Approved: 3/30/94
Date

MINUTES OF THE SENATE COMMITTEE ON EDUCATION

The meeting was called to order by Chairperson Dave Kerr at 1:00 p.m. on March 21, 1994 in Room 123-S of the Capitol.

All members were present.

Committee staff present: Ben Barrett, Legislative Research Department
Carolyn Rampey, Legislative Research Department
Avis Swartzman, Revisor of Statutes
LaVonne Mumert, Committee Secretary

Conferees appearing before the committee:
Senator Todd Tiahrt
Paul Callaway, MD, Wichita
Tom Kettler, MD, Overland Park
Carl Christman, MD, Wichita
George Moore, Wichita
Donna Logan, MD, Wichita
Cleta Renyer, Right to Life of Kansas, Inc.
Connie Hubbell, State Board of Education
Lois Culver, Planned Parenthood of Greater Kansas City
Barbara Holzmark, National Council of Jewish Women and Governor's Commission on Education for Parenthood
Cathy Breidenthal, YWCA of Kansas City
Douglas Johnston, Planned Parenthood of Kansas, Inc.

Others attending: See attached list

The Committee was provided with a copy of a letter from the Rockwell Administration Center urging that SB 556, which contains supplemental funding of $75,000 for a low enrollment weighting study, be opposed (Attachment No. 1). The Committee also received a letter from the Kansas Department of Transportation regarding the number of injuries and/or deaths in school buses in response to the Committee's request during the hearing on SB 558 (Attachment No. 2).

HCR 5016 - Constitutional amendment, state board of education

Chairman Kerr brought up the bill for discussion and possible action. He noted that a hearing was held on the bill during the 1993 session and, during the 1994 session, Representative Jennison had presented a suggested amendment to the resolution. No motion was made concerning the resolution.

SCR 1629 - Requesting the state board of education to draft regulations regarding instruction on human sexuality and AIDS

Senator Tiahrt testified in support of the resolution (Attachment No. 3). He said the resolution is designed to stress that abstinence is the only 100% effective way of avoiding unwanted pregnancies, sexually transmitted diseases (STDs) and AIDS; present failure rates of condoms and provide information on other means of preventing pregnancy and STDs.

Paul Callaway, MD, Wichita, testified in favor of the resolution and presented graphs showing the incidence of STDs in the United States and Kansas (Attachment No. 4). He discussed STDs and their effects. Dr. Callaway talked about condoms and their failure as a contraceptive and as a preventative for STD and AIDS/HIV. He said that the focus should be on risk elimination.

Tom Kettler, MD, Overland Park, testified in support of SCR 1629 (Attachment No. 5). He said he does not believe the present sex education system is effective in preventing teen pregnancies, STD rates and AIDS cases. He said his support of abstinence-based sex education is based on medical information.

Carl Christman, MD, Wichita, spoke in favor of the resolution. He talked about teen pregnancies and the incidence of STDs, some of which are untreatable and possibly fatal. He said that young people respond to what is expected of them, so it is important not to send a message of expected sexual activity.

George Moore, Wichita, testified in favor of the resolution (Attachment No. 6). He said he is a high school counselor and described the problems of teenage pregnancies. He stressed that teenagers should be given a strong message concerning abstinence by media, parents and schools.

Donna Logan, MD, Wichita, spoke in support of SCR 1629 (Attachment No. 7). She talked about some of her young patients and said they are not getting a message that abstinence is healthy and normal.

Cleta Renyer, Right to Life of Kansas, Inc., testified in favor of the resolution (Attachment No. 8). She said the resolution has the potential to help lower the spread of STDs and the number of teen pregnancies.

Connie Hubbell, State Board of Education, provided a copy of the Board's Rules and Regulations on Human Sexuality/AIDS Education (Attachment No. 9). Ms. Hubbell said that she knows of no school district that does not use a strong abstinence based curriculum. She noted that there are procedures for parents or guardians to request that their child be excused from any or all portions of the program. Ms. Hubbell stated that the program allows for strong local control and that the material in SCR 1629 is already being promoted.

Lois Culver, Planned Parenthood of Greater Kansas City, testified in opposition to the resolution (Attachment No. 10). She said the current State Board of Education guidelines on human sexuality and AIDS are excellent and should be left in place.

Barbara Holzmark, National Council of Jewish Women and Kansas Governor's Commission on Education for Parenthood, testified in opposition to SCR 1629 (Attachment No. 11). She said that local districts should continue to determine their own curriculum.

Cathy Breidenthal, YWCA of Kansas City, testified in opposition to the resolution (Attachment No. 12). She said that school districts have a mandate to provide inclusive factual information and serve the majority of students.

Douglas Johnston, Planned Parenthood of Kansas, Inc., testified in opposition to the resolution and provided written testimony from Marian Shapiro, Planned Parenthood of Kansas, Inc., and Debra Haffner, SIECUS (Attachment No. 13).

The Committee also received testimony in opposition to the resolution from Carla Dugger, American Civil Liberties Union (Attachment No. 14).

Chairman Kerr announced that the hearing would be concluded at the March 22 meeting of the Committee.

Senator Oleen made a motion that the minutes of the March 14, 15 and 16, 1994, meetings be approved. Senator Frahm seconded the motion, and the motion carried.

The meeting was adjourned at 2:30 p.m. The next meeting is scheduled for March 22, 1994.

SENATE EDUCATION COMMITTEE

TIME: 1:00 PLACE: 123-S DATE: 3/21/94

GUEST LIST

NAME	ADDRESS	ORGANIZATION
Susan Chase	Topeka	KNEA
Lu Echo	"	4th Enrollment USDs
Mark Tallman	"	KASB
Darlene Stearns	Topeka	RCAK
Doug Johnston	Dickinson	Planned Parenthood
Barbara Hakmark	Leawood	KS. Gov. Commission on Educ for Parenthood Nat'l Council of Jewish Women
Sharon Lockhart	Leawood	Oldest Women's League
Lora Cabral	Overland Park	Planned Parenthood of Greater Kans. City
Cathie Breidenthal	KCKS	KNEA
Erika Tor	Kansas City	Planned Parenthood of GKC
Kelley Kultala	KCKS	Spectator
Jennifer Brandeberry	KC	PTA
Marian Jansen	Topeka	Intern
Sheila Arndt	Missionks	Washburn UW.U
Lisa Burton	Topeka	Washburn University
Helen Stephens	✓	BV USD 229
Sharon Iseden	Topeka	ICSBE
Janet Wilson	Topeka	KSBE
Al Woodsiden	Topeka	Washburn University
Sue Ledbetter	Wichita	NOW
Karen A. Fosson	Overland Park	Shawnee Mission Schools
Connie Hubbell	Topeka	State Board of Education
Kathleen White	Prairie Village	State Bd. of Educ.
Denise Apt	Topeka	KSA

SENATE EDUCATION COMMITTEE

TIME:_____ PLACE:_____ DATE:_____

GUEST LIST

NAME	ADDRESS	ORGANIZATION
[illegible]	Topeka	SDE
Diane Gjerstad	Wichita	USD 259
Tom Ketter	OP KS	Private Physician
DON STEGEMAN	PV KS	SPECTATOR
RUSS FREY	Topeka	KUMA
Scott Bahr	LeRoy	Girl Scout
MARCI BRAY	INDEPENDENCE	CADETTE SCOUT
Elizabeth Gray	Independence	Scout (Adult)
CARL MATHEWS	LAWRENCE	
Jennifer Mathews	Lawrence	Lawrence High School
GERALD HENDERSON	TOPEKA	USA of KS
Karen Kinney	Topeka	~~AHB~~
George Mahr	Wichita	—
David Payne	Wichita	Kansas Family Research Inst.

Growing Together
USD 489

MAR 11

Rockwell Administration Center
Unified School District No. 489
323 West 12th Street
Hays, Kansas 67601-3893
TEL (913) 623-2400
FAX (913) 623-2409

March 9, 1994

Delbert Gross
House of Representatives
State Capitol Building
300 SW 10th Avenue
Topeka, KS 66612-1504

Dear Delbert:

There are currently several Senate bills in House committees which we would like to call to your attention in hopes that our comments will encourage you to vote, and encourage your fellow representatives to support or oppose, our positions as listed below:

Please SUPPORT:

SB 785 - Increase in "inservice education" grants for our teachers to adjust to changes in the academic and school outcomes, particularly in light of the legislative support of the QPA/outcomes based process of education reform

SB 574 - Add "improvement in student academic performance" to the list of criteria in state statute on teacher and administrator evaluations. Because of tenure laws for teachers it is often very difficult to dismiss teachers for merely being mediocre or for having reached the "peter principle" in their careers. Language requiring a measurable improvement in an assessment of their efforts would be most beneficial to administrators, boards and ultimately to children.

Please OPPOSE:

SB 556 - Supplemental funds of $75,000 to study low enrollment weighting. We are currently in the process of completing such a study through our lawsuit efforts and have employed national experts. A study by the state will only delay a decision in this area and would not add substantially to the findings are our experts. Our children in

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Attachment 1

USD 489 have waited long enough for equitable funding of their education. There would be $221 million to redistribute statewide without LEW; 312 LEW would provide an additional $420/student statewide, 500 LEW an additional $300/student statewide. This is merely a delaying tactic on the part of some who want to postpone implementing Judge Luckert's decision.

HB 3029 - House Education hearing - This measure uses a state average for weighting of special education students. The weighting based on averages will reward districts with lower than average prevalency and financially burden districts with higher than average prevalency; it doesn't take into account private and parochial students who must be served; it does not provide for accountability to the needs of individual students as per Judge Bullock's ruling in the landmark financial aid case.

Thank you for your consideration. If you have questions, please do not hesitate to contact Fred Kaufman or one of the Board members.

Sincerely,

KSpicer

Kathy Spicer
Board of Education

pc: Dave Kerr, Chrm. Senate Education Committee
Duane Goosen, Chrm. House Education Committee
Doug Walker, Senate Education Committee
Tim Emmert, Special Education Task Force

STATE OF KANSAS

KANSAS DEPARTMENT OF TRANSPORTATION
Docking State Office Building
Topeka 66612-1568
(913) 296-3566
FAX - (913) 296-1095

Michael L. Johnston
Secretary of Transportation

Joan Finney
Governor of Kansas

March 15, 1994

Senator Dave Kerr, Chairman
Senate Education Committee
Rm. 120-S
State Capitol
Topeka, Kansas 66612

Dear Senator Kerr:

This is in response to your question regarding the comparison of injury and/or deaths between the already seat belt fitted Type "A" school bus and the not fitted Type "D" school bus.

According to Larry Bluthardt, Director of Pupil Transportation, the National Center for Statistics and Analysis in Washington, D.C. does not provide information on school bus traffic accidents broken down into Type I, II, or A,B,C and D buses. According to Grace Hazzard, N.C.S.A., this information is not available because law enforcement agency reports do not require this information.

Suzanne Stack, National Highway Traffic Safety Administration, believes bus types are not comparable. She faxed KDOT a copy of a report for the National Transportation Safety Board titled "Crashworthiness of Small Poststandard School Buses". The report states,

> ...the disparate size and mass of a small school bus compared with a large school bus means that findings about the advantages or disadvantages of passenger lapbelts on large school buses have little relevance to whether or not passenger lapbelts are needed on small school buses. For similar reasons, studies of the crash performance of lapbelts in the rear seat of a passenger car are not necessarily applicable to lapbelts in a small school bus. The differences in size and interior features between a passenger car and school bus are too great.

Robert L. Barlett, Investigator-in-Charge with the National Transportation Safety Board, sent us two safety study publications that support the premise that this information is unavailable. Those studies, "Crashworthiness of Small Poststandard School Buses", and "Crashworthiness of Large Poststandard School Buses" are available for review.

Finally, the information in the fax transmittal from Collins Industries, Inc. to you dated March 7, 1994, on Senate Bill No.558, only dealt with the fatalities within the school bus loading and unloading zone and was not a comparison of seat belts between Type A and Type D school buses.

Sincerely,

Robert Haley

Robert Haley
Division of Administration

cc: Nancy Bogina, Exec. Assist. to the Secretary
Bill Watts, Chief of Management and Budget

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Attachment 2

STATE OF KANSAS

TODD TIAHRT
SENATOR, 26TH DISTRICT
1329 AMITY
GODDARD, KS 67052
316-794-8903
STATE CAPITOL 143-N
TOPEKA, KANSAS 66612-1504
913-296-7367

TOPEKA

SENATE CHAMBER

COMMITTEE ASSIGNMENTS
VICE CHAIRMAN: ASSESSMENT & TAXATION
VICE CHAIRMAN: JOINT COMMITTEE ON COMPUTERS & TELECOMMUNICATIONS
MEMBER: EDUCATION
TRANSPORTATION & UTILITIES
JOINT COMMITTEE ON LEGISLATIVE POST AUDIT

TESTIMONY FOR SCR 1629

Thank you Chairman Kerr for allowing me to present this Senate Concurrent Resolution.

