, and goal-setting skills to enhance health.

4.4.1 Know steps in assessing risks and making responsible decisions.
4.4.2 Know how to set goals for a healthy lifestyle.
4.4.3 Know characteristics needed to be a responsible friend and family member.
4.4.4 Understand ways to communicate care, consideration, and respect of self and others.
4.4.5 Know communication and problem-solving skills to set personal boundaries, resolve conflicts, and develop positive relationships.

Standard 5: BEHAVIORS AND RISKS

Students demonstrate the ability to practice health-enhancing behaviors and reduce health risks.

4.5.1 Understand the relationship between food choices and personal health.
4.5.2 Know how to distinguish behaviors that are safe from those that are risky or harmful.
4.5.3 Know responsible health behaviors and needs.
4.5.4 Know safety rules and practices used in home, school, and community settings.
4.5.5 Know ways to avoid and reduce threatening situations.

** Indicates word or phrase is defined in Glossary*

Standard 6: HEALTH – RELATED INFORMATION

Students demonstrate the ability to access and evaluate health-related information, products, and services.

4.6.1 Know community health service providers and their roles.
4.6.2 Know how to locate resources from home, school, and community that provide valid health information.

Standard 7: HEALTH ADVOCACY

Students demonstrate the ability to advocate for personal, family, and community health.*

4.7.1 Know various ways to convey accurate health information and ideas to individuals and groups.
4.7.2 Know methods for assisting others in making positive health choices.

Standard 1: GROWTH AND DEVELOPMENT

Students understand the fundamental concepts of growth and development.

Benchmarks
4.1.1 Know the cycle of growth and development in humans from infancy to older adult.
4.1.2 Understand how individuals differ in their rates of growth and development.
4.1.3 Know basic structure and functions of the human body systems.
4.1.4 Know the importance of intellectual, emotional, social, spiritual*, and physical health during childhood.

Examples of Specific Knowledge that Support the Standard and Benchmarks
4.1.1 birth to death
4.1.2 body size, teeth, physical and mental capabilities, physical features, voice
4.1.3 skeletal, muscular, circulatory, respiratory, digestive, reproductive, nervous systems
4.1.4 positive self-image, friendships, body language, expressing feelings, condition of body

Examples of Activities that Support the Standard and Benchmarks
4.1.1 Students visit the new baby ward at the local hospital and/or visit a local nursing home. They draw pictures, write a story, or orally describe what they saw related to the cycle of human growth and development and discuss similarities and differences among their observations.
4.1.2 Students trace their body outlines on large sheets of paper and add physical features. They tape them to the wall in progression of height and describe the similarities and differences they notice.
4.1.3 Students listen to a health care* professional who uses X-rays or other appropriate professional materials to explain one of the body systems. They prepare questions for the speaker before the presentation and ask their questions of the speaker. The class may want to write down the answers to the questions and include them in a booklet as a record of what they learned.
4.1.4 Students list a positive attribute of each person in the class. They share some of them orally and distribute the rest to the appropriate individuals. They classify each of the statements they received from their classmates according to whether they are related to their intellectual, emotional, social, spiritual, or physical health.

** Indicates word or phrase is defined in Glossary*

Standard 2: HEALTH PROMOTION AND DISEASE PREVENTION

Students understand concepts related to health promotion and disease prevention.

Benchmarks
4.2.1 Understand relationships between personal health behaviors and individual well being.
4.2.2 Know how the family influences personal health.
4.2.3 Understand how childhood injuries and illnesses can be prevented or treated.
4.2.4 Understand the importance of personal hygiene.

Examples of Specific Knowledge that Support the Standard and Benchmarks
4.2.1 personal habits, attitudes, lifestyles, quality of life
4.2.2 economics, functional/dysfunctional families, family values, and family relationships
4.2.3 appropriate dress, personal hygiene, basic first aid, health professionals
4.2.4 washing hands, brushing teeth, bathing

Examples of Activities that Support the Standard and Benchmarks
4.2.1 Students discuss the importance of health screening to promote personal health (e.g., vision, hearing, scoliosis, etc.). They draw a health triangle* and at each point, write, draw pictures, or paste pictures of behaviors and attitudes that promote health and well being (Meeks & Heit, 1994a).
4.2.2 Students identify five family values that promote meaningful and lasting relationships.
4.2.3 Students draw pictures or write a story about a situation when it would be appropriate to apply the "Rest, Ice, Compression, and Elevation" (R.I.C.E.) theory. [R.I.C.E. is a treatment for some fractures or other problems.]
4.2.4 Students do a hand-washing activity using cinnamon, glitter, pepper, or paprika. [Note: The "Glow Germ" activity available from all ND Teacher Centers can also be used to demonstrate the relationship between proper hand washing and germ control.]

Standard 3: ENVIRONMENTAL AND COMMUNITY HEALTH

Students understand the effects of environmental and external factors on personal, family, and community health.

Benchmarks
4.3.1 Know how media influence thoughts, feelings, and health behaviors.
4.3.2 Know how elements of the environment affect personal health.
4.3.3 Know how positive health behaviors contribute to a healthy environment.

Examples of Specific Knowledge that Supports the Standard and Benchmarks
4.3.1 advertisements, TV programs, music, athletes
4.3.2 clean air, water, and land; noise pollution
4.3.3 no littering; reduce, recycle, reuse; conservation

Examples of Activities that Support the Standard and Benchmarks
4.3.1 Students examine the labels on containers and advertisements for various brands of cereals, yogurt, and other food products and compare the advertising messages with the actual nutritional content for the products (Meeks & Heit, 1994a).
4.3.2 Students brainstorm ways humans can keep the environment a healthful and safe place in which to live (e.g., aerosol sprays, litter, dripping faucets). They explain why each action makes the environment healthy for humans.
4.3.3 Students recycle aluminum cans to raise money for a safer and healthier environment. They follow the process of recycling materials to draw connections between individual action and total community health. [Note: Include local media in publicizing the students' efforts.]

** Indicates word or phrase is defined in Glossary*

Standard 4: HEALTH - ENHANCING SKILLS

Students demonstrate the ability to use problem-solving, decision-making, communication, and goal-setting skills to enhance health.

Benchmarks	
4.4.1	Know steps in assessing risks and making responsible decisions.
4.4.2	Know how to set goals for a healthy lifestyle.
4.4.3	Know characteristics needed to be a responsible friend and family member.
4.4.4	Understand ways to communicate care, consideration, and respect of self and others.
4.4.5	Know communication and problem-solving skills to set personal boundaries, resolve conflicts, and develop positive relationships.

Examples of Specific Knowledge that Supports the Standard and Benchmarks	
4.4.1	brainstorm; consider consequences, pros and cons, effects on others
4.4.2	personal well-being, eating behaviors, physical activity, nutrition
4.4.3	respect, courtesy, manners, honesty
4.4.4	listening, encouragement, communication, confidentiality
4.4.5	cooperation, negotiation, bargaining, compromise

Examples of Activities that Support the Standards and Benchmarks	
4.4.1	Students respond to a series of health-related questions beginning with "What would you do if..." (e.g., someone offered you a cigarette, someone didn't wash his/her hands after leaving the bathroom). Responses should promote positive relationships. This could be used in a writing activity or a journal entry.
4.4.2	Students conduct a home activity in which they discuss health-related decisions and set five family health goals. [Note: Teachers may want to give a health-related reward when family goals are met (e.g., toothbrush, book, coupon for health product).]
4.4.3	After students read actual want ads, they write an ad advertising for a friend. The ad should include five characteristics that a good friend would possess.
4.4.4	In groups, students brainstorm and record ways to communicate one of the following: caring, consideration, respect for self, or respect for others. They discuss times when they have done this for others or others have done it for them. They share their list and a few examples with the other groups.
4.4.5	Students help formulate classroom rules with accompanying positive and negative consequences.