You might find it odd that I would quote the current Surgeon General Joycelyn Elders but I found an article in the America's Agenda, Winter 1994 edition.

> "Teenage pregnancy is the root cause of poverty... If we could reduce the problem of children having children it would markedly reduce the number of people who end up on welfare...we have not taught them to say no when they are in the heat of passion. They need to have made that decision already".

From the material I have reviewed, this state we does not present all the information relating to sex education. Unless it is initiated by the instructor, our material never tells kids they can say "no". We merely present them the options for birth control, excluding the most effective means available, abstinence. We are also falling short by not presenting the truth of how ineffective are some means of birth control.

SCR 1629 does stress that abstinence is the only 100% effective way of avoiding sexually transmitted diseases and AIDS. It requires that pupils will be provided with statistics based on the most recent medical information citing the failure rates of condoms in preventing AIDS and other sexually transmitted diseases. It talks about the dangers of drug abuse especially involving the use of hypodermic needles. It talks about the financial obligations of children born in and out of wedlock. It talks about what's lawful and unlawful, concerning sexual acts with another person and it emphasizes the power to control personal behavior.

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Attachment 3

This is not an abstinence only methodology. It presents the use of condoms and other means of preventing pregnancy and sexually transmitted diseases. This is a common sense approach to sexual education. It explores all options and tells the truth about the transmittal of AIDS, failure rates of various forms of birth control and satisfies at least one of the recommendations of Surgeon General Elders concerns, "to say no when they are in the heat of passion". I urge this committee to give it strong consideration.

Sincerely,

Todd Tiahrt
State Senator

Testimony before the Senate Education Committee
on SCR 1629

By: Paul Callaway MD
7217 Oxford
Wichita, KS 67226

I am Dr. Paul Callaway, a family physician from Wichita, KS. After ten years of private practice in southern Oklahoma, I am now in full time academic medicine as the Associate Director of a family medicine residency program. While in private practice I supervised maternity care at the county health department, in addition to providing obstetrical and gynecological care for my own patients. My special interest lie in the evaluation and treatment of patients with Human Papilloma Virus infection, an epidemic sexually transmitted disease. I regularly lecture to both residents and medical students regarding sexually transmitted diseases, and I am director of a cervical dysplasia clinic at the residency. This clinic provides evaluation and treatment of abnormal PAP smears for women who cannot afford care elsewhere. My experiences have stimulated an interest in the programs for primary prevention of Sexually Transmitted Diseases (STD's).

We all agree that our current prevention programs are not adequate. CDC data reveal 12 million newly diagnosed cases of STD's annually with 63% occurring in persons younger than 25 years of age. In the 1960's gonorrhea and syphilis were the only commonly occurring STD's. Despite both diseases being easily treated with injectable antibiotics; sterility, miscarriages, neurological disease and even deaths occurred from complications or delayed diagnosis and treatment. There are now approximately 20 different kinds of STD's, many of which are viral and INCURABLE. The symptoms and consequences of these viral STD's (including Herpes, HPV *human papilloma virus*, and HIV) can range from minor nuisances such as *genital sores and warts, and possible Cesarean delivery*, to severe and lethal, including *congenital Herpes with severe neurologic impairment or death; cervical and external genital cancer; or AIDS and ultimate death.* A review of the medical literature, the CDC data, or just a visit to any local health department's STD clinic will verify that we have a serious problem, both at home in Kansas, and across our entire nation.

Current wisdom has supported the use of condoms as our primary defense against this increase in sexually transmitted disease. Clearly there are times when condom recommendation is the most prudent choice. However as we analyze sex education curriculum within the schools, it is mandatory that the risks are clearly identified, including the deficiencies of condom use.

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Attachment 4

As a **contraceptive**, the condom is less than perfect. In a study published in *OB/GYN DIAGNOSIS*, Dr. Sondheimer of the University of Pennsylvania School of Medicine Family Planning Clinic reported a 25% pregnancy rate during the first year of condom use. These couples were motivated to use the condom as a primary form of birth control, yet all of them admitted that, on at least one occasion, they did not use the condom. The American College of Obstetricians and Gynecologists in a March 1991 newsletter referred to the condom as an "antiquated system of birth control."

In the area of **STD prevention**, the condom also clearly has weaknesses. A study from Rutgers University, published in *Medical Aspects of Human Sexuality* by Dr. Samuels showed infection rates for students with Chlamydia were the same for those who used condoms as for those who used no barrier contraceptives at all. A study by Bauer, et al, published in *JAMA* 1991 revealed 46% of women presenting to a university health service for a routine annual gynecological examination were infected with HPV (Human Papilloma Virus). This study revealed the presence of this virus not only internally on the cervix, but also on the external genital area. Considering the area of genital contact that the condom "covers", it is clear that the condom will not be effective in HPV prevention. This concept is further supported by the works of recognized experts in the field of HPV research (references listed). HPV infection has been shown to be the cause of cervical dysplasia (cervical intraepithelial neoplasia), a pre malignant condition which can lead to cervical cancer.

Finally, we should consider the effectiveness of a condom in **AIDS/HIV prevention.** Although the CDC reports that latex condoms substantially reduce the risk for HIV transmission, a review of the meta-analysis show that condoms only reduced HIV transmission by 69%. The *Medical Institute for Sexual Health,* Dec. 1993 Update states, "The CDC may consider 69% 'substantial', but the resultant 31% failure rate in prevention means many HIV infections, all resulting in premature death."

If we disregard this data, and accept that condoms *should* prevent STD's, we must examine why the incidence of STD occurrence is continuing to rise. Condoms are relatively cheap, available and rather simple to use. Sports heroes and well known rock musicians endorse the regular use of condoms. But despite being bombarded with information, adolescents believe they are invincible, AND they don't **like** to use them. When condoms are removed, the potential for exposure to infectious secretions presents an additional risk to condom users. A study published in *Family Planning Perspectives*, Jan. 1992, showed a 7.9% breakage rate, and 7.2% that "slip off." When we consider that a 15 to 30% failure rate for condoms as a

contraceptive is accepted, and when we consider that a woman can become pregnant only 3 to 4 days a month whereas STD's can be transmitted 31 days a month, the failure of a condom as prevention of STD's should not surprise us.

The bottom line on the recommendation of condoms in the "information based" sex education curriculum, is the reasoning that they must be **better than nothing**. There is however, a serious flaw in the SAFE SEX (and even the newer term SAFER SEX) logic. While giving a perception of safety, the individual is placing themselves at high risk for STD's. Since many of these diseases are asymptomatic in the early stages, the disease is further spread during "safe sex." Instead of being *better than nothing*, behavior is endorsed that has lifelong effects. The individual who contracts an incurable STD as the result of a condom failure will truly have a right to feel betrayed by the SAFE SEX agenda. The cost may be just personal embarrassment, or it may cost their life, depending on which STD they encounter. It will cost the tax payer also. CDC director Dr. William Roper recently outlined the Sexually Transmitted Diseases Accelerated Prevention Campaign which had a $92 million price tag.

The solution, in my opinion, is to begin to focus on **risk elimination** instead of **risk reduction.** Promotion of abstinence based curriculum informs the students of the only 100% effective way to prevent STD's. The students are truly empowered to accept healthy life styles while understanding that sex is normal, important, healthy, and fun in the context of a lifelong monogamous relationship. Although adolescents behavior are influenced by their hormones, they are not merely "animals in heat" who cannot be held responsible for their behavior. Just as they can be taught the dangers of tobacco, drugs, and alcohol, and change their behavior accordingly, they can be taught the necessity of abstinence, and change their behavior accordingly. I hope these comments help you favorably consider the passage RESOLUTION NO. 1629. Thank you for your attention.

Reference List
listed in order of use within the document

S. Sondheimer, *OB/GYN DIAGNOSIS*, vol. 6, no. 3, pg 7, 1987, from Family Planning Clinic: University of Pennsylvania School of Medicine, Philadelphia, Pennsylvania

American College of Obstetrics and Gynecology, *NEWSLETTER*, March 1991

S. Samuels, *MEDICAL ASPECTS OF HUMAN SEXUALITY*, Dec. 1989, pg. 16

Bauer, et al, *JAMA*, Jan. 23/30, 1991, Vol. 265, No. 4

K. Noller, *OB/GYN CLINICAL ALERT*, Sept. 1992

R. Reid, *American College of Obstetricians and Gynecologist Newsletter,* August 1989

M. Campion, *OB/GYN News,* Vol. 26, No. 12, 1991

M. Greenberg, *OB/GYN News*, August, 1993

Medical Institute for Sexual Health UPDATE Dec. 1993

J. Trussel, et al, *Family Planning Perspectives*, Jan. 1992

United States

Year	Gonorrhea	Syphilis	HIV	Chlamydia*
1988	719536	40117	30719	
1989	733151	44540	33595	
1990	690169	50223	41653	
1991	607472	41006	43701	
1992	485765	33200	45472	
1993	392192	25875	93282	
% Change:	-45.49%	-35.50%	303.66%	

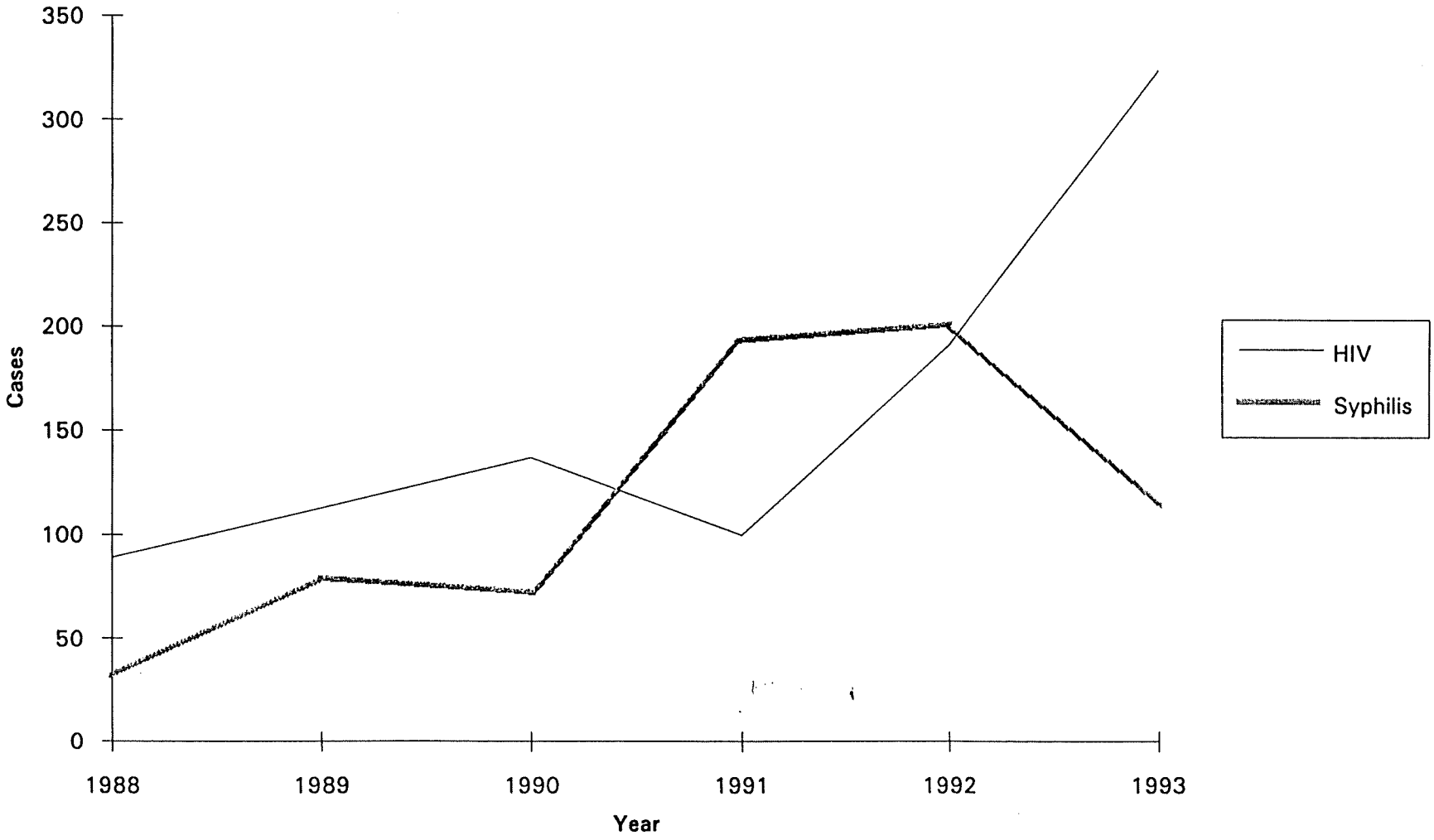
* Chlamydia statistics not reported by many states

Kansas

Year	Gonorrhea	Syphilis	HIV	Chlamydia
1988	4427	32	89	3701
1989	5268	79	113	4091
1990	4846	72	137	5605
1991	4527	193	100	6786
1992	4716	201	191	7024
1993	3669	114	324	5694
% Change:	-17.12%	356.25%	364.04%	53.85%

NOTE: HPV Statistics not compiled by CDC or KDHE.
NOTE: Case definition for HIV expanded by CDC for 1993.