Standard 5: BEHAVIORS AND RISKS

Students demonstrate the ability to practice health-enhancing behaviors and reduce health risks.

Benchmarks	
4.5.1	Understand the relationship between food choices and personal health.
4.5.2	Know how to distinguish behaviors that are safe from those that are risky or harmful.
4.5.3	Know responsible health behaviors and needs.
4.5.4	Know safety rules and practices used in home, school, and community settings.
4.5.5	Know ways to avoid and reduce threatening situations.

Examples of Specific Knowledge that Supports the Standard and Benchmarks	
4.5.1	food pyramid, balanced diet, three meals/day, food content, safe handling of foods, healthy snacks, nutrients/fuels
4.5.2	seat belts, helmets
4.5.3	active lifestyle, healthy eating behaviors, physical activity*
4.5.4	fire/tornado drills, school safety procedures, water safety, animal safety
4.5.5	strategies for dealing with strangers and being home alone, travel safety rules

** Indicates word or phrase is defined in Glossary*

Examples of Activities that Support the Standard and Benchmarks
4.5.1 Students collect food pictures from magazines. They combine all pictures and create the food pyramid according to the number of servings for each group.
4.5.2 Students make posters that explain pedestrian, bicycle, roller blade and motor vehicle traffic rules, safety procedures, and signs (including the use of seat belts and safety helmets).
4.5.3 Students participate in a local health fair by sponsoring such activities as Jump-for-Heart, Bike-a-Thons, etc.
4.5.4 Students plan a fire escape route from every room in their homes. They discuss "stop, drop, roll" and basic fire safety procedures.
4.5.5 Students role-play refusal skills to avoid threatening situations.

Standard 6: HEALTH – RELATED INFORMATION

Students demonstrate the ability to access and evaluate health-related information, products, and services.

Benchmarks
4.6.1 Know community health service providers and their roles.
4.6.2 Know how to locate resources from home, school, and community that provide valid health information.

Examples of Specific Knowledge that Supports the Standard and Benchmarks
4.6.1 roles of health care* professionals, firefighters, police, counselors
4.6.2 dial 911, provide pertinent information, make appointment with school counselor

Examples of Activities that Support the Standard and Benchmarks
4.6.1 Students create a list of community health service providers and invite several (e.g., health care* professional, police, firefighter, counselor) to speak to the class about what they do in the community. After hearing from the speakers, pairs of students choose one of the professions and role play a scene of what they might do in that role. For example, one pair might choose the role of a dentist and act out a trip to the dentist office with one student playing the dentist and the other playing the patient.
4.6.2 Students role-play a 911 call, providing all personal information and a description of the emergency situation.

Standard 7: HEALTH ADVOCACY

Students demonstrate the ability to advocate for personal, family, and community health.*

Benchmarks
4.7.1 Know various ways to convey accurate health information and ideas to individuals and groups.
4.7.2 Know methods for assisting others in making positive health choices.

Examples of Specific Knowledge that Supports the Standard and Benchmarks
4.7.1 examples, appearance, attitude, role-model
4.7.2 encouragement, positive peer pressure

** Indicates word or phrase is defined in Glossary*

Examples of Activities that Support the Standard and Benchmarks

4.7.1 Students collectively make a sign that promotes accurate health information (e.g., smoking, drugs, hygiene, alcohol).

4.7.1 Students demonstrate to another class, and role model to siblings, the correct procedure for brushing teeth.

4.7.1 Students make signs to remind students to "cover their sneeze." They post the signs throughout the school.

4.7.2 Students create brochures about positive choices in various areas of health. [Note: A software program that may help is *Student Writing Center.*]

4.7.2 Students identify a troublesome situation and examine it by using the following key phrases: (1) Stop what you're doing. (2) Think about what might happen. (3) Look around for something to do instead. (4) Give yourself a pat on the back. [*Get Real about Tobacco*, K-3, Lesson 6]

Summary Of Grades 5-8 Benchmarks

Standard 1: GROWTH AND DEVELOPMENT

Students understand the fundamental concepts of growth and development.

8.1.1 Understand physical, intellectual, social, and emotional changes throughout the life cycle.
8.1.2 Understand the processes of conception, prenatal development, and birth.
8.1.3 Understand physical, intellectual, social, and emotional changes associated with puberty and adolescence.

Standard 2: HEALTH PROMOTION AND DISEASE PREVENTION

Students understand concepts related to health promotion and disease prevention.

8.2.1 Know strategies for stress management.
8.2.2 Know the benefits of nutrition* and physical activity* as they relate to total wellness.
8.2.3 Know sources, symptoms, and treatment of diseases and other health problems.

Standard 3: ENVIRONMENTAL AND COMMUNITY HEALTH

Students understand the effects of environmental and external factors on personal, family, and community health.

8.3.1 Know that family, community, culture, media, technology, and other factors have an impact on health practices.
8.3.2 Know how local, state, and federal efforts and policies on environmental issues impact health.
8.3.3 Know how the physical environment can affect personal health.

Standard 4: HEALTH – ENHANCING SKILLS

Students demonstrate the ability to use problem-solving, decision-making, communication, and goal-setting skills to enhance health.

8.4.1 Know appropriate social skills to build and maintain positive relationships.
8.4.2 Understand the process of goal setting and how it affects health choices.
8.4.3 Know strategies for coping with peer pressure.
8.4.4 Understand how health and learning are affected by nutrition*, physical activity*, drugs and sex.

Standard 5: BEHAVIORS AND RISKS

Students demonstrate the ability to practice health-enhancing behaviors and reduce health risks.

8.5.1 Know strategies and skills that are used to attain personal health goals.
8.5.2 Know characteristics and conditions associated with positive self-esteem.
8.5.3 Know consequences of specific risk behaviors for one's self and others.
8.5.4 Understand precautions related to personal safety.
8.5.5 Know risks associated with harmful chemicals and drugs.

** Indicates word or phrase is defined in Glossary*

Standard 6: HEALTH – RELATED INFORMATION

Students demonstrate the ability to access and evaluate health-related information, products, and services.

8.6.1 Know how to locate and use community resources and services that provide valid health information.
8.6.2 Know situations that require professional health services.
8.6.3 Know the validity and cost of common health information, products, and services.

Standard 7: HEALTH ADVOCACY

Students demonstrate the ability to advocate for personal, family, and community health.*

8.7.1 Know how to distinguish between myths and facts related to health issues.
8.7.2 Know various communication methods to accurately express health information.
8.7.3 Understand how to influence and support others in making positive health choices.

Standard 1: GROWTH AND DEVELOPMENT

Students understand the fundamental concepts of growth and development.

Benchmarks

8.1.1 Understand physical, intellectual, social, and emotional changes throughout the life cycle.
8.1.2 Understand the processes of conception, prenatal development, and birth.
8.1.3 Understand physical, intellectual, social, and emotional changes associated with puberty and adolescence.