Kansas HIV and Syphilis, 1988-93

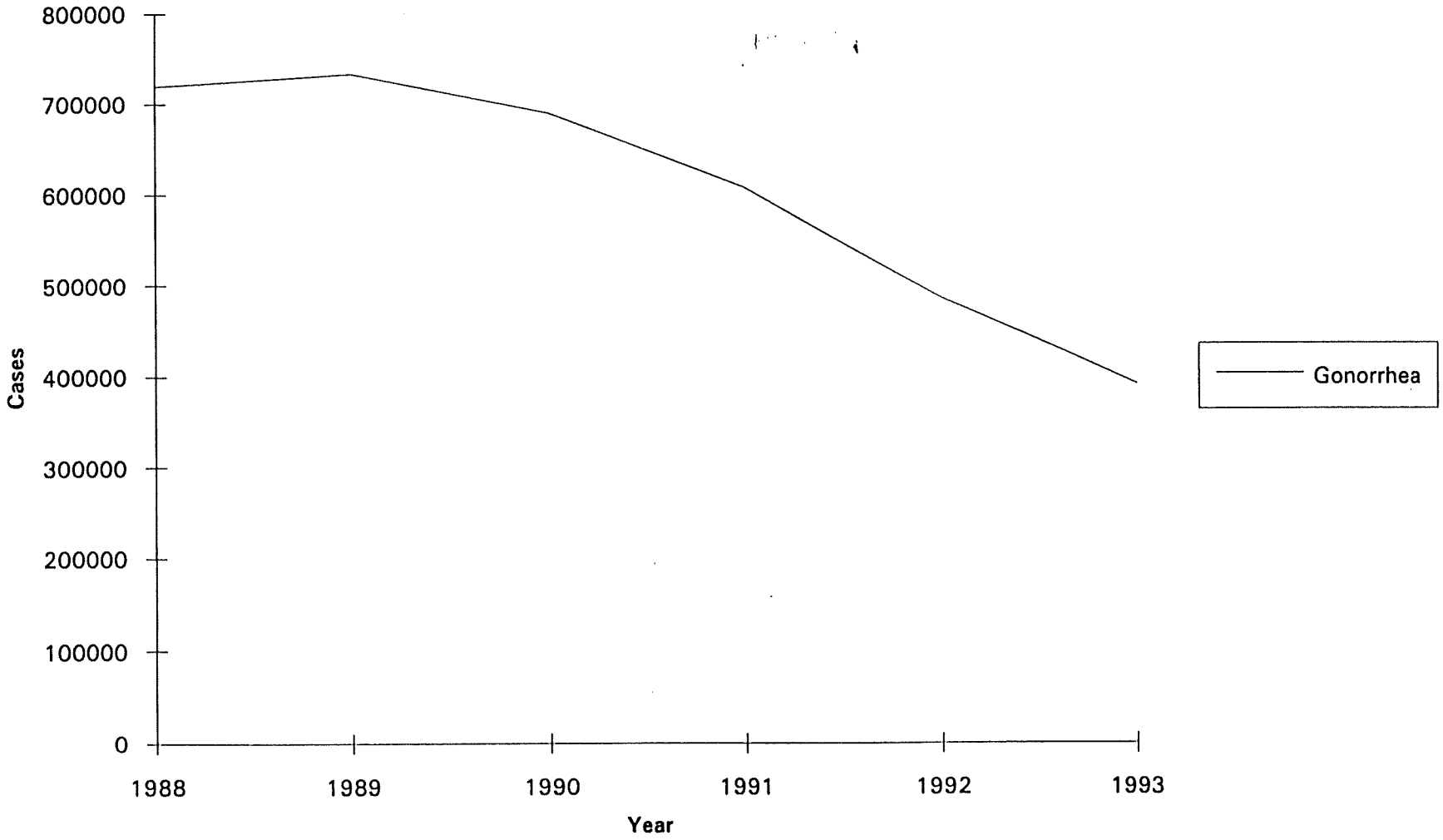


Source: CDC Morbidity and Mortality Weekly Reports

Kansas Gonorrhea and Chlamydia, 1988-93

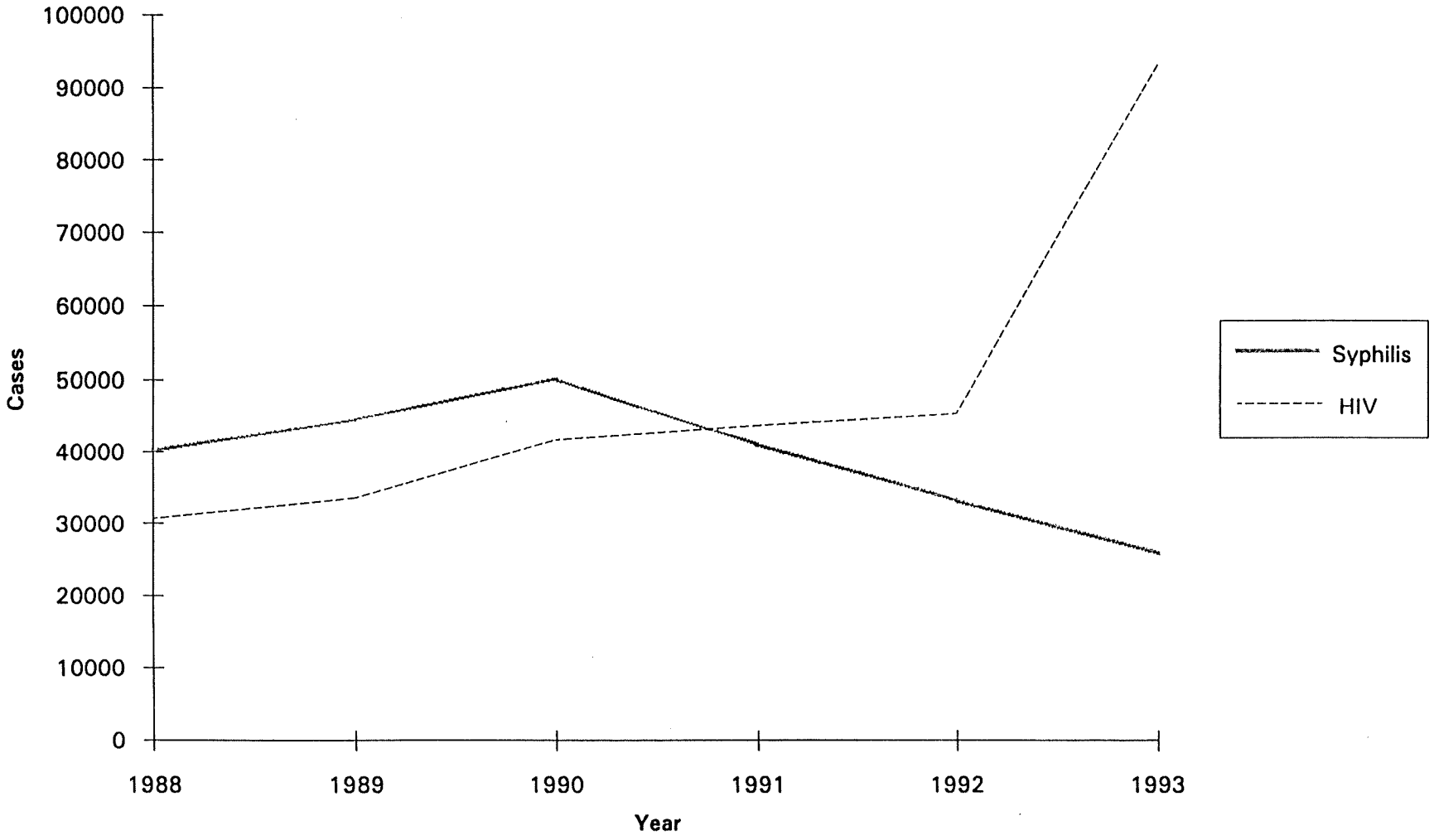
Source: CDC Morbidity and Mortality Weekly Reports and Kansas Dept. of Health and Environment

United States Gonorrhea, 1988-93



Source: CDC Morbidity and Mortality Weekly Reports

United States Syphilis and HIV, 1988-93



Source: CDC Morbidity and Mortality Weekly Reports. NOTE: Syphilis Includes Primary and Secondary Cases Only

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Mark R. Kahler, M.D.
Thomas G. Miller, M.D.
Carol J. Feltheim, M.D.
Jeffrey J. Earl, D.O.
Tom E. Kettler, M.D.
Yutaka Kawase, M.D.

Calvin E. Beck, Jr., M.D.
Theodore J. Williams, M.D.
Randall W. Madison, M.D.
Robert L. Schuchardt, M.D.
Joyce L. Simon, M.D.
Mark L. Gillett, M.D.

Testimony Before the Senate Education Committee
on
SCR 1629

Monday, March 21, 1994

Chairman Kerr and Members of the Committee:

Thank you for the opportunity to speak in support of SCR 1629. My name is Tom Kettler. I graduated from Wichita State University and then attended medical school at the University of Kansas. I am married and have three children. My wife is a practicing dermatologist and I am a practicing family physician. My history of support for sexual abstinence as the primary prevention of unintended pregnancy and sexually transmitted diseases (STDs) goes back to my family practice residency at Baylor College of Medicine in Houston, Texas, serving the indigent of Harris County. This was my first exposure to thirteen and fourteen year olds being pregnant and contracting life-long STDs. The majority of the teens in my practice now are in the Blue Valley and Shawnee Mission school districts of Johnson County. My patients are now better educated, but I still see fifteen year olds with herpes and cervical cancer and seventeen year olds that have been pregnant three times. Gonorrhea, chlamydia, pelvic inflammatory disease and venereal warts also continue to be a part of my practice. Some would say we need more of the present information-based sex education, more use of condoms, more school-based clinics in our high schools such as those modeled in Little Rock, Arkansas. My opinion is that we should concentrate on abstinence-based sex education. Condoms certainly are not as effective as we are made to believe and cannot be relied upon for 100% protection and prevention of pregnancy, AIDS and other STDs. Abstinence can be. In my discussions with junior high and high school students during this past year in both public and private schools regarding abstinence and the safe sex myth, I have been impressed with the sincerity of their questions and their willingness to listen. Do you know the number one reason that teens have sexual intercourse? The answer they give me and that studies confirm is peer pressure. I believe that our present system of sex education is not effective. STD rates, teen pregnancies and AIDS cases have increased, all in the face of the present sex education curriculum. There is a well-known analogy that I have been confronted with and that is: If your child was in a plane that was going to crash, wouldn't you want the child to have a parachute? Another way to address this is to think of your child on top of the World Trade Center. Would you give your child a parachute that opens eight out of ten times or would try to dissuade the child from jumping. Don't misunderstand - if the child still wants to jump, by all means, give them the best parachute you can get (be it multi-colored, glow-in-the-dark or plain), but don't equate this issue with a plane that is going to crash. Teens must not be given the message that engaging in sex is something they have no choice in or control over. They need all the facts in order to make a responsible decision. This past week I had the unpleasant experience of telling a seventeen year old junior in high school that she was pregnant. She looked at me in disbelief and her first words in response were, "I can't be pregnant, I used condoms every time I had sex. I am extremely careful, more careful than any of my friends. I can't be pregnant." As she spoke I was amazed at her faith in the condom to prevent pregnancy. Somewhere along the way, maybe from our society's efforts at sex education, she had gotten the wrong message. I couldn't help but wonder if she would have made a different choice had she been better informed. One thing Americans take pride in is our ability to make the right decision if given enough factual information. My decision to support

11725 W. 112th St. • Overland Park, Kansas 66210 • 469-5579

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Attachment 5

abstinence-based sex education is, I believe, grounded in factual, nonbiased medical information. It is my hope that you, too, can come to a similar conclusion that the only primary prevention strategy for the 1990's is abstinence-based sex education. Thank you.

Chairperson and Committee Members

I am George Moore. I am the father of two daughters and have taught in the Wichita Public Schools for over twenty-two years. I have taught in Junior and Senior High and have been a class counselor at South High School for seven years. This May I will graduate my second senior class.

I used to teach students as if they could think about the act of sex as mature young adults. My school district still teaches that "the responsibility for making decisions concerning your own sexuality lies with you". I have now decided that students don't think about the sex act, they just do it. As a popular T.V. commercial says: "Women are looking for someone to say I do, men are looking for someone to say I will". I think this scenario describes more often that not a typical teenage relationship.

Sex education should begin at home. Parents should discuss this topic openly and honestly with their children. Many don't. The media should deal with this ever expanding social issue of teenage pregnancy. They do. There are a multitude of television shows and motion pictures that show or allude to teenage sexual relations. Television commercials say abstain from sex but if you don't, use protection and on the screen they flash a condom. Peers should talk openly and honestly about sex. They do. For them it's 'cool' to make it with your 'baby'. You're not 'fresh' if you're a virgin. They frequently lie to one another and make up sexual fantasy stories to make themselves look older - and better than their friends.

Typically schools deal with the reproductive system in Biology and teach information on sexual decision making in Home Economic classes so that teenagers can make wise decisions. Many teachers in other areas don't deal with this topic because they feel uncomfortable with it. As a counselor I am encountering more students who are confused and distraught as a result of their sexual activity.

We are sending mixed messages. There are advertisements for condoms to protect sexually active people from H.I.V. Schools tell their students that there are consequences for being active sexually and teenage pregnancy is high on the list. However, these very same schools provide day care centers. The schools also provide homebound programs so pregnant girls can do homework before and after delivery. Babies of teenagers are shown off at school and dotted over by friends and teachers.

When a girl becomes pregnant she soon learns about all the things available to her. A medical card helps make everything okay. Kids are very well informed about 'working the system'. It's common street knowledge. Along with the medical card comes the other hand-outs such as food stamps and of course welfare benefits. Their "rights" once they become pregnant.

Teenagers do not think about the consequences of their actions. They think 'it' will never happen to them. It does! I see it every day! Girls waddling down the hall, miscarriages occur in the office, there are runaways, relationships split, family fights sometimes lead to divorce or kicking the girl out of the house. I deal with students that are sick for weeks before delivery. I listen to girls cry when they become pregnant and

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they can't tell their parents or boyfriend. I agonize with them when they decide between keeping the baby, abortion or adoption. I cry with them when they are forced to drop out of school or realize that they can't go to college. While I have considered just the girl's point of view there is also the problems that go along with the boys who have to deal with the consequences of an unwanted pregnancy. Their role in this situation is obviously different, but they still have consequences.

What we are doing just isn't working! We have to teach abstinence. As adults we need to be able to tell kids to "JUST SAY NO!" - "DON'T DO IT!" No sex before marriage should be the message sent in unison by media, parents and schools.

I am not naive enough to believe that this message will end all teenage pregnancies. However, this is the message that I will give to my daughters and I advocate that all parents and schools should teach abstinence in all of their sex education courses. It would have to be better than what we are doing now, because the number of teenage pregnancies under the present system is growing at an alarming rate.

I am asking that a bill be passed advocating that an abstinence based sex education message be adopted in all public school classes that teach sex education in an effort to reduce the number of teenage pregnancies.

Proponent Testimony before the Senate Education Committee
Re: SCR 1629

Donna Logan, MD
7027 Aberdeen
Wichita, KS 67206

March 21, 1994

I find it rather interesting that I am standing in front of you right now. A week ago, I had no idea that I would be here and was not even aware of this specific resolution we are discussing today. I have seen sex education issues enter the legislative limelight over the last several years, but my training and my practice have consumed most of my attention.

I am currently a Senior resident at Wesley Family Practice Residency Program in Wichita. In June, my husband (who is also a resident) and I will complete our training in this specialty and later in the year will begin private practice in Kansas.

You might ask yourself what a young, "novice" physician might have to say about the issue we're discussing today. I haven't had the years of private practice experience that other physicians have had, and I'm not a community leader. What I can share with you today is what I've seen in three years I've been seeing patients and hopefully it will shed some light on this issue.

As you might know already, the patient population a resident sees is skewed much more toward those with Medicaid or the uninsured, though I do have a fair number of insured patients as well. Our Family Practice residency tries to promote patient continuity by keeping patients with one doctor, rather than utilize the "clinic" system, where a patient gets whoever is in that day. This way you can begin to address those "hidden agenda" items that patients won't share with you when you see them just once for an acute care visit.

Last year, I saw a fourteen-year-old female in my office. When I asked about sexual activity, she told me that she has had ten sexual partners. When my jaw dropped open, she responded "What? Isn't that normal?" I went on to discuss her risk of STD's and an abstinent approach to sexuality. She had no idea that this behavior was not "normal".

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Another thirteen-year-old girl I saw told me how her mother doesn't mind when she sleeps over at her boyfriend's house. Her mother who was present agreed and said "at least I know where my daughter is at night." That situation drew my attention to the uphill battle of providing role models for some of these youth.

Last month I delivered two fifteen-year-old girls. They had thought they would never get pregnant, that it would never happen to them. One of them had even been born when her mother was fifteen. Now they are children raising children. Neither one of them really wanted to have sex that much, but they though that they had to to please their boyfriends.

I haven't even mentioned the number of sexually transmitted diseases I see from week to week. Girls as young as 13 or 14 are showing up positive for gonorrhea, chlamydia or genital warts. Again and again, they seem amazed that "it happened to them".

Physicians are often cautioned not to be too self-disclosing in their patient encounters, as it is not good to become "enmeshed" with the patient's problems. Against this advice, I have come to share several times with select adolescents in my practice the fact that I waited until I was married to have intercourse. Their mouth opens as far as mine did when they told me their stories of multiple sexual partners.

I can frequently see in their faces that I am the first person that has ever told them that "not doing it" might be normal. They also notice that I appear to be a successful, well-dressed and happy young woman. If they can at least associate "good outcome" with sexual restraint, I am happy.

A year ago, my husband Jim was asked to speak to a fifth and sixth grad class in Wichita about sexual development. The film they were showing before he was to talk depicted sexual intercourse in a visual, cross-sectional illustration. It talked about orgasm for the male and female, and painstakingly made **no** conclusion about the appropriateness or timing of intercourse or about interpersonal commitment. As he proceeded to talk with them about sexual development, the nature of their questions impressed upon him the power of our culture to establish "the sex act" as the pinnacle for being part of the ***in*** crowd. It seemed as though whether or not you would "do it" was a moot point. Most of the kids seemed rather reckless about sexuality and had no concept of *action leading to consequence.*

It is this recklessness that prompts me to push abstinence with my young patients, and to be in support of this resolution which promotes abstinence as the only 100%-effective method of birth control and STD prevention.

In today's health care environment, preventive medicine is the focus. The basic principles of preventive medicine speak of primary, secondary and tertiary prevention. Primary prevention is risk elimination or avoidance. Secondary prevention is reducing or ameliorating the risk. Tertiary prevention is treating the disease early to prevent a worse outcome. I am confused as a physician why the primary prevention of sexually transmitted diseases and unplanned pregnancies, namely abstinence, is dismissed as not feasible or unattainable.

The thing that concerns me the most about this resolution today is the knowledge that the word "abstinence" has become an emotion-laden and polarizing word. It is upsetting that an unquestionably good health practice has become suspect just because it happens to coincide with some religious teaching.

An abstinence-based approach to sexual education will give our young men and women the permission they need to say "no" to sex outside of a committed, monogamous relationship. Everything else they see on TV, in the movies and in magazines suggests that sex is great, youth is forever, and that one shouldn't worry about tomorrow's problems.

Why can't our schools empower our children to live more responsible lives? Why can't our schools teach that actions have consequences? If our children's health is a national and state priority, and a sexually abstinent lifestyle helps maintain good health, why can't our schools be an instrument of health-promotion and encourage sexual abstinence?

Thank you for letting me speak to you today. I hope you will favorably consider this resolution.

RIGHT TO LIFE OF KANSAS, INC.
701 S.W. Jackson St., Suite 203, Topeka, KS 66603-3729 (913) 233-8601

March 21,1994

Senate Education Committee
Senate Concurrent Resolution 1629

I am testifying in behalf of Right to Life of Kansas and we support SCR 1629. We feel that this could be a beginning of a truly "safe sex" program. There are so many problems with the sex education in our schools today. Unless the schools have chosen an abstinence based program the students are receiving information on all aspects of sexuality without moral guidelines. The results are staggering. I will quote two excerpts from a Focus on the Family newspaper ad January 21,1993 called "In Defense of a Little Virginity".

"The federal government has spent almost $3 billion of our taxes since 1970 to promote contraceptives and 'safe sex' among our teenagers. Isn't it time we asked, What have we gotten for our money? These are the facts:

1. The Federal Centers for Disease Control estimate that there are now 1 million cases of HIV infection nationwide.[1]
2. 1 in 100 students coming to the University of Texas health center now carries the deadly virus.[2]
3. The rate of heterosexual HIV transmission has increased 44% since September 1989.[3]
4. Sexually transmitted diseases(STDs) infect 3 million teenagers annually.[4]
5. 63% of all STD cases occur among persons less than 25 years of age.[5]
6. 1 million new cases of pelvic inflammatory disease occur annually.[6]
7. 1.3 million new cases of gonorrhea occur annually;[7] strains of gonorrhea have developed that are resistent to penicillin.
8. Syphilis is at a 40-year high with 134,000 new infections per year.[8]
9. 500,000 new cases of herpes occur annually;[9] it is estimated that 16.4% of the U.S. population ages 15-74 is infected, totaling more than 25 million Americans- among certain groups, the infection rate is as high as 60%.[10]
10. 4 million cases of chlamydia occur annually,[11] 10-30% of 15-19 year-olds are infected.[12]

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11. There are now 24 million cases of human pappiloma virus(HPV), with a higher prevalence among teens.[13]

"To date, over 20 different and dangerous sexually transmitted diseases are rampant among the young. Add to that the problems associated with promiscuous behavior: infertility, abortions and infected newborns. The cost of this epidemic is staggering, both in human suffering and in expese to society; yet epidemiologists tell us we've seen only the beginning."

"Want proof of that fact? Since the federal government began its major cotraception program in 1970, unwed pregnancies have increased 87% among 15-19 year-olds.[15] Likewise abortion among teens rose 67%;[16] unwed births went up 61%[17] And venereal disease has infected a generation of young people."

Senate Concurrent Resolution 1629 gives us hope if properly promoted in our schools that the trend could be turned around so we would have fewer STD's, fewer teen pregnancies and the ultimate, no abortions.

Cleta Renyer

Cleta Renyer
Right to Life of Kansas

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Kansas State Board of Education

120 S.E. 10th Avenue, Topeka, Kansas 66612-1182

March 21, 1994

TO: Senate Education Committee

FROM: State Board of Education

SUBJECT: 1994 Senate Concurrent Resolution 1629

My name is Connie Hubbell, Legislative Coordinator of the State Board of Education. It is a pleasure for me to appear before this Committee on behalf of the State Board.

The State Board of Education adopted rules and regulations on human sexuality/aids education in November, 1987. After reviewing considerable input via public hearings, the attached rules and regulations were adopted. These rules and regulations allow local boards of education to determine the curriculum in their individual school districts.

Local boards of education will be reviewing their human sexuality/AIDS education curricula as part of the quality performance accreditation process and reporting the results.

Dale M. Dennis
Deputy/Assistant Commissioner
Division of Fiscal Services and Quality Control
(913) 296-3871
Fax No. (913) 296-7933

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STATE BOARD OF EDUCATION

RULES AND REGULATIONS
HUMAN SEXUALITY/AIDS EDUCATION

(1) Each board of education shall provide a comprehensive education program in human sexuality, including information about sexually transmitted diseases, especially acquired immune deficiency syndrome (AIDS).

(2) The program shall:

(A) Include instruction at the elementary and secondary levels;

(B) require that teachers and building administrators have appropriate academic preparation or inservice training designed to develop a basic knowledge of and a sensitivity to the area of human sexuality;

(C) require that all teachers who teach courses in human sexuality hold appropriate certification to provide such instruction; except that until September 1, 1992, teachers assigned to teach human sexuality education shall hold any valid certification appropriate for the level; and

(D) include procedures whereby any pupil, whose parent or guardian so requests, shall be excused from any or all portions of the program without any penalty resulting from such action.