Examples of Specific Knowledge that Supports the Standard and Benchmarks

8.1.1 similarities and differences with body changes, thinking processes, and self-esteem
8.1.2 role of egg and sperm, prenatal care (e.g., physical activity*, nutrition*, rest, drug use, etc.), birth, birth defects [e.g., Fetal Alcohol Syndrome (FAS), Fetal Alcohol Effects (FAE)]
8.1.3 growth spurt, menstruation, peer pressure, self-esteem, mood swings, importance of peers

Examples of Activities that Support the Standard and Benchmarks

8.1.1 Students interview or observe a person in various stages of the life cycle (i.e., birth through older adult). They meet in groups to discuss their findings and to develop a timeline that shows characteristics of emotional, intellectual, physical, and social growth at the various stages.
8.1.1 Students create a pamphlet describing the stages of grief and dying.
8.1.2 As the teacher simulates the birth process using a sock and a small stuffed animal, students write down what the parts of the sock represent (i.e., foot part of sock represents the uterus, the neck represents the birth canal) and how contractions, movement through the birth canal, and stretching of the vagina to accommodate the baby are represented. Alternatively, students could be given the suggested, or other, materials and asked to simulate the birth process. (Adapted from Meeks & Heit, 1994a.)
8.1.3 Students view a film on adolescent development. After viewing, they discuss in groups common adolescent concerns about growth spurts, menstruation, peer pressure, mood swings, self-esteem, hygiene and health habits. Each group lists stresses teens feel related to the issues and positive ways of coping with the stresses

** Indicates word or phrase is defined in Glossary*

Standard 2: HEALTH PROMOTION AND DISEASE PREVENTION

Students understand concepts related to health promotion and disease prevention.

Benchmarks
8.2.1 Know strategies for stress management.
8.2.2 Know the benefits of nutrition* and physical activity* as they relate to total wellness.
8.2.3 Know sources, symptoms, treatment, and prevention of diseases and other health problems.

Examples of Specific Knowledge that Supports the Standard and Benchmarks
8.2.1 relaxation techniques, knowledge of stresses, depression, suicide
8.2.2 nutrition* and physical activity* in relation to physical, emotional, and social health
8.2.3 sexually transmitted infections (STI)*, leading causes of death for different age groups, risk behaviors that lead to premature death

Examples of Activities that Support the Benchmarks
8.2.1 Students construct a multi-level mobile depicting stresses and coping techniques.
8.2.2 Students develop an infomercial* promoting nutrition* and physical activity* in relation to total wellness.
8.2.3 Students develop a set of questions about health promotion to ask a traditional or non-traditional healthcare professional. After the speaker's presentation, the students write a summary or prepare a graphic organizer (e.g., concept web) to show what they learned from the speaker.
8.2.3 Students prepare and present an oral report about the sources, symptoms, treatment, and prevention of a particular disease or health problem.

Standard 3: ENVIRONMENTAL AND COMMUNITY HEALTH

Students understand the effects of environmental and external factors on personal, family, and community health.

Benchmarks
8.3.1 Understand how family, community, culture, media, technology, and other factors affect health.
8.3.2 Understand how local, state, and federal efforts and policies on environmental and social issues affect health.
8.3.3 Know how the physical environment can affect personal health.

Examples of Specific Knowledge that Supports the Standard and Benchmarks
8.3.1 effects of advertising (e.g., use of cartoon characters to promote smoking), influence of family or ethnic eating behaviors, influence of positive role models, effects of media use (e.g., TV, Internet, computer games) on physical activity*
8.3.2 ban on smoking, enforcement of underage drinking and tobacco purchase laws, environmental protection issues, individual school issues
8.3.3 second-hand smoke, pollution, rural/urban environment, available health care*, germs

** Indicates word or phrase is defined in Glossary*

Examples of Activities that Support the Standard and Benchmarks	
8.3.1	Students write a poem or essay on what it means to be a positive role model.
8.3.1	Students evaluate ads for influence on health behaviors.
8.3.2	Students prepare a list of questions for a guest speaker who will address the laws and responsibilities that teenage parents face. Students then summarize what they learned from the speaker's presentation.
8.3.2	Students brainstorm a list for one of the following: 1) comments/actions that could be considered as sexual harassment; 2) possible consequences (i.e., emotional, social) to the victim; and 3) methods of confronting sexual harassment.
8.3.2	Students research HIV policies at the school, state, and federal level concerning confidentiality, precautions, and prevention.
8.3.3	Students create a mural that depicts how the physical environment affects health.

Standard 4: HEALTH – ENHANCING SKILLS

Students demonstrate the ability to use problem-solving, decision-making, communication, and goal-setting skills to enhance health.

Benchmarks	
8.4.1	Know appropriate social skills to build and maintain positive relationships.
8.4.2	Understand the process of goal setting and how it affects health choices.
8.4.3	Know strategies for coping with peer pressure.
8.4.4	Understand how health and learning are affected by nutrition*, physical activity*, drugs, and sex.

Examples of Specific Knowledge that Supports the Standard and Benchmarks	
8.4.1	making and maintaining friendships, respect for authority, citizenship
8.4.2	goal-setting steps related to nutrition* (e.g., eating more fruits and vegetables to reduce cancer risks), physical activities*, and weight management
8.4.3	refusal skills, alternatives, resolving conflicts
8.4.4	obesity, heart disease, high blood pressure, pregnancy, sexually transmitted infections (STI)*, addiction, etc.

Examples of Activities that Support the Standard and Benchmarks	
8.4.1	Students write a friendship "Bill of Rights".
8.4.1	Students write a want ad advertising for a friend.
8.4.2	Students set a personal health goal and track progress toward achievement. (Parental involvement is encouraged.)
8.4.3	Students produce a puppet show demonstrating peer pressure.
8.4.3	Students role-play ways to deal with peer pressure.
8.4.4	Students write an essay on abstinence*.
8.4.4	Students design a tee shirt depicting a positive health habit.

Standard 5: BEHAVIORS AND RISKS

Students demonstrate the ability to practice health-enhancing behaviors and reduce health risks.

Benchmarks	
8.5.1	Know strategies and skills that are used to attain personal health goals.
8.5.2	Know characteristics and conditions associated with positive self-esteem.
8.5.3	Know consequences of specific risk behaviors for one's self and others.
8.5.4	Understand precautions related to personal safety.
8.5.5	Know risks associated with harmful chemicals and drugs.

** Indicates word or phrase is defined in Glossary*

Examples of Specific Knowledge that Supports the Standard and Benchmarks

8.5.1 hygiene, grooming, fitness plans, disease-free/maintenance
8.5.2 confidence, self-worth, volunteerism, over-achievers
8.5.3 probation; becoming handicapped; loss of life, relations, and reputation
8.5.4 use of safety equipment, obey laws, avoidance of high-risk situations, first aid basics, abstinence*/birth control
8.5.5 addiction, getting caught, suicide, driving under the influence (DUI), loss of control

Examples of Activities that Support the Standard and Benchmarks

8.5.1 Students plan and keep a fitness calendar for a set period of time.
8.5.2 Students create a self-esteem collage within a silhouette.
8.5.2 Given a hand print of each of their classmates, students give one another a "pat on the back" by writing a positive statement in each person's print.
8.5.3 Students prepare several questions to ask a person who is physically challenged due to an injury. The questions should help the students understand the person's injury and how it might have been avoided.
8.5.4 Students write a set of "safety tips-of-the-day" that could be announced over the intercom daily to promote safety in and out of school. (Students might want to gather some data, through a survey perhaps, to see if safety improves as a result of the announcements.)
8.5.5 Students draw a comic strip or write a newspaper article depicting the consequences of taking risks.

Standard 6: HEALTH – RELATED INFORMATION

Students demonstrate the ability to access and evaluate health-related information, products, and services.

Benchmarks

8.6.1 Know how to locate and use community resources and services that provide valid health information.
8.6.2 Know situations that require professional health services.
8.6.3 Know the validity and cost of common health information, products, and services.