(3) Each board of education shall determine the specific curriculum of the program and the grades in which the program is to be offered. The curriculum shall be specified in writing and shall be on file in the board of education office.

(4) The provisions of this subsection shall not be construed as requiring, endorsing or encouraging the establishment of school-based health clinics or the teaching of birth control methods.

Planned Parenthood®
of Greater Kansas City
Serving Western Missouri and Eastern Kansas since 1935

Testimony
of
Lois A. Culver, M.A.
Director of Education and Training
Planned Parenthood of Greater Kansas City
before the
Senate Education Committee
of the Kansas Legislature
on
March 21, 1994
in opposition to
Senate Concurrent Resolution No. 1629

I am Lois Culver. I have been director of Education and Training for Planned Parenthood of Greater Kansas City for over twenty years. I am a resident of Overland Park, Kansas, and my three grown children went through the Shawnee Mission schools.

Planned Parenthood is a major resource on sexuality education for a number of school districts and individual schools in western Missouri and eastern Kansas. Our Education Department staff is often consulted about developing human sexuality programs and resources.

I am here today to speak against Senate Concurrent Resolution No. 1629 which urges the state board of eduction to adopt new guidelines on human sexuality and AIDS education in Kansas.

Planned Parenthood congratulates Kansas for being nationally recognized as having one of the finest statewide sexuality education programs in the United States. We strongly recommend maintaining the present State Board of

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Education guidelines which they adopted in 1987 when the mandate on sexuality education and AIDS education was established.

While we do not formally endorse or oppose any one specific curriculum, we do have concerns about curricula which are misleadingly termed "abstinence-based" but are, in reality, "abstinence only." It appears that the proposed resolution is an abstinence-only approach.

This approach would ignore facts like the following:

* 70% of all teens have had sexual intercourse by the time they graduate from high school;
* in the United States, by age 15, one-quarter of all girls and one-third of all boys have had intercourse;
* Kansas had 6,165 teen pregnancies in 1992;
* an increasing number of teens are contracting the HIV/AIDS virus.

Instead of providing factual information about the proper use of condoms to prevent pregnancies and the spread of sexually transmitted diseases, including AIDS, the guidelines proposed in SCR 1629 emphasize the failure rates. Conspicuously absent are guidelines to include contraceptive information and disease prevention in a clear and accurate way, with an intent to inform and educate. Planned Parenthood believes in empowerment for young people through knowledge.

The present guidelines encourage comprehensive, age-appropriate sexuality and AIDS education. Furthermore, they urge parental involvement in the development of local programs and already allow parents to keep their children from participating without discrimination if they so choose.

Planned Parenthood agrees that family life and sexuality education must be a cooperative effort between parents, schools, churches or synagogues and appropriate community institutions. As

role models and providers of information, parents are the first and most important teachers of sexuality. However, many parents find it difficult to talk with their children about sex. That is why, according to a 1991 study, nine out of every 10 parents polled want some type of comprehensive sexuality education in the schools.

Choosing a program that is appropriate for a school district and community can be challenging. To help parents and educators evaluate curricula, Planned Parenthood suggests the following guidelines to determine if a sexuality program is comprehensive. Quality curricula should:

1) **meaningfully involve parents** as partners in the education process, whenever possible; quality education programs promote and enhance family communication on issues of sexuality and reproductive health;

2) **be comprehensive and reality-based**, providing accurate, age-appropriate, up-to-date, balanced information about all aspect of sexuality and reproductive health, including contraception;

3) **support abstinence** as the wisest choice for the vast majority of young people because it is the only option which is 100% effective in preventing pregnancy; however, abstinence should be included as one option in a range of psoitive, healthy choices reflecting responsible behavior;

4) **teach critical thinking** and decision-making skills through evaluation of the choices and consequences facing young people;

5) **challenge stereotypes** based on race, gender and sexual orientation in order to promote understanding and respect;

6) **recogize and value diversity**, be it cultural, racial, religious or otherwise; curricula should educate youth to respect differences in the backgrounds and life experiences of their peers,

the families of their peers and others;

7) **examine potentially controversial topics** such as homosexuality, abortion and masturbation **in an unbiased manner**, free from any one religious or political perspective.

The proposed Senate Concurrent Resolution No. 1629 would not satisfy most of these criteria and, if adopted, would surely shortchange--or deprive--the children and youth of Kansas of essential information that they need to grow up to be sexually healthy and to make responsible decisions.

Planned Parenthood, therefore, urges this Committee not to approve SCR 1629 and asks instead that it maintain the excellent guidelines the State Board of Education already has in place and which serve as a model for other states across the nation who are developing state-wide mandates.

nal Council
o. n Women
NCJW
2nd Century Celebration
Daring to Make
a Difference

TESTIMONY OF BARBARA HOLZMARK: REPRESENTING:
NATIONAL COUNCIL OF JEWISH WOMEN
KANSAS GOVERNOR'S COMMISSION ON
EDUCATION FOR PARENTHOOD

SUBMITTED TO THE KANSAS SENATE EDUCATION COMMITTEE

.....MONDAY, MARCH 21, 1994

MR. CHAIRMAN AND MEMBERS OF THE SENATE EDUCATION COMMITTEE, MY NAME IS BARBARA HOLZMARK AND I AM HERE TODAY IN OPPOSITION TO SCR 1629, A RESOLUTION WHICH URGES THE STATE BOARD OF EDUCATION TO ADOPT GUIDELINES IN PROVIDING INSTRUCTIONS TO PUPILS REGARDING HUMAN SEXUALITY AND AIDS UNDER THE QPA PROCESS.

I AM WEARING TWO HATS TODAY, BOTH OF EQUAL IMPORTANCE. I AM THE STATE PUBLIC AFFAIRS CHAIRPERSON FOR THE STATE OF KANSAS REPRESENTING THE NATIONAL COUNCIL OF JEWISH WOMEN. SECONDLY, I AM PRESIDENT OF THE KANSAS GOVERNOR'S COMMISSION ON EDUCATION FOR PARENTHOOD.

THE NATIONAL COUNCIL OF JEWISH WOMEN (NCJW) IS THE OLDEST JEWISH WOMEN'S ORGANIZATION IN THE UNITED STATES. FROM ITS FOUNDING IN 1893, ITS GOALS AND PURPOSES HAVE EMBODIED JEWISH VALUES AND DEMOCRATIC PRINCIPLES. NCJW BELIEVES THAT VOLUNTARY CITIZEN ACTION WITH MUTUAL UNDERSTANDING AND COOPERATION AMONG DIVERSE GROUPS IS VITAL TO THE DEVELOPMENT OF RESPONSIBLE SOCIAL POLICY AND EFFECTIVE PUBLIC AND PRIVATE PROGRAMS WHICH SERVE HUMAN NEEDS. THUS, WE WORK THROUGH A PROGRAM OF RESEARCH, EDUCATION, ADVOCACY AND COMMUNITY SERVICE TO IMPROVE THE QUALITY OF LIFE FOR WOMEN, CHILDREN AND FAMILIES AND STRIVE TO ENSURE INDIVIDUAL RIGHTS AND FREEDOMS FOR ALL.

TO QUOTE FROM OUR NATIONAL RESOLUTIONS: "THE NATIONAL COUNCIL OF JEWISH WOMEN BELIEVE THAT A STRONG SYSTEM OF QUALITY PUBLIC EDUCATION IS ESSENTIAL TO AMERICAN DEMOCRACY. ACCESS TO QUALITY EDUCATION IS A FUNDAMENTAL RIGHT FOR ALL INDIVIDUALS." WE THEREFORE ENDORSE AND RESOLVE TO WORK FOR A COMPREHENSIVE HUMAN SEXUALITY PROGRAM, INCLUDING HIV-DISEASE EDUCATION, TO BE TAUGHT BY TRAINED PERSONNEL IN THE PUBLIC SCHOOLS. WE WILL FURTHER WORK FOR MEASURES TO AVOID STEREOTYPING AND OTHER BIASES IN ALL PROGRAMS AND MATERIALS. NCJW FURTHER BELIEVES THAT INDIVIDUAL LIBERTIES AND RIGHTS GUARANTEED BY THE CONSTITUTION ARE KEYSTONES OF A FREE AND PLURALISTIC SOCIETY. OUR RESPONSIBILITY IS TO PROTECT THESE RIGHTS. INCLUDED HERE IS THE PROTECTION OF THE RIGHT TO PRIVACY IN SEXUAL RELATIONS BETWEEN CONSENTING ADULTS.

SENATE CONCURRENT RESOLUTION 1629 IS MOOT. QUALITY EDUCATION IS BEING PROVIDED, A COMPREHENSIVE HUMAN SEXUALITY PROGRAM INCLUDING AIDS EDUCATION IS BEING OFFERED BY EACH SCHOOL DISTRICT IN THE STATE OF KANSAS THROUGH THE MANDATE

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OF HUMAN SEXUALITY AND AIDS EDUCATION FOR ELEMENTARY AND SECONDARY ACCREDITED SCHOOLS IN THE STATE OF KANSAS.

I NOW SPEAK TO YOU AS PRESIDENT OF THE KANSAS GOVERNOR'S COMMISSION ON EDUCATION FOR PARENTHOOD. IN JANUARY OF 1986, I CHAIRED THE COMMITTEE THAT CONDUCTED A RANDOM SURVEY OF PTA PRESIDENTS AND SCHOOL PRINCIPALS ACROSS THE STATE OF KANSAS. THE FINDINGS OF THAT SURVEY BECAME THE RECOMMENDATION TO THE GOVERNOR'S COMMISSION THAT THEY, IN FACT, RECOMMEND TO THE STATE BOARD OF EDUCATION, A MANDATE OF HUMAN SEXUALITY, K-12. I TESTIFYIED NUMEROUS TIMES BEFORE THE STATE BOARD, AND WHEN THEY FINALLY VOTED, THEY VOTED TO MANDATE HUMAN SEXUALITY K-12 AND INCLUDE AIDS EDUCATION. THE GUIDELINES ARE, IN FACT, IN PLACE AND HAVE BEEN SINCE AUGUST, 1987. THE KANSAS STATE BOARD OF EDUCATION TOOK ACTION BY REQUIRING ALL ACCREDITED SCHOOL SYSTEMS PROVIDE ELEMENTARY AND SECONDARY PROGRAMS IN HUMAN SEXUALITY AND ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS) EDUCATION BY SEPTEMBER, 1988. THE BOARD ALSO DIRECTED THE COMMISSIONER OF EDUCATION TO DEVELOP A SET OF GUIDELINES CONCERNING HUMAN SEXUALITY AND AIDS EDUCATION THAT COULD BE USED BY SCHOOL DISTRICT PERSONNEL IN DEVELOPING SUCH PROGRAMS. THE GUIDELINES CONTAINED THREE PARTS: PART I, PROGRAM DEVELOPMENT AND RESOURCE SELECTION; PART II, CURRICULUM AND STAFF DEVELOPMENT; AND PART III, PROGRAM EVALUATION AND PARENT EDUCATION. SCHOOL DISTRICTS WERE RESPONSIBLE FOR THE DEVELOPMENT AND IMPLEMENTATION OF LOCAL PROGRAMS. NO PORTION OF THESE GUIDELINES WERE TO BE REGARDED AS MANDATORY. THEY WERE TO PROVIDE GUIDANCE ONLY. LOCAL BOARDS OF EDUCATION WERE RESPONSIBLE FOR THE DEVELOPMENT AND IMPLEMENTATION OF PROGRAMS CONSISTENT WITH THE PROVISIONS OF SBR 91-31-3 (g).

EACH LOCAL SCHOOL DISTRICT WAS TO DEVELOP A COMPREHENSIVE PROGRAM WITH THE FOLLOWING CHARACTERISTICS:

1. SEQUENCED FROM PREKINDERGARTEN OR KINDERGARTEN THROUGH SENIOR HIGH SCHOOL.

2. BASED ON CHILD GROWTH AND DEVELOPMENT

3. EMPHASIS ON BASIC LIFE SKILLS THROUGHOUT THE PROGRAM

4. PROVISION OF ACCURATE INFORMATION ABOUT PHYSICAL, EMOTIONAL, AND SOCIAL HUMAN GROWTH AND DEVELOPMENT.

5. PROVISION OF ACCURATE INFORMATION ABOUT SEXUALLY TRANSMITTED DISEASES INCLUDING AIDS.

THE GOALS OF THE HUMAN SEXUALITY AND AIDS EDUCATION WERE INTENDED TO:

1. ENHANCE THE SELF-ESTEEM OF ALL STUDENTS

2. INCREASE THE KNOWLEDGE LEVEL OF ALL STUDENTS ABOUT HUMAN SEXUALITY

3. IMPROVE RESPONSIBLE DECISION-MAKING SKILLS OF ALL STUDENTS.

4. IMPROVE THE QUALITY OF LIFE FOR ALL STUDENTS.

FURTHERMORE, IN DEVELOPING THESE PROGRAMS, THERE MUST BE PUBLIC INVOLVEMENT FROM THE FOLLOWING: PARENTS, COMMUNITY, CLERGY, MEDICAL PROFESSIONALS, PUPILS, COUNSELORS AND OTHERS.

HUMAN SEXUALITY EDUCATION HAS BEEN AND WILL CONTINUE TO BE AN AREA FRAUGHT WITH CONTROVERSY. I URGE YOU TO OPPOSE SENATE CONCURRENT RESOLUTION 1629 AND ALLOW LOCAL SCHOOL DISTRICTS, ALONG WITH THEIR OWN COMMUNITY INVOLVEMENT, TO DETERMINE THEIR OWN HUMAN SEXUALITY AND AIDS EDUCATION CURRICULA. THE STATE BOARD OF EDUCATION HAS DONE THEIR PART AND CONTINUE TO BE A RESOURCE TO ALL SCHOOL BOARDS AND SCHOOL DISTRICTS ACROSS THE STATE OF KANSAS.

YWCA
of Kansas City, Kansas

1017 North 6th Street
Kansas City, KS 66101
(913) 371-1105
Fax (913) 371-3251

TO: Senator Kerr
Chairperson and Members of the Senate Education Committee

I am speaking as a concerned individual, mother of two teenagers and as a representative of the YWCA of Kansas City, Kansas. Our organization provides programming in the interrelated areas of juvenile offender reintegration; HIV/AIDS Care coordination and education for women, adolescents and children; teen pregnancy prevention and teen parent education; and teen leadership peer education in the schools and community. Because of our commitment to address these serious issues and our position as a resource for our school districts in human sexuality and AIDS education, we have a keen interest in the curriculum.

I was involved in the initial curriculum development and feel that our school district has done an admirable job in implementation and making every effort to involve parents in the process. This curriculum and our programming is based on the premise that our duty is to serve all students regardless of lifestyle, profile of their family unit, religious preference, culture or race. At the YWCA we support a comprehensive approach to human sexuality, teen pregnancy and AIDS, respecting different approaches, whether a church or community group takes an abstinence only approach or one based on factual information on all options. However, as an educational institution serving a diverse population, the public schools have an obligation to provide factual comprehensive information and basic life skills that are inclusive rather than exclusive. It is important that the public schools serve the majority while giving consideration to a small minority (1%-3%) through the opt-out clause.

I find it very disturbing and ironic that as we see a dramatic increase in teens with AIDS and a continuing rise in juvenile crime and teen pregnancy in our state (as documented in the recent Kids Count Data Book) that we are talking about going backwards instead of forwards to an even more comprehensive approach to these critical problems facing our young people. I am certain that all of us wish that our some 50% of our young people were not sexually active. We need to work diligently to discourage this activity due to the potentially disastrous consequences. However, the reasons that some teens are sexually active are as complex as the teens themselves. Recent studies show that some 70% of sexually active girls were sexually abused as children. In other words, they did

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not "choose" to be sexually active. Many others are caught up in a cycle of teen pregnancy and poverty that makes prevention efforts very difficult. Therefore, an abstinence only approach is not realistic. The proposed legislation suggests emphasizing the failure rates of condoms. While not 100% effective, if used properly with other birth control methods, they are every effective in preventing HIV and other sexually transmitted diseases and pregnancy. It is difficult enough to persuade sexually active teens, particularly males, to use protection, without giving out information that it will not be effective. I refuse to believe that we are willing to write off 40-50% of our young people - our future.

I wish you had the opportunity to hear from some of our 70 high school volunteers who go through extensive training as peer educators and positive role models for others, particularly younger teens. The one thing that they would tell you is the importance of being honest, well-informed and non-judgmental. For their sakes and the future of all our youth, let us respect their views as we look at the proposed legislation.

Thank you for the opportunity to address this committee.

Sincerely,

Cathy Breidenthal
Executive Director
YWCA of Kansas City, Kansas

Testimony Against HB 2304 From Marian Shapiro

Director of Education, Planned Parenthood of Kansas

Thank you for the opportunity to give testimony on the important issue of sexuality and AIDS education. As a certified sexuality educator and **Red Cross AIDS Instructor**, I am concerned about the health and safety of young people in Kansas, and also my own two children. These are dangerous times when a teenager can make one poor judgment, take one drink too many, or mistake sex for love, and wind up with a fatal disease. As parents I think we all want our kids to be spared learning things the hard way. It's too dangerous today.

Some people think the way to keep kids safe is to say, "Just say NO." And any responsible teacher of AIDS and human sexuality will tell students that the only 100% safe way to keep from getting pregnant or getting a sexually transmitted disease is to abstain from sexual intercourse. We definitely must give support and encouragement for teens to abstain.

But if teachers and parents stop there, and give no information about prevention, then they're gambling with our teenagers' lives. They are withholding information that young people need if they choose not to heed our advice to abstain, but have sex anyway. If we teach abstinence only, we are ignoring the needs of 75% of females and 86% of males who are sexually active by the age of 19, according to a 1988 national study from the Alan Guttmacher Institute. A Congressional report from the **Select Committee on Children,Youth and Families** reported on two national surveys of adolescent sexual behavior which found that 58% of sexually active females had had at least two sexual partners, 25% had had three to five partners, and 11% had had six or more partners. So if we teach only abstinence, we are risking the lives of these sexually active adolescents who need to know that condoms can only work when used consistently and correctly, and that sex **without** a condom is 20 to 100 times more dangerous than sex **with** a condom.

Opponents of sex education have resorted to fabricating their own "research" which shows condoms to be full of large holes. We need to inform young people that the natural membrane condoms do indeed have pores that can allow HIV to get through, but this is not true of LATEX condoms. To give teens distorted, misleading information is confusing and dishonest when they are trying to get correct, factual information and act responsibly. I urge you to rely on the scientifically sound research provided by the most respected AIDS experts in the world at the **Centers for Disease Control** in Atlanta and the **National Institutes of Health** in Bethesda. Attached to my testimony is a current fact sheet provided by the CDC on the efficacy of condoms in the prevention of disease. Also attached is a fact sheet from the **Planned Parenthood Federation of America** on the **Sexual and Reproductive Behavior of U.S. Teens** with all references documented, and a fact sheer from the **Alan Guttmacher Institute**.

Parents have been telling their children to abstain for generations. Only when the children closely share the values of their parents are some of them likely to heed the admonition to abstain. The majority of teens, however, are making a different choice, with or without permission from their parents, teachers or churches. We cannot gamble with their lives by denying them the health information they need to protect themselves from HIV (among other things) which can kill them!

Parents continue to have the right to withhold their own children from the educational unit on sexuality if they so choose. They do **not** have the right, however, to keep life-saving information from everyone else's children. Most American parents welcome help from the schools in educating their children about sexually transmitted diseases and teenage pregnancy. Only 2% of parents nationally withhold their children from sex education. To allow a small minority of parents to impose their values on all the children of Kansas is unconscionable. We all want to support the students who are making the effort to abstain. But we can't afford to ignore the needs of the kids who need our help the most, the kids who are at risk and sexually active. If passed, this bill will cost lives of young Kansans. It is misguided and irresponsible. I urge you to vote against HB 2304.

Sen. Ed.
3/21/94
Attachment 13

CDC HIV/AIDS PREVENTION

CENTERS FOR DISEASE CONTROL AND PREVENTION

Facts about

Condoms and Their Use in Preventing HIV Infection and Other STDs

With more than 1 million Americans infected with HIV, most of them through sexual transmission, and an estimated 12 million other sexually transmitted diseases occuring each year in the United States, effective strategies for preventing these diseases are critical.

The proper and consistent use of latex condoms when engaging in sexual intercourse—vaginal, anal, or oral—can greatly reduce a person's risk of acquiring or transmitting STDs, including HIV infection. In fact, *recent studies provide compelling evidence that latex condoms are highly effective in protecting against HIV infection when used properly for every act of intercourse.*

Latex condoms are highly effective when used consistently and correctly—new studies provide additional evidence that condoms work

The protection that proper use of latex condoms provides against HIV transmission is most evident from studies of couples in which one member is infected with HIV and the other is not, i.e., "discordant couples." In a study of discordant couples in Europe, among 123 couples who reported *consistent* condom use, *none* of the uninfected partners became infected. In contrast, among the 122 couples who used condoms *inconsistently*, 12 of the uninfected partners became infected.

As these studies indicate, condoms must be used *consistently* and *correctly* to provide maximum protection. *Consistent use* means using a condom from start to finish with each act of intercourse. *Correct condom use* should include the following steps:

- Use a new condom for each act of intercourse.
- Put on the condom as soon as erection occurs and before any sexual contact (vaginal, anal, or oral).
- Hold the tip of the condom and unroll it onto the erect penis, leaving space at the tip of the condom, yet ensuring that no air is trapped in the condom's tip.
- Adequate lubrication is important, but use only water-based lubricants, such as glycerine or lubricating jellies (which can be purchased at any pharmacy). Oil-based lubricants, such as petroleum jelly, cold cream, hand lotion, or baby oil, can weaken the condom.
- Withdraw from the partner immediately after ejaculation, holding the condom firmly to keep it from slipping off.

Myths About Condoms

There continues to be misinformation and misunderstanding about condom effectiveness. The Centers for Disease Control and Prevention (CDC) provides the following updated information to address some common myths about condoms. This information is based on findings from recent epidemiologic, laboratory, and clinical studies.

▶ *Myth #1: Condoms don't work*

Some persons have expressed concern about studies that report failure rates among couples using condoms for pregnancy prevention. Analysis of these studies indicates that the large range of efficacy rates is related to incorrect or inconsistent use. The fact is: latex condoms are highly effective for pregnancy prevention, but only when they are used properly. Research indicates that only 30 to 60 percent of men who claim to use condoms for contraception actually use them for every act of intercourse. Further, even people who use condoms every time may not use them correctly. Incorrect use contributes to the possibility that the condom could leak from the base or break.

▶ *Myth #2: HIV can pass through condoms*

A commonly held misperception is that latex condoms contain "holes" that allow passage of HIV. Although this may be true for natural membrane condoms, laboratory studies show that intact latex condoms provide a continuous barrier to microorganisms, including HIV, as well as sperm.

▶ *Myth #3: Condoms frequently break*

Another area of concern expressed by some is about the quality of latex condoms. Condoms are classified as medical devices and are regulated by the FDA. Every latex condom manufactured in the United States is tested for defects before it is packaged. During the manufacturing process, condoms are double-dipped in latex and undergo stringent quality control procedures. Several studies clearly show that condom breakage rates in this country are less than 2 percent. Most of the breakage is due to incorrect usage rather than poor condom quality. Using oil-based lubricants can weaken latex, causing the condom to break. In addition, condoms can be weakened by exposure to heat or sunlight or by age, or they can be torn by teeth or fingernails.

Preventing HIV Infection and Other STDs

Recommended Prevention Strategies

Abstaining from sexual activity is the most effective HIV prevention strategy. However, for individuals who choose to be sexually active, the following are highly effective:

- Engaging in sexual activities that do not involve vaginal, anal, or oral intercourse
- Having intercourse only with one uninfected partner
- Using latex condoms correctly from start to finish with each act of intercourse

Other HIV Prevention Strategies

▶ *Condoms for Women*

The FDA recently approved a female condom, which will soon be available in the United States. A limited study of this condom as a contraceptive indicates a failure rate of about 26 percent in 1 year. Although laboratory studies indicate that the device serves as a mechanical barrier to viruses, further clinical research is necessary to determine its effectiveness in preventing transmission of HIV.

▶ *Spermicides*

The role of spermicides in preventing HIV infection is uncertain. Condoms lubricated with spermicides are not likely to be more effective than condoms used with other water-based lubricants. Spermicides added to the tip of the condom are also not likely to add protection against HIV.

Making Responsible Choices

In summary, sexually transmitted diseases, including HIV infection, are preventable, and individuals have several responsible prevention strategies to choose from. But the effectiveness of each one depends largely on the individual. Those who practice abstinence as a prevention strategy will find it effective only if they always abstain. Similarly, those who choose any of the other recommended prevention strategies, including condoms, will find them highly effective if used correctly and consistently.