Examples of Specific Knowledge that Supports the Standard and Benchmarks

8.6.1 depression, dysfunctional eating* (e.g., compulsive overeating, size bias, restrictive dieting, eating disorders*), negative body image, addictions, pregnancy, date rape
8.6.2 phone book, hotlines, clinics/hospitals, local clergy, school counselor, trusted adults, parents
8.6.3 quackery/fads, health claims, role of state agencies, consumer fraud, brand-names, generic items

Examples of Activities that Support the Standard and Benchmarks

8.6.1 Using highway sign shapes, students construct "warning signs" showing the warning signs of addiction, depression, eating disorders* and dysfunctional eating*, etc.
8.6.2 Students create a youth "yellow pages" listing resources and services that provide valid health information.
8.6.3 Students analyze health ads and health products to determine credibility with follow-up correspondence to the company.
8.6.3 Students, working in groups, "create" a health product and make a marketing presentation to the rest of the class. Classmates can vote on whether they would buy the product or not.
8.6.3 Students compare and contrast generic health products with name-brand health products.

** Indicates word or phrase is defined in Glossary*

Standard 7: HEALTH ADVOCACY

Students demonstrate the ability to advocate for personal, family, and community health.*

Benchmarks	
8.7.1	Know how to distinguish between myths and facts related to health issues.
8.7.2	Know various communication methods to accurately express health information.
8.7.3	Understand how to influence and support others in making positive health choices.

Examples of Specific Knowledge that Supports the Standard and Benchmarks	
8.7.1	myths regarding pregnancy, HIV transmission, and drugs, etc.
8.7.2	verbal, non-verbal, listening, writing
8.7.3	skill in compromising, listening, leading, organizing, speaking, resolving conflicts; knowledge of facts; assertiveness

Examples of Activities that Support the Standard and Benchmarks	
8.7.1	Students develop a game that shows that they can differentiate between health facts and health myths.
8.7.2	Students develop a public service announcement or newspaper ad relating to current health issues.
8.7.3	Students write and illustrate a health booklet for lower elementary students.
8.7.3	Students teach a health concept to lower elementary students.

* *Indicates word or phrase is defined in Glossary*

Summary Of Grades 9-12 Benchmarks

Standard 1: GROWTH AND DEVELOPMENT

Students understand the fundamental concepts of growth and development.

12.1.1 Understand the interrelationships of intellectual, emotional, social, spiritual*, and physical health throughout life.
12.1.2 Understand the interrelationships of family and individual health.
12.1.3 Understand physical, intellectual, social, and spiritual* changes that occur throughout life, and how these changes differ among individuals.
12.1.4 Understand how physical, intellectual, social, and cultural factors influence attitudes and behaviors regarding sexuality.
12.1.5 Understand the impact of personal health behaviors on the functioning of body systems.
12.1.6 Understand the importance of prenatal and perinatal care to both mother and child.

Standard 2: HEALTH PROMOTION AND DISEASE PREVENTION

Students understand concepts related to health promotion and disease prevention.

12.2.1 Understand how the body's systems function to prevent or combat disease.
12.2.2 Understand the importance of regular physical examinations in detecting and treating diseases early.
12.2.3 Know how to assess behaviors and their relationships to health promotion and disease prevention.
12.2.4 Understand the social, political, and economic effects of disease on individuals, families, and communities.

Standard 3: ENVIRONMENTAL AND COMMUNITY HEALTH

Students understand the effects of environmental and external factors on personal, family, and community health.

12.3.1 Know how the community, media, and technology can influence the health of individuals.
12.3.2 Understand how cultural diversity enriches and challenges health behaviors.
12.3.3 Understand how the physical environment influences the health of the community.
12.3.4 Know how public health policies and government regulations impact health-related issues.

Standard 4: HEALTH – ENHANCING SKILLS

Students demonstrate the ability to use problem-solving, decision-making, communication, and goal-setting skills to enhance health.

12.4.1 Know how use, misuse, and abuse of alcohol, tobacco, and other drugs can play a role in dangerous behavior and can have adverse consequences for the community.
12.4.2 Know how to set personal health goals and design a specific plan to enhance health for quality of life.
12.4.3 Know how to use a process in decision making as it relates to a healthy lifestyle.
12.4.4 Know how to apply a problem-solving process to enhance and/or protect health.

** Indicates word or phrase is defined in Glossary*

Standard 5: BEHAVIORS AND RISKS

Students demonstrate the ability to practice health-enhancing behaviors and reduce health risks.

12.5.1 Know the role of individual responsibility for enhancing health.
12.5.2 Know strategies to use for health enhancement.
12.5.3 Know possible causes of conflicts in schools, families, and communities and strategies to prevent conflict in these situations.
12.5.4 Know how refusal, negotiation, and collaboration skills can be used to avoid potentially harmful situations.

Standard 6: HEALTH – RELATED INFORMATION

Students demonstrate the ability to access and evaluate health-related information, products, and services.

12.6.1 Know how to access health information, products, and services outside the community.
12.6.2 Know factors that influence personal selection of health care resources, products, and services.
12.6.3 Know how to evaluate resources from home, school, and the community that present health information, products, and services.
12.6.4 Understand the cost and accessibility of a variety of health care services.
12.6.5 Know situations that require professional health services in the areas of prevention, treatment, and rehabilitation.
12.6.6 Know local, state, federal, and private agencies that protect and/or inform the consumer.

Standard 7: HEALTH ADVOCACY

Students demonstrate the ability to advocate for personal, family, and community health.*

12.7.1 Know how to express information and opinions about health issues.
12.7.2 Know how individuals can improve or maintain community health.
12.7.3 Know how to influence and support others in making positive health choices.
12.7.4 Know how to work cooperatively when advocating for healthy communities.

Standard 1: GROWTH AND DEVELOPMENT

Students understand the fundamental concepts of growth and development.

Benchmarks
12.1.1 Understand the interrelationships of intellectual, emotional, social, spiritual*, and physical health throughout life.
12.1.2 Understand the interrelationships of family and individual health.
12.1.3 Understand physical, intellectual, social, and spiritual* changes that occur throughout life, and how these changes differ among individuals.
12.1.4 Understand how physical, intellectual, social, and cultural factors influence attitudes and behaviors regarding sexuality.
12.1.5 Understand the impact of personal health behaviors on the functioning of body systems.
12.1.6 Understand the importance of prenatal and perinatal care to both mother and child.

** Indicates word or phrase is defined in Glossary*

Examples of Specific Knowledge that Supports the Standard and Benchmarks

12.1.1 holistic*, stages of life, dimensions of health, functioning and adapting
12.1.2 family dynamics
12.1.3 life changes
12.1.4 culture, attitudes, dynamics in relation to sexuality
12.1.5 birth control, tobacco, alcohol, drugs, sexual activity
12.1.6 prenatal and perinatal care, teen pregnancy, unintended pregnancy

Examples of Activities that Support the Standard and Benchmarks

12.1.1 Students, working in groups, are assigned a dimension of health. Each group discusses its dimension and shares with the other groups how its dimension is affected by, or interacts with, the other dimensions of health.

12.1.2 Students are divided into "family units". Each family stands in a circle and the members of the family are connected with yarn around their thumbs. The teacher gives an adverse health event to one member who steps back. Students describe how the other family members are affected. (The activity uses physical closeness to represent emotional closeness to demonstrate that those emotionally closest are most affected and those farthest away are least affected.)

12.1.3 Students listen to a guest speaker who has experienced a major life change or event and summarize, orally or in writing, how that change or event affected the person's dimensions of wellness.

12.1.4 Students research how sexuality is dealt with in a variety of cultures. They select a scenario in which some aspect of sexuality in our culture changes (e.g., men get pregnant, women get pregnant by rubbing elbows, women impregnate women, women can get pregnant after the age of 30 but not before) and discuss how this change might affect our life choices and how other cultures see us.

12.1.5 Students pair up and designate one person as A and the other as B. Person A is given a list of behavior choices (e.g., use or not use alcohol or drugs, engage or not engage in sexual activity, eat well-balanced meals or eat unbalanced meals, diet or not, sleep too little or get adequate rest). Person B is given a list of consequences (e.g, addiction, pregnancy, obesity or nutritional deficits). Person A makes a behavior choice and B responds with a consequence and explains why the consequence is appropriate. After matching each choice with a consequence, each pair joins with another pair to discuss personal health behaviors that could lead to permanent damage to a body system or premature death. They list positive health behaviors and write personal health behavior contracts to avoid disease and premature death.

12.1.6 Students examine case studies of unintended or unwanted pregnancies. They identify, in chronological order (i.e., beginning with sexual encounters through decision making after pregnancy occurs), how help might be obtained. Students critique the roles of the case study characters.

Standard 2: HEALTH PROMOTION AND DISEASE PREVENTION

Students understand concepts related to health promotion and disease prevention.

Benchmarks

12.2.1 Understand how the body's systems function to prevent or combat disease.
12.2.2 Understand the importance of regular physical examinations in detecting and treating diseases early.
12.2.3 Know how to assess behaviors and their relationships to health promotion and disease prevention.
12.2.4 Understand the social, political, and economic effects of disease on individuals, families, and communities.

** Indicates word or phrase is defined in Glossary*

Examples of Specific Knowledge that Supports the Standard and Benchmarks

12.2.1 communicable and non-communicable diseases, vaccinations, allergic reactions, sexually transmitted infections* (STI's), HIV, etc.

12.2.2 primary*, secondary*, and tertiary prevention* [e.g., testicular self exam (TSE), breast self exam (BSE)]

12.2.3 alcohol, tobacco and other drug use; sedentary lifestyle; dietary patterns; sexual behaviors; intentional and unintentional injury; HIV

12.2.4 effects of disease on the individual, family and community (e.g., absenteeism, work, income, location, epidemics, and quarantine)

Examples of Activities that Support the Standard and Benchmarks

12.2.1 Students are given a construction paper T-shirt with one of the following titles written on it: antibody, skin, white blood cell, and T cell. Students write facts about the title on their shirt and tape the facts to the back side of the shirt. Four students are selected by the teacher to come to the front of the room. The teacher introduces them as if they were members of a sports team. For example, "Here is #32, Skin." Then Skin says something that shows why he is a member of the "defensive" team (e.g., "My job today is not to break down so that any pathogen that tries to get by me will be blocked."). The activity continues until all students have been introduced.

12.2.2 Students watch and listen as a health care provider demonstrates and explains the parts and procedures of a physical exam and its role in the early prevention, detection, and treatment of disease. They use a graphic organizer or other format to summarize what they learned.

12.2.3 One student is given a half-full glass of sodium hydroxide and all other members of the class each receive a half-full glass of DISTILLED water. Students walk around the room and exchange two or three drops of water with several other students. After three or four trades, the students test their glasses of water with the indicator, phenolthaline. They discuss how the activity demonstrates the transmission of HIV. (Note: Use plastic medicine cups or other small containers that hold less than a quarter cup. For more information about HIV, contact the AIDS trainer at your local Teacher Learning Center.)

12.2.4 Students use the Internet to research a rare disease, such as progeria, for which major drug companies are not currently developing drugs because it is not economically feasible. They present the results of their research in writing or orally, discussing the economic and social consequences of having the disease and any political efforts to gather support for developing treatments for the disease.

12.2.4 Students divide into three groups, which are designated as social, political, or economic. Each group discusses and records the effects of HIV/AIDS on individuals, families, and communities for their assigned area.

Standard 3: ENVIRONMENTAL AND COMMUNITY HEALTH

Students understand the effects of environmental and external factors on personal, family, and community health.

Benchmarks

12.3.1 Know how the community, media, and technology can influence the health of individuals.

12.3.2 Understand how cultural diversity enriches and challenges health behaviors.

12.3.3 Understand how the physical environment influences the health of the community.

12.3.4 Know how public health policies and government regulations impact health-related issues.

** Indicates word or phrase is defined in Glossary*

Examples of Specific Knowledge that Supports the Standard and Benchmarks

12.3.1 Information offered through community organizations, volunteer work at hospitals, food banks, childcare centers

12.3.2 cultural diversity, various food sources of nutrients available in different cultural and ethnic cuisine, influence of cultural factors on the treatment of diseases

12.3.3 natural and man-made disasters, pesticides and herbicides, environmental issues that affect the food and water supply and the nutritional quality of food

12.3.4 public health regulations and policy, Occupational Safety and Health Administration (OSHA) regulations, Right to Know laws, Department of Health and Human Services regulations, licensing laws, safe food handling, food production controls, household waste disposal controls, clean air, disposal of nuclear waste

Examples of Activities that Support the Standard and Benchmarks

12.3.2 Students, individually or in groups, prepare questions about volunteer programs to ask a speaker from a local hospital, fire department, United Way, etc. After listening to the speaker, each group prepares a poster promoting volunteerism.

12.3.2 Students participate in an ethnic diversity day in school by bringing foods from their families' culture to share with fellow classmates. They might include a nutritional analysis of the food or write a short report on the relationship between the food and health in that culture.

12.3.3 Students, individually or in groups, prepare a set of questions about the safe handling and usage of pesticides and herbicides. They invite an appropriate speaker (e.g., grain elevator chemical representative, plant nursery worker, landscaper) to share information on the topic. They summarize what they learned by using a graphic organizer, writing a song, preparing a poster, or producing some other product that helps them use what they learned to deepen their understanding of the topic.

12.3.3 Students conduct an environmental study of their school, including the placement of air filter cartridges inside and outside the school. They collect and test samples of water taken from school sources and examine the school premises for a risk-free (i.e., safe and healthy) environment.

12.3.4 Students invite a local Public Health Nurse or Environmental Health Specialist to discuss licensing laws, safe food handling, etc. They summarize what they learned from the presentation by writing a journal entry or newspaper article, or by developing a concept web or other graphic organizer.

12.3.4 After students read articles or view videotapes on the topic of teen parenting, they write a persuasive letter to a fictitious character from the article or videotape, outlining several realities ,positive or negative, for that character to consider (e.g., child custody laws, child support).

12.3.4 Students create advertisements that inform about or discourage sexual harassment. They display the advertisements throughout the school building.

Standard 4: HEALTH – ENHANCING SKILLS

Students demonstrate the ability to use problem-solving, decision-making, communication, and goal-setting skills to enhance health.

Benchmarks

12.4.1 Know how use, misuse, and abuse of alcohol, tobacco, and other drugs can play a role in dangerous behavior and can have adverse consequences for the community.

12.4.2 Know how to set personal health goals and design a specific plan to enhance health for quality of life.

12.4.3 Know how to use a process in decision making as it relates to a healthy lifestyle.

12.4.4 Know how to apply a problem-solving process to enhance and/or protect health.

** Indicates word or phrase is defined in Glossary*

Examples of Specific Knowledge that Supports the Standard and Benchmarks

12.4.1 definition of use, misuse, abuse; drugs; consequences (e.g., domestic violence, house fires, motor vehicle crashes, date rape, transmission of diseases through needle sharing or sexual activity)

12.4.2 drug free, stress management, cholesterol levels, blood pressure, physical activity*, self-actualization, tolerance, empathy

12.4.3 knowledge, assessment, implementation, evaluation

12.4.4 comparisons of risks vs. benefits and outcomes

Examples of Activities that Support the Standard and Benchmarks

12.4.1 Students invite representatives of Mothers Against Drunk Driving (MADD), Students Against Drunk Driving (SADD), Alcoholics Anonymous (AA), Alanon, Crime Bureau, etc. to be members of a panel that will share information on the relationship between use of alcohol and other drugs and dangerous behavior and consequences for the community. Students should prepare questions beforehand and/or summarize information after the presentation by preparing a written report or visual representation.