For further information, contact:

CDC National AIDS Hotline: 1-800-342-AIDS
Spanish: 1-800-344-7432
Deaf: 1-800-243-7889

CDC National AIDS Clearinghouse
P.O. Box 6003
Rockville, MD 20849-6003

FACTS in BRIEF

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Teenage Sexual and Reproductive Behavior

SEXUAL ACTIVITY

- 97% of women and 99% of men aged 15–19 are unmarried.
- 50% of unmarried women and 60% of unmarried men aged 15–19 have had sexual intercourse.
- Levels of sexual activity increase with each year of age: 27% of unmarried 15-year-old women and 33% of unmarried 15-year-old men have had intercourse at least once; at age 19, 75% of women and 86% of men have had intercourse.
- Teenagers are having sex for the first time at younger ages: In 1982, 19% of unmarried women aged 15 had had intercourse; in 1988, 27%. In 1979, 56% of unmarried men aged 17 living in metropolitan areas had had intercourse; in 1988, 72%.
- Sexual activity levels vary considerably by race and ethnicity—among unmarried 15–19-year-old men, 81% of blacks, 60% of Hispanics and 57% of whites have had intercourse. Proportions among women aged 15–19 are 59%, 45% and 48%.
- Most of the increase in female sexual activity in the 1980s was among white teenagers and those in higher income families, narrowing the previous racial, ethnic and income differences.
- 6 in 10 sexually active women aged 15–19 report having had 2 or more sexual partners.

SEX EDUCATION

- Nearly all junior and senior high school teachers report that their schools offer sex education, but most think it is often provided too late and that too little time is spent on the subject.
- On average, secondary schools offer only 6½ hours a year on sex education—fewer than 2 of those hours focus on contraception and the prevention of sexually transmitted diseases.
- Most states and large school districts in the United States support sex education in their public schools, yet ⅓ of the states and ⅓ of the larger school districts do not require or encourage their schools to teach pregnancy prevention.
- Measuring the relationship between sex education programs and teenage pregnancy is limited by many factors, including lack of data on teenagers' sexual activity at the state or local level.
- Studies have found no conclusive evidence that sex education causes teenagers to become sexually active earlier or later.
- In-depth studies of a few specific sex education programs have shown that some approaches contribute to greater delay in teenagers becoming sexually active, at least in the short term.
- Sex education programs have been shown to effectively provide information about reproduction and contraception and thus increase teenagers' knowledge about these subjects.

CONTRACEPTIVE USE

- More teenage women surveyed in 1988 used a contraceptive method the first time they had intercourse than in 1982 (65% vs. 48%), yet ½ used no protection the first time they had sex.
- Contraceptive use at first intercourse has increased almost entirely because of a doubling in condom use during the 1980s (from 23% to 47%).
- 79% of sexually active teenage women use a contraceptive method—up from 71% in 1982. They are more likely, however, than any other age group to be nonusers: 1 in 5 use no method.
- 57% of sexually active unmarried men aged 15–19 used a condom the last time they had intercourse, and among those aged 17–19 in metropolitan areas, condom use more than doubled between 1979 and 1988—from 21% to 58%.
- 66% of black, 54% of white and 53% of Hispanic men aged 15–19 used a condom the last time they had sex.
- In general, young women are more likely than older women to become pregnant while using any contraceptive—11% of teenage pill users experience a contraceptive failure during the first year of use, compared with 6% among women aged 15–44.

TEENAGE PREGNANCY

- U.S. teenagers have one of the highest pregnancy rates in the western world—twice as high as in England and Wales, France and Canada; 3 times as high as in Sweden; and 7 times as high as in the Netherlands.
- Each year more than one million teenagers (1,033,730 in 1988)—1 in 9 women aged 15–19 and 1 in 5 who are sexually active—become pregnant.
- 50% of teenage pregnancies conceived in 1987 resulted in a birth, 36% in an abortion and an estimated 14% in miscarriage.
- In 1988, the teenage pregnancy rate (pregnancies per 1,000 women age 15–19) was 113, and 74 among those aged 15–17.
- Minority teenagers have twice the pregnancy rate of white teenagers—in 1988, the rates were 197 and 93, respectively.
- By age 18, 1 in 4 (24%) teenagers will become pregnant at least once—and more than 4 in 10 (44%) will do so by age 20.
- 21% of white teenagers and 40% of minority teenagers will become pregnant at least once by age 18, and 41% of whites and 63% of nonwhites by age 20.
- Nearly 1 in 5 teenagers who experience a premarital pregnancy become pregnant again within a year. Within 2 years, more than 31% have a repeat pregnancy.

- 8 in 10 teenage pregnancies are unintended—9 in 10 among unmarried teenagers and about half among married teenagers.
- States with the highest teenage pregnancy rates in 1985 were CA (151), AK (144), GA (132), TX (131), AZ (128); states with the lowest rates were ND (60), MN (62), IA (67), SD (70), WI (73).
- The number of teenage pregnancies and the teenage pregnancy rate rose gradually during the 1970s, leveled off until 1986, and rose in the late 1980s. In 1972, the rate was 95; in 1980, 111; in 1986, 108; and in 1988, 113.

CHILDBEARING

- The U.S. teenage childbearing rate is halfway between Canada's and Latin America's. By age 20, 1 in 9 women in Canada, 2 in 10 in the United States, 3 in 10 in Brazil and 5 in 10 in Guatemala, have had their first child.
- About ½ of all teenage pregnancies end in births. In 1989, teenage births totaled 517,989 (11,486 to those under age 15) and 67% were to those unmarried—56% of the births to whites and 92% of the births to blacks.
- 7 in 10 births to teenagers result from unplanned pregnancies.
- The teenage birthrate (births per 1,000 women aged 15–19) in 1989 was 58—among whites, 49, and among minorities, 97.
- The birthrate for teenagers aged 15–17 increased 19% between 1986 and 1989; the 1989 rate was the highest since 1974. Most of the increase occurred among nonwhites and Hispanics.
- Of women having their first birth in 1989, 24% were teenagers. Among whites, 2 in 10 first births were to teenagers and among blacks, 4 in 10 were to teenagers.
- 25% of all babies born to teenagers are not first births.
- Less than 10% of teenagers who give birth place their babies for adoption.
- On average, 33% of women under age 20 who give birth receive inadequate prenatal care, either because they start care late in their pregnancy or because they have too few medical visits.

CONSEQUENCES OF EARLY CHILDBEARING

- The younger the mother, the greater the likelihood that she and her baby will experience health complications, as a result of later prenatal care, poor nutrition, and other lifestyle factors.
- Teenage mothers are at greater risk of socioeconomic disadvantage throughout their lives than those who delay childbearing until their 20s. They are generally less educated and have more children and higher levels of nonmarital, unintended births.
- More teenage mothers are now graduating from high school than ever before, yet only ½ of the women who have their first child at age 17 or younger will have graduated by age 30.
- Teenagers who become mothers are disproportionately poor and dependent on public assistance for their economic support.
- Public funds pay for the delivery costs of at least ½ of the births to teenagers.
- The government spent over $25 billion in 1990 for social, health and welfare services to families begun by teenage mothers. Babies born to teenagers in 1990 will cost U.S. taxpayers over $7 billion over the next 20 years.
- Children of teenage mothers are at greater risk of lower intellectual and academic achievement, behavior problems, and problems of self-control than are children of older mothers, primarily because of the effects of single parenthood, lower maternal education and larger family size.
- Although it is not inevitable, the daughters of teenage mothers are more likely to become teenage parents themselves.

ABORTION

- 4 in 10 teenage pregnancies (excluding miscarriages) end in abortion.
- While the teenage abortion rate (number of abortions per 1,000 women aged 15–19) among minorities (76) is considerably higher than the rate among whites (37), minorities are as likely as whites to end a pregnancy in abortion (abortion ratio).
- 26% of all abortions in the United States each year are to women under age 20—in 1988 the number of abortions in this age group was 406,370 (172,000 to those under age 18).
- Every year, about 4% of women aged 15–19 have an abortion.
- The three reasons most often given by teenagers for choosing to have an abortion are: concern about how having a baby would change their lives, feeling that they are not mature enough to have a child, and financial problems.
- 21 states currently have mandatory parental involvement laws in effect for a minor to obtain an abortion: AL, AR, GA, ID, IN, KS, LA, MA, MD, MN, MO, ND, NE, OH, RI, SC, TN, UT, WI, WV and WY. The laws in all of these states except ID, MD and UT stipulate that a minor can seek a court order authorizing the procedure without parental knowledge; MD allows a physician to waive parental notification. CT requires counseling by a professional for minors under age 16; ME requires parental consent or counseling by a professional.
- In contrast, in 46 states and the District of Columbia, mothers who are minors may legally plave their child for adoption without parental involvement.
- 61% of minors have abortions with a parent's knowledge; 45% of parents are told by their daughter. The great majority of parents support the decision to have an abortion.

SOURCES OF DATA

Most of the data in this factsheet are from research conducted by The Alan Guttmacher Institute and/or published in *Family Planning Perspectives*. Additional sources include: The Centers for Disease Control, The Center for Population Options, the National Center for Health Statistics, and the National Academy of Sciences' report *Risking the Future*.

FOR MORE INFORMATION FROM THE ALAN GUTTMACHER INSTITUTE:

Abortion and Women's Health: A Turning Point for America?, 1990, 74 pp., $12.00.

Preventing Pregnancy, Protecting Health: A New Look at Birth Control Choices in the United States, 1991, 129 pp., $20.00.

Our Daughters' Decisions: The Conflict in State Law on Abortion and Other Issues, 1992, 33 pp., $5.00.

Readings on Teenage Pregnancy from Family Planning Perspectives, 1985–1989, 1989, 352 pp., $30.00.

Risk and Responsibility: Teaching Sex Education in America's Schools Today, 1989, 24 pp., $5.00.

Teenage Pregnancy in Industrialized Countries, 1986, 310 pp., $30.00 clothbound, $12.95 paperbound (Yale University Press).

Teenage Pregnancy in the United States: The Scope of the Problem and State Responses, 1989, 72 pp., $15.00.

Today's Adolescents, Tomorrow's Parents: A Portrait of the Americas, 1990, 97 pp., $20.00, available in English and in Spanish.

Family Planning Perspectives, 1-year subscription: $38.00 for institutions, $28.00 for individuals.

State Reproductive Health Monitor: Legislative Proposals and Actions, 1-year subscription: $120.00 for institutions, $100.00 for individuals.

Washington Memo, 1-year subscription: $60.00 for institutions, $50.00 for individuals.

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1/4/93

13-6

Fact Sheet

Planned Parenthood® Federation of America, Inc.
810 Seventh Avenue New York, New York 10019 (212) 541-7800
2010 Massachusetts Ave. NW Washington, DC 20036 (202) 785-3351

Sexual and Reproductive Behavior Among U.S. Teens

Sexual Activity

- In 1988, 50 percent of unmarried 15-19-year-old women and 60 percent of unmarried 15-19-year-old men reported that they had had sexual intercourse. (1) (2)

- Levels of sexual activity increase with each successive year of age. In 1988, 27 percent of unmarried 15-year-old women and 33 percent of unmarried 15-year-old men had had intercourse; 75 percent of women aged 19 and 86 percent of men aged 19 had had intercourse at least once. (1) (2)

- Teens are initiating sex at younger ages: From 1982 to 1988, the percentage of unmarried 15-year-old women who had had intercourse rose from 19 percent to 27 percent. From 1979 to 1988, the percentage of unmarried men aged 17 living in metropolitan areas who had had intercourse rose from 56 percent to 72 percent. (1) (2) (3)

- Sexual activity levels also vary considerably by racial and ethnic group: In 1988, among those never-married, 81 percent of black men, 60 percent of Hispanic men, and 57 percent of white men aged 15-19 had had intercourse. The proportions among all women aged 15-19 were 61 percent, 49 percent, and 52 percent, respectively. (1) (2)

- Most of the increase in female sexual activity in the 1980s was among white teenagers and those in higher-income families, narrowing the previous racial, ethnic, and income differences. (1)

- In 1988, six in 10 sexually active women aged 15-19 reported having had two or more sexual partners. (1)

Sexuality Education

- The ability to measure the relationship between sexuality education programs and teen pregnancy is limited by many factors, including the lack of data on the sexual activity of teens on the state or local level. (19)

- Studies have found no conclusive evidence that sex education, however defined, causes teens to become sexually active earlier or later. (17) (18)

- In-depth studies of a few specific sex education programs have shown evidence of greater delay in teens' becoming sexually active, at least over the short run. (22) (23)

- Sexuality education programs have been shown to effectively provide information about reproduction and contraception and thus increase teenagers' knowledge about these subjects. (17) (18) (20)

- Nearly all junior and senior high school teachers report that their schools offer sexuality education in some form, but most think that too little time is spent and that sexuality education is often provided too late. (16)

- On average, secondary schools offer only 6 1/2 hours a year on all sexuality education topics, and less than two of those hours focus on contraception and the prevention of sexually transmitted diseases (STDs). (16)