12.4.2 Students conduct a personal health assessment that includes health behaviors. They identify at least one behavior to incorporate into a lifestyle behavior change and conduct research to identify healthy approaches to this change. The change can be implemented in an eight-week change project.

12.4.3 Students bring in a music selection and the accompanying lyrics, typed for distribution to other members of the class. Students listen to a few minutes of several songs and then respond to questions about the positive or negative lifestyles portrayed in the songs [e.g., Does this song promote a positive healthy lifestyle? Does this song promote moral decision making skills? What kind of health choices is it promoting in the dimensions of health (i.e., physical, intellectual, emotional, and spiritual*)?].

12.4.3 Each student is given a card with a scenario related to a health issue (e.g., wearing a seat belt, using alcohol, engaging in sexual activity, dieting) written on it. The students use the "Responsible Decision Making Model" (Meeks/Heit, 1994a) to address the situation.

12.4.4 Students, working in groups, are assigned a medical emergency. They problem solve the situation and develop a poster that demonstrates simple first aid procedures for that emergency.

Standard 5: BEHAVIORS AND RISKS

Students demonstrate the ability to practice health-enhancing behaviors and reduce health risks.

Benchmarks

12.5.1 Know the role of individual responsibility for enhancing health.

12.5.2 Know strategies to use for personal health enhancement.

12.5.3 Know possible causes of conflicts in schools, families, and communities and strategies to prevent conflict in these situations.

12.5.4 Know how refusal, negotiation, and collaboration skills can be used to avoid potentially harmful situations.

Examples of Specific Knowledge that Supports the Standard and Benchmarks

12.5.1 self-responsibility for dietary choices (e.g., fast food), label reading, activity choices, stress reduction, abstinence

12.5.2 self-discipline, commitment, perseverance, support

12.5.3 bullying, power plays or struggles, peer pressure, gangs

12.5.4 "Just say no", definition of negotiation and collaboration, negotiation and collaboration skills, open-mindedness

** Indicates word or phrase is defined in Glossary*

Examples of Activities that Support the Standard and Benchmarks

12.5.1 Students perform and evaluate a personal health assessment (e.g., Standardized Presidential/Cooper* for 1 mile run/walk, food diary, label reading, etc.).

12.5.2 Students analyze short- and long-term consequences of a high fat or a high sodium diet. They identify personal strategies they could use to reduce the risk of those consequences for their own health.

12.5.3 Students read or listen to a story about conflict, such as *Smoky Night* by Eve Bunting. They are then divided into three groups, schools, families, or communities, to discuss common conflicts, the causes of those conflicts, and strategies to prevent the conflicts. Each group reports back to the class, and the class brainstorms other possible solutions.

12.5.4 Students are given a conflict scenario and role play a peer mediation team using the "Model for Resistance Skills" to handle the conflict.

Standard 6: HEALTH – RELATED INFORMATION

Students demonstrate the ability to access and evaluate health-related information, products, and services.

Benchmarks

12.6.1 Know how to access health information, products, and services outside the community.

12.6.2 Know factors that influence personal selection of health care resources, products, and services.

12.6.3 Know how to evaluate resources from home, school, and the community that present health information, products, and services.

12.6.4 Understand the cost and accessibility of a variety of health care services.

12.6.5 Know situations that require professional health services in the areas of prevention, treatment, and rehabilitation.

12.6.6 Know local, state, federal, and private agencies that protect and/or inform the consumer.

Examples of Specific Knowledge that Supports the Standard and Benchmarks

12.6.1 access, yellow pages, Internet, Chamber of Commerce, public health

12.6.2 cost, benefits, resources, products, services, Consumer Guide, advice from health professionals

12.6.3 evaluate the validity and credibility of resources and information

12.6.4 health insurance coverage, deductibles, premium, care options

12.6.5 persistent depression, prenatal and perinatal care, treatment or management of disease, alcohol or drug-related problems, neglect and child abuse

12.6.6 Food and Drug Administration (FDA), Environmental Protection Agency (EPA), Occupational Safety and Health Administration (OSHA), local prosecutor's office

Examples of Activities that Support the Standard and Benchmarks

12.6.1 Students choose a community in another state and access the Internet to find credible information about medical care in that community.

12.6.2 Students perform a medical cost comparison including insurance cost and coverage.

12.6.3 Students compare and contrast services, education, and certification of various professional health care providers (e.g., M.D. and chiropractor, provider of herbal supplements and pharmacist).

12.6.4 Students invite a health insurance representative to class to discuss premiums, deductibles, care options, etc. After listening to the speaker, they work in groups to develop a poster of that highlights what consumers need to know about health insurance.

** Indicates word or phrase is defined in Glossary*

Examples of Activities that Support the Standard and Benchmarks

12.6.5 Students go on a field trip to a health care facility in the area. They prepare a graphic organizer (e.g., concept web) to summarize what they learned on the trip.

12.6.6 Students identify local agencies that protect and inform consumers. They contact at least three different agencies and obtain information about the services each agency provides and how the services can be accessed. They display the information they gather, using a graphic organizer or some other representation. [Note: Teachers may wish to designate one or more particular types of agencies (e.g., an agency that assists drug-dependent people who want to stop using drugs) the students have to contact.]

Standard 7: HEALTH ADVOCACY

Students demonstrate the ability to advocate for personal, family, and community health.*

Benchmarks

12.7.1 Know how to express information and opinions about health issues.

12.7.2 Know how individuals can improve or maintain community health.

12.7.3 Know how to influence and support others in making positive health choices.

12.7.4 Know how to work cooperatively when advocating for healthy communities.

Examples of Specific Knowledge that Supports the Standard and Benchmarks

12.7.1 expressing health issues through art, and written and oral communication

12.7.2 environmental and economic issues, development of policies and laws, exercising voting privileges

12.7.3 peer trainers, counseling

12.7.4 collaboration with community leaders

Examples of Activities that Support the Standard and Benchmarks

12.7.1 Students participate in a media activity day by dividing into teams and presenting information on a health issue through billboard, video, radio talk host, radio/TV public service announcement, etc.

12.7.2 Students role play a city council meeting where the topic of discussion is restriction of second hand smoking in public buildings in their community.

12.7.3 Students read a passage such as "Positively Negative" (Meeks/Heit, 1995) and discuss the facts in the passage. They write an adaptation of the material that contains at least ten statements beginning with I (e.g., "I will sit in nonsmoking sections of restaurants and avoid lung cancer."). Students read their adaptations to the class and comment on one another's statements and compare and contrast the numerous health benefits represented by the statements.

12.7.4 Students discuss risks associated with Halloween trick-or-treating (e.g., contaminated candy, crossing streets and negotiating steps while in costume) and develop guidelines for dealing with these and other potential dangers.

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Summary of Benchmarks By Standard

Standard 1: GROWTH AND DEVELOPMENT

Students understand the fundamental concepts of growth and development.

Grades K-4 Benchmarks

4.1.1 Know the cycle of growth and development in humans from infancy to older adult.
4.1.2 Understand how individuals differ in their rates of growth and development.
4.1.3 Know basic structure and functions of the human body systems.
4.1.4 Know the importance of intellectual, emotional, social, spiritual*, and physical health during childhood.

Grades 5-8 Benchmarks

8.1.1 Understand physical, intellectual, social, and emotional changes throughout the life cycle.
8.1.2 Understand the processes of conception, prenatal development, and birth.
8.1.3 Understand physical, intellectual, social, and emotional changes associated with puberty and adolescence.

Grades 9-12 Benchmarks

12.1.1 Understand the interrelationships of intellectual, emotional, social, spiritual*, and physical health throughout life.
12.1.2 Understand the interrelationships of family and individual health.
12.1.3 Understand physical, intellectual, social, and spiritual* changes that occur throughout life, and how these changes differ among individuals.
12.1.4 Understand how physical, intellectual, social, and cultural factors influence attitudes and behaviors regarding sexuality.
12.1.5 Understand the impact of personal health behaviors on the functioning of body systems.
12.1.6 Understand the importance of prenatal and perinatal care to both mother and child.

Standard 2: HEALTH PROMOTION AND DISEASE PREVENTION

Students understand concepts related to health promotion and disease prevention.

Grades K-4 Benchmarks

4.2.1 Understand relationships between personal health behaviors and individual well being.
4.2.2 Know how the family influences personal health.
4.2.3 Understand how childhood injuries and illnesses can be prevented or treated.
4.2.4 Understand the importance of personal hygiene.

Grades 5-8 Benchmarks

8.2.1 Know strategies for stress management.
8.2.2 Know the benefits of nutrition* and physical activity* as they relate to total wellness.
8.2.3 Know sources, symptoms, and treatment of diseases and other health problems.

Grades 9-12 Benchmarks

12.2.1 Understand how the body's systems function to prevent or combat disease.
12.2.2 Understand the importance of regular physical examinations in detecting and treating diseases early.
12.2.3 Know how to assess behaviors and their relationships to health promotion and disease prevention.
12.2.4 Understand the social, political, and economic effects of disease on individuals, families, and communities.

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Standard 3: ENVIRONMENTAL AND COMMUNITY HEALTH

Students understand the effects of environmental and external factors on personal, family, and community health.

Grades K-4 Benchmarks

4.3.1 Know how media influence thoughts, feelings, and health behaviors.
4.3.2 Know how elements of the environment affect personal health.
4.3.3 Know positive health behaviors, which contribute to a healthy environment.

Grades 5-8 Benchmarks

8.3.1 Know that family, community, culture, media, technology, and other factors have an impact on health practices.
8.3.2 Know how local, state, and federal efforts and policies on environmental issues impact health.
8.3.3 Know how the physical environment can affect personal health.

Grades 9-12 Benchmarks

12.3.1 Know how the community, media, and technology can influence the health of individuals.
12.3.2 Understand how cultural diversity enriches and challenges health behaviors.
12.3.3 Understand how the physical environment influences the health of the community.
12.3.4 Know how public health policies and government regulations impact health-related issues.

Standard 4: HEALTH – ENHANCING SKILLS

Students demonstrate the ability to use problem-solving, decision-making, communication, and goal-setting skills to enhance health.

Grades K-4 Benchmarks

4.4.1 Know steps in assessing risks and making responsible decisions.
4.4.2 Know how to set goals for a healthy lifestyle.
4.4.3 Know characteristics needed to be a responsible friend and family member.
4.4.4 Understand ways to communicate care, consideration, and respect of self and others.
4.4.5 Know communication and problem-solving skills to set personal boundaries, resolve conflicts, and develop positive relationships.

Grades 5-8 Benchmarks

8.4.1 Know appropriate social skills to build and maintain positive relationships.
8.4.2 Understand the process of goal setting and how it affects health choices.
8.4.3 Know strategies for coping with peer pressure.
8.4.4 Understand how health and learning are affected by nutrition*, physical activity*, drugs, and sex.

Grades 9 – 12 Benchmarks

12.4.1 Know how use, misuse, and abuse of alcohol, tobacco, and other drugs can play a role in dangerous behavior and can have adverse consequences for the community.
12.4.2 Know how to set personal health goals and design a specific plan to enhance health for quality of life.
12.4.3 Know how to use a process in decision making as it relates to a healthy lifestyle.
12.4.4 Know how to apply a problem-solving process to enhance and/or protect health.

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Standard 5: BEHAVIORS AND RISKS

Students demonstrate the ability to practice health-enhancing behaviors and reduce health risks.

Grades K – 4 Benchmarks

4.5.1 Understand the relationship between food choices and personal health.
4.5.2 Know how to distinguish behaviors that are safe from those that are risky or harmful.
4.5.3 Know responsible health behaviors and needs.
4.5.4 Know safety rules and practices used in home, school, and community settings.
4.5.5 Know ways to avoid and reduce threatening situations.

Grades 5-8 Benchmarks

8.5.1 Know strategies and skills that are used to attain personal health goals.
8.5.2 Know characteristics and conditions associated with positive self-esteem.
8.5.3 Know consequences of specific risk behaviors for one's self and others.
8.5.4 Understand precautions related to personal safety.
8.5.5 Know risks associated with harmful chemicals and drugs.

Grades 9-12 Benchmarks

12.5.1 Know the role of individual responsibility for enhancing health.
12.5.2 Know strategies to use for health enhancement.
12.5.3 Know possible causes of conflicts in schools, families, and communities and strategies to prevent conflict in these situations.
12.5.4 Know how refusal, negotiation, and collaboration skills can be used to avoid potentially harmful situations.

Standard 6: HEALTH – RELATED INFORMATION

Students demonstrate the ability to access and evaluate health-related information, products, and services.

Grades K-4 Benchmarks

4.6.1 Know community health service providers and their roles.
4.6.2 Know how to locate resources from home, school, and community that provide valid health information.

Grades 5-8 Benchmarks

8.6.1 Know how to locate and use community resources and services that provide valid health information.
8.6.2 Know situations that require professional health services.
8.6.3 Know the validity and cost of common health information, products, and services.

Grades 9 – 12 Benchmarks

12.6.1 Know how to access health information, products, and services outside the community.
12.6.2 Know factors that influence personal selection of health care resources, products, and services.
12.6.3 Know how to evaluate resources from home, school, and the community that present health information, products, and services.
12.6.4 Understand the cost and accessibility of a variety of health care services.
12.6.5 Know situations that require professional health services in the areas of prevention, treatment, and rehabilitation.
12.6.6 Know local, state, federal, and private agencies that protect and/or inform the consumer.

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Standard 7: HEALTH ADVOCACY

Students demonstrate the ability to advocate for personal, family, and community health.*

Grades K-4 Benchmarks

4.7.1 Know various ways to convey accurate health information and ideas to individuals and groups.
4.7.2 Know methods for assisting others in making positive health choices.

Grades 5 – 8 Benchmarks

8.7.1 Know how to distinguish between myths and facts related to health issues.
8.7.2 Know various communication methods to accurately express health information.
8.7.3 Understand how to influence and support others in making positive health choices.

Grades 9 – 12 Benchmarks

12.7.1 Know how to express information and opinions about health issues.
12.7.2 Know how individuals can improve or maintain community health.
12.7.3 Know how to influence and support others in making positive health choices.
12.7.4 Know how to work cooperatively when advocating for healthy communities.

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Resources

- **Consumer Protection Agency**
  (see Government pages of local phone book)

- **County Extension Offices**
  (see Government pages of local phone book)

- **County Social Services**
  (see Government pages of local phone book under "County - Social Services)

- **Environmental Health Practitioner**
  (Check the yellow pages of the local phone book under "public health" or "government" or call information at 1-411.)