- Most states and large school districts in the U.S. support sexuality education in their public schools, yet one-third of the states and one-fifth of the larger school districts do not require or encourage their schools to teach pregnancy prevention. (16)

Contraceptive Use

- Substantially more teenage women today use a contraceptive method the first time they have intercourse than did so in 1982 (65 percent versus 48 percent). Yet one-third use no protection the first time they have sex. (1)

- The overall increase in contraceptive use at first intercourse is almost entirely the result of a dramatic increase in condom use, which doubled during the 1980s (from 23 to 47 percent). (1)

- In 1988, 79 percent of sexually active teenage women were currently using a contraceptive method -- up from 71 percent in 1982. (1)

- Teenage women are more likely to use contraception now than in the early 1980s, but sexually active teenagers are more likely than any other age group to be nonusers of contraception -- one in five currently use no method of contraception. (1)

- In 1988, 57 percent of sexually active unmarried young men aged 15-19 reported that they used a condom the last time they had intercourse. Among those aged 17-19 living in urban areas, condom use more than doubled between 1979 and 1988 -- from 21 to 58 percent. (2)

- Considerable differences exist by race and ethnic group in condom use among unmarried men aged 15-19: In 1988, 66 percent of black men, 54 percent of white men, and 53 percent of Hispanic men used a condom the last time they had intercourse prior to being surveyed. (2)

- In general, young women are more likely than older women to have an accidental pregnancy while using any given method of contraception. 11 percent of teenage pill-users experience a contraceptive failure during the first year of use, while the user-failure rate among women aged 15-44 is 6 percent. (4)

Teenage Pregnancy

- Each year more than one million teenagers become pregnant (1,014,620 in 1987) -- one in nine women aged 15-19 and one in five who are sexually active. (5)

- In 1987, the teenage pregnancy rate was 109 per 1,000 women aged 15-19. The rate was 72 per 1,000 among those aged 15-17. (5)

- Nonwhite teenagers have twice the pregnancy rate of white teenagers -- in 1987, the rates were 189 and 90, respectively. (5)

- 50 percent of teenage pregnancies conceived in 1987 resulted in a birth, 36 percent in an abortion, and an estimated 14 percent in miscarriage. (1)

- By age 18, one in four young women (24 percent) will have a pregnancy; by age 20 more than four in 10 (44 percent) will do so. (7)

- 21 percent of white teenagers and 40 percent of nonwhite teenagers will have a pregnancy by age 18; 41 percent of whites and 63 percent of nonwhites will do so by age 20. (7)

- Nearly one in five teenagers who experience a premarital pregnancy will get pregnant again within a year. Within two years, more than 31 percent will have a repeat pregnancy. (7)

- Eight in 10 teenage pregnancies are unintended -- nine in 10 pregnancies among unmarried teenagers and about half of those among married young women. (1)

- States with the highest teenage pregnancy rates in 1985 were: California (151), Alaska (144), Georgia (132), Texas (131), Arizona (128); states with the lowest rates were: North Dakota (60), Minnesota (62), Iowa (67), South Dakota (70), Wisconsin (73). (6)

- The number of teen pregnancies and the teen pregnancy rate (pregnancies per 1,000 women aged 15-19) rose gradually during the 1970s but leveled off in the 1980s. In 1972, the pregnancy rate was 95; in 1980, it was 111; and in 1987 the rate was 109. (5) (6)

- U.S. teenagers have one of the highest pregnancy rates in the western world -- twice as high as rates found in England, France, and Canada, three times as high as that in Sweden; and seven times as high as the Dutch rate. (8)

- A 1985 international teenage pregnancy study concluded that teen pregnancy rates are lower in countries where there is greater availability of contraceptive services and sex education.

- The U.S. teenage childbearing rate is halfway between Canada's and Latin America's. By the end of their teenage years, one in nine women in Canada, two in 10 in the U.S., three in 10 in Brazil, and five in 10 in Guatemala, have their first child. (9)

Teenage Childbearing

- About half of all teenage pregnancies end in births. In 1988, teenage births totaled 488,941. (11)

- In 1988, two-thirds of births to women under age 20 were to unmarried women -- 54 percent of the births to whites and 91 percent of the births to blacks were nonmarital. (11)
- In 1988, there were 10,588 babies born to teenagers aged 14 and younger -- 94 percent of these births were nonmarital. (11)
- Nearly three-quarters (73 percent) of births to teenagers result from pregnancies that are unintended. (1)
- The teen birthrate in 1988 was 53.6 births per 1,000 women aged 15-19; the rate among those aged 10-14 was 1.4. (11)
- The birthrate for teens aged 15-17 increased 10 percent between 1986 and 1988; the 1988 rate was higher than in any year since 1977. The increase occurred entirely among nonwhites and Hispanics. The birthrate in 1988 among white teenagers aged 15-19 was 43.7 and 95.3 among nonwhite teenagers. (11)
- Of women having their first birth in 1988, 23 percent were teenagers -- among whites, two in 10 first births were to teenagers; among blacks, four in 10 were to teenagers. (11)
- Nearly one-quarter (23 percent) of all babies born to teenagers in 1988 were not first births. (11)
- More than nine in 10 teenagers who give birth keep their babies; few place their babies for adoption. (12)
- On average, 33 percent of women under age 20 who give birth receive inadequate prenatal care, either because they start care late in their pregnancy or they have too few medical visits. (21)

Consequences of Early Childbearing

- Teenage mothers are at greater risk of socioeconomic disadvantage throughout their lives than those who delay childbearing until their twenties. They are generally less-educated, have larger families, and have higher levels of nonmarital, unintended births. (7)
- More teenage mothers are now graduating from high school than ever before, yet only half of the women who have their first child at age 17 or younger will have graduated from high school by age 30. (14)
- Teenagers who become mothers are disproportionately poor and dependent on public assistance for their economic support. (7)
- Public funds pay for the delivery costs of at least half of the births to teenagers. (24)
- The government spent over $21 billion in 1989 for social, health, and welfare services to families begun by teen mothers. Babies born to teen mothers in 1989 will cost U.S. taxpayers $6 billion over the next 20 years. (15)
- The children of teenage mothers are at greater risk of lower intellectual and academic achievement, social behavior problems, and problems of self-control than are children of

older mothers, primarily due to the effects of single parenthood, lower maternal education, and larger family size. (7)

- Although it is not inevitable, the daughters of teenage mothers are more likely to become teenage parents themselves. (13)

- The younger the mother, the greater the likelihood that she and her baby will experience health complications, primarily due to later prenatal care, poor nutrition, and other lifestyle factors. (7)

Teenage Abortion

- Four in 10 teenage pregnancies (excluding miscarriages) end in abortion. (6)

- While the rate of abortion (number of abortions per 1,000 women) among nonwhite teenagers (73) is considerably higher than the rate among white teenagers (36), the likelihood that nonwhite teenagers will end a pregnancy in abortion (abortion ratio) is about the same as for whites. (5)

- 26 percent of all abortions in the U.S. each year are to women under age 20 -- in 1987 the total number of abortions in this age group was 406,790. (5)

- Every year, about 4 percent of women aged 15-19 have an abortion. (10)

- The top three reasons cited by pregnant teenagers for choosing to have an abortion were concern about how having a baby would change their lives, their feeling that they are not mature enough to have a child, and financial problems. (10)

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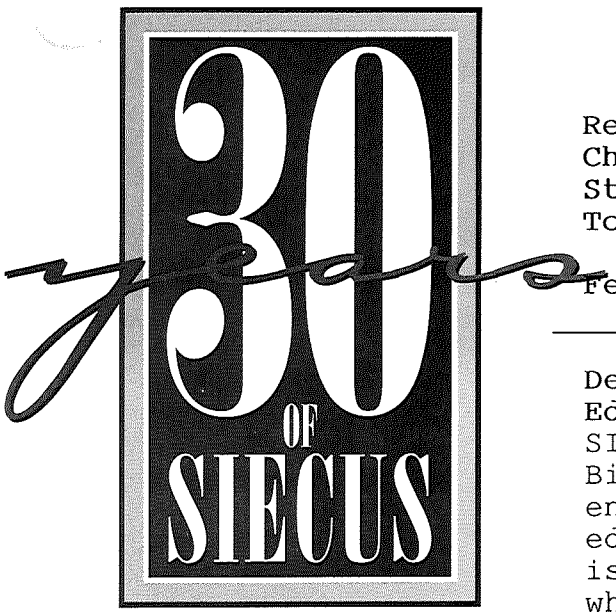

Representative Duane Goosen
Chairman, Education Committee
State Capitol
Topeka, Kansas

February 16, 1994

Dear Chairman Goosen and the Committee on Education:
SIECUS offers this testimony against House Bill No. 2304 because of our interest in ensuring effective, appropriate sexuality education for all children and youth. SIECUS is a thirty year old, non-profit organization which collects and disseminates information about sexuality, advocates for the right of all people to make healthy decisions related to their sexuality, and educates professionals and policy makers about new developments in the field.

In 1993, SIECUS published a report entitled *Unfinished Business* assessing the current State curricula and policies related to sexuality education. Kansas' *Human Sexuality and AIDS Education Guidelines* was identified as one of the four best programs in the country. House Bill 2304 has the potential to undermine the excellent educational guidelines which Kansas currently has in place. House Bill 2304 could be damaging for the following reasons:

* Although abstinence from sexual intercourse, is the only 100% effective way to prevent transmission of STDs including HIV and teaching about the real benefits of abstinence is advisable, the current bill ignores the 75% of young women and 86% of young men who have intercourse at least once by the age of 19.

* House Bill 2304 requires emphasis on the failure rates of contraception and condoms which will lower student confidence in condoms and thus discourage condom use. According to the U.S. Centers for Disease Control, short of abstinence, condoms are the most effective means of preventing STDs, including HIV.

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* House Bill 2304 approaches sexuality education with an emphasis only on the dangers and consequences of sexuality. In addition, the bill does not require courses in human sexuality to help students to develop interpersonal skills. According to the scientific literature, the sexuality education courses which are most effective in helping students postpone intercourse or to use contraception when they do have intercourse are those which are skills-based and include information on both abstinence and contraception.

* National polls consistently show that 85% of adults support sexuality education in the public schools, and over 90% support HIV/AIDS education. I urge you not to be swayed by the small group of people who would deny children information which is critical to their health and well-being.

SIECUS strongly recommends that you vote against House Bill 2304. The children and youth of Kansas deserve the balanced, responsible approach to sexuality education already outlined in the Kansas *Human Sexuality and AIDS Education Guidelines*.

Please feel free to contact me at any time if I can provide further information or assistance.

Sincerely,

Debra W. Haffner

Debra W. Haffner, MPH
Executive Director

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Statement in Opposition to SCR 1629
Senate Education Committee, Hon. Dave Kerr, Chair
March 21, 1994
Carla Dugger, Associate Director

The ACLU opposes SCR 1629 because we support its antithesis --comprehensive sexuality education. We believe that a person's ability to exercise the individual freedoms guaranteed by the Constitution is facilitated by having access to full and complete information. By "comprehensive sexuality education," we mean a thorough, scientifically accurate curriculum that examines such subjects as human development, relationships, personal skills, sexual behavior and health, and society and culture. Accordingly, we must oppose the use of curricula that reflect a single religious or moralistic viewpoint about controversial issues.

The ACLU also opposes the use of curricula whose content reflects discrimination on the basis of gender, sexual orientation, marital status, race, and class. The issue is not that we seek to censor such biased material and bar its circulation in schools; rather, we object to the use of such material as the *exclusive* base for instruction in a subject.

"Stress abstinence" curricula such as that urged in SCR 1629 instill fear and shame to discourage teenagers from engaging in sexual activity. This bill would provide little information that can help sexually active teenagers protect themselves from pregnancy or disease. It touts scientific and medical inaccuracies, stereotypes, and moralistic/religious prescriptions for proper behavior and values. We specifically oppose SCR 1629 on the grounds that it urges the codification of homophobia.

It is one of many ironies of the proponents' arguments of "stress abstinence" curricula that they work to prevent the use of condoms and suppress information about their proper use, then point with derision to a statistically small failure rate as evidence for further suppression.

SCR 1629 is unnecessary and redundant because comprehensive sexuality education programs already emphasize that abstinence from sexual activity is the only 100% foolproof way of avoiding pregnancy and sexually transmitted disease. All instruction about alternative preventive measures begins from this premise.

Even worse than its redundancy is the fact that SCR 1629, if its provisions are adopted by the state board of education, would require school districts to incur heavy costs in replacing curricular materials.

Sen. Ed.
3/21/94
Attachment 14