- **Get Real About AIDS**
  Comprehensive Health Education Foundation
  22323 Pacific Highway South
  Seattle, WA 98198
  206-824-2907

- **Health Care Providers**
  (see yellow pages of local phone book under the following headings:
  - Audiologists
  - Chiropractors
  - Health Clubs
  - Health Fitness and Nutrition Consultants
  - Home Health Services
  - Mental Health Services
  - Occupational Therapy
  - Optometrists
  - Physical Therapists
  - Physicians

- **Know Your Body Program**
  Kendall/Hunt Publishing Company
  4050 Westmark Drive
  P.O. Box 1840
  Dubuque, IA 52004-0810
  1-800-228-0810

- **Life Skills Training**
  Princeton Health Press
  115 Wall Street
  Princeton, NJ 08540
  1-800-636-3415

- **Local and State Health Departments**
  - **Local Health Department**
    (check yellow pages under "public health or government," or call Information 1-411 and request the specific city or county public health, or call the ND Department of Health)

  - **North Dakota Department of Health**
    600 E. Boulevard Avenue, Dept. 301
    Bismarck, ND 58505-0200
    (701) 328-2372

  - **North Dakota Department of Health**
    Division of Health Promotion and Education
    Resource Library
    600 E. Boulevard Avenue, Dept. 301
    Bismarck, ND 58505-0200
    (701) 328-2368

- **Mid-continent Regional Educational Laboratory (McREL)**
  2550 S. Parker Rd., Suite 500
  Aurora, CO 80014
  (303) 337-0990
  Fax (303) 337-3005

- **North Dakota Caring Foundation, Inc.**
  4510 13th Avenue, Southwest
  Fargo, ND 58121-0001

- **North Dakota College and University Nursing Education Administrators**
  - **Dickinson State University**
    Department of Nursing
    291 Campus Drive
    Dickinson, ND 58601
    (701) 227-2133
    Fax (701) 227-2006

  - **Fort Berthold Community College**
    AASPN Program
    Box 490
    New Town, ND 58763
    (701) 627-4738
    Fax (701) 627-3609

  - **Jamestown College**
    Department of Nursing
    6010 College Lane
    Jamestown, ND 58405
    (701) 252-3467, ext.2497
    Fax (701) 253-4318

  - **Medcenter One College of Nursing**
    512 North Seventh Street
    Bismarck, ND 58501
    (701) 323-6271
    Fax (701) 323-6967

  - **Minot State University**
    College of Nursing
    500 University Avenue West
    Minot, ND 58701
    (701) 857-3101
    Fax (701) 839-6933

  - **North Dakota State College of Science**
    Department of Nursing
    800 Sixth Street North
    Wahpeton, ND 58075
    (701) 671-2967
    Fax (701) 671-3609

North Dakota College and University Nursing Education Administrators

- **North Dakota State University**
  Tri-College Nursing Consortium
  136 Sudro Hall
  Fargo, ND 58105
  (701) 231-7772
  Fax (701) 231-7606

- **University of Mary**
  Division of Nursing
  7500 University Drive
  Bismarck, ND 58504
  (701) 255-7500
  Fax (701) 255-7687

- **University of North Dakota - Williston**
  Practical Nursing Program
  Box 1326
  Williston, ND 58801
  (701) 774-4290
  Fax (701) 774-4275

- **United Tribes Technical College**
  AASPN Program
  3315 University Drive
  Bismarck, ND 58504
  (701) 255-3285, ext. 265
  Fax (701) 255-1844

- **University of North Dakota**
  College of Nursing
  P.O. Box 9025
  Grand Forks, ND 58202-9025
  (701) 777-4555
  Fax (701) 777-4096

North Dakota Prevention Resource Center (curriculum kits)

600 2nd Street, #1E
Bismarck, ND 58504
701-328-8919

North Dakota Teacher Center Network

- **Bismarck-Mandan Teacher Center**
  1107 Airport Rd.
  Bismarck, ND 58504-6712
  (701) 221-3420
  Fax (701) 221-3711

- **West River Teacher Center**
  Dickinson State University
  1679 6th Avenue W.
  Dickinson, ND 58601-2904
  (701) 483-2129
  Fax (701) 483-2028

- **Grand Forks Area Teacher Center**
  Box 7189,UND Station
  Grand Forks, ND 58202-7189
  (701) 777-4394
  Fax (701) 777-4393

- **Devils Lake Area Teacher Center**
  406 4 Avenue
  Devils Lake, ND 58301-2418
  (701) 662-6793
  Fax (701) 662-7684

- **Fargo, West Fargo, Moorhead Area Teacher Center**
  1725 N Broadway
  Fargo, ND 58102-9243
  (701) 446-5441
  Fax (701) 446-5499

- **Mayville Area Teacher Center**
  330 3rd St. NE
  Mayville, ND 58257-1299
  (701) 786-4796
  Fax (701) 786-4890

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- **North Dakota Teacher Center Network**
  - **Minot Area Teacher Center**
    1609 4th Avenue NW
    Minot, ND 58703-2911
    (701) 857-4488 or 857-4467
    Fax (701) 857-4489

  - **Wahpeton Area Teacher Center**
    NDSCS
    800 6th St. N
    Wahpeton, ND 58076-0002
    (701) 671-2242
    Fax (701) 671-2145

  - **Valley City Area Teacher Center**
    101 College St. SW
    Valley City, ND 58072-4098
    (701) 845-7221
    Fax (701) 845-0002

  - **Williston Area Teacher Center**
    UND-W
    P.O. Box 1326
    Williston, ND 58802-1326
    (701) 774-4270
    Fax (701) 774-4275

- **Regional Human Service Centers**
  (under U.S. Government, Health and Human Services Section in phone book)
  ISAD Health Services Corporation, Home/Health/Hospice (515) 246-0126
  Medicare Claims 1-800-247-2267

- **Social Security Administration Office** (state office)
  1025 N. 3 Street
  Bismarck, ND 58501
  (701) 222-1833 or 1-800-772-1213

- **Social Security Administration** (federal office)
  900 Altmeir Building
  6401 Security Blvd.
  Baltimore, MD 21235

Glossary

Abstinence - Not engaging in a particular behavior.

Advocate - To speak or write in support of something.

Dysfunctional eating - Includes irregular or chaotic eating, consistent undereating, and consistent overeating of more than the body wants or needs. It exists on a continuum between normal eating and eating disorders, and may be of mild, moderate, or severe intensity.

Eating disorders - Refers to anorexia nervosa, bulimia nervosa, and binge eating.

Health care - Care pertaining to health or care provided by a health care professional, including medical doctors as well as others.

Health triangle – A balanced sense of well being that includes physical, mental, and social.

Holistic - Relating to or concerned with wholes or with complete systems rather than analysis of, treatment, or dissection into parts. Holistic health views health in terms of physical, emotional, social, intellectual, and spiritual components.

Infomercial – A television or radio program that gives information as it tries to sell a product.

Medical care - Care pertaining to medicine or care provided by a medical doctor.

Physical activity - Any bodily movement produced by skeletal muscles that results in energy expenditure (i.e., something one does).

Physical fitness - A set of attributes that people have or achieve that relates to the ability to perform physical activity; something one acquires, a characteristic or an attribute one can achieve by being physically active.

Primary prevention - Actions designed to prevent disease from occurring, includes health promotion activities.

Secondary prevention - Early diagnosis and prompt treatment, includes activities such as screening for diseases (e.g., vision, hearing, etc.).

Sexually transmitted infections (STIs) – more commonly referred to as sexually transmitted diseases which are diseases that can be transmitted through various forms of sexual contact. HIV is an example of a disease that is transmitted primarily through sexual intercourse.

Spiritual - Pertaining to a person's beliefs that promote a positive attitude and caring concern for others.

Standardized Presidential/Cooper – types of fitness assessments. The Standardized Presidential is a fitness assessment given under specified conditions and based on guidelines set by the President's Council on Physical Fitness and Sports. The Cooper assessment was developed by the Cooper Clinic, a cardiovascular fitness aerobic research and testing center located in Dallas, Texas. Results of their 1989 study on mortality/fitness indicated that the higher the level of physical fitness the lower the all-cause mortality rate. This result is most likely due to lowered rates of cardiovascular disease and cancer.

Tertiary prevention - Treatment, care, and rehabilitation of people to prevent further progression of a disease.

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