TEEN PREGNANCY PREVENTION

HEARING

BEFORE THE

SUBCOMMITTEE ON HUMAN RESOURCES

OF THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

ONE HUNDRED SEVENTH CONGRESS

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THURSDAY, NOVEMBER 15, 2001

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HUMAN RESOURCES,
Washington, DC.

The Subcommittee met, pursuant to call, at 10:00 a.m., in room B–318, Rayburn House Office Building, Hon. Wally Herger [Chairman of the Subcommittee] presiding.

[The advisory announcing the hearing follows:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HUMAN RESOURCES

FOR IMMEDIATE RELEASE
November 8, 2001
No. HR–9

CONTACT: (202) 225–1025

Herger Announces Hearing on Teen Pregnancy Prevention

Congressman Wally Herger (R–CA), Chairman, Subcommittee on Human Resources of the Committee on Ways and Means, today announced that the Subcommittee will hold a hearing on national progress in reducing teen pregnancy and related issues as the Subcommittee prepares for reauthorization next year of key features of the 1996 welfare reform law. **The hearing will take place on Thursday, November 15, 2001, in room B–318 Rayburn House Office Building, beginning at 10:00 a.m.**

In view of the limited time available to hear witnesses, oral testimony at this hearing will be from invited witnesses only. Witnesses will include representatives of the U.S. Department of Health and Human Services, program administrators, researchers, and other experts in pregnancy prevention strategies. However, any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing.

BACKGROUND:

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (P.L. 104–193), commonly referred to as the 1996 welfare reform law, made dramatic changes in the Federal-State welfare system designed to aid low-income American families. The law repealed the former Aid to Families with Dependent Children program, and with it the individual entitlement to cash welfare benefits. In its place, the 1996 legislation created a new Temporary Assistance for Needy Families (TANF) block grant that provides fixed funding to States to operate programs designed to achieve several purposes: (1) provide assistance to needy families, (2) end the dependence of needy parents on government benefits by promoting job preparation, work, and marriage, (3) prevent and reduce the incidence of out-of-wedlock pregnancies, and (4) encourage the formation and maintenance of two-parent families.

In addition to a basic program orientation toward preventing teen and other out-of-wedlock pregnancies as a key method of combating long-term welfare dependence, the law includes several specific provisions designed to address this issue, including: (1) the provision of $250 million in abstinence education funding, (2) permission for States to limit cash welfare for unmarried teen parents, and (3) the requirement that teens be in school and living at home or with an adult in order to receive assistance. States also are authorized to use block grant funds to provide, or assist in locating, adult-supervised living arrangements, such as second-chance homes, for teen mothers.

In announcing the hearing, Chairman Herger stated: "Teen pregnancy cuts short the teen parents' opportunities to build a promising future, and puts their child at a fundamental disadvantage in so many ways. It means years of dependence for many struggling young families, which is a cycle that has repeated itself too often in recent generations. It is easy to see why preventing and reducing the incidence of teen pregnancy is absolutely critical to progress on welfare reform. I look forward

to hearing about the effects of the welfare law's provisions and what lessons we have learned that can help us as we move ahead next year."

FOCUS OF THE HEARING:

This hearing will focus on teen pregnancy prevention efforts since enactment of the welfare reform law in 1996, and recommendations for further improvements to prevent and reduce the incidence of teen pregnancy during the reauthorization of the TANF program in 2002.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Please Note: Due to the change in House mail policy, any person or organization wishing to submit a written statement for the printed record of the hearing should send it electronically to "hearingclerks.waysandmeans@mail.house.gov", along with a fax copy to 202/225–2610, by the close of business, Thursday, November 29, 2001. Those filing written statements who wish to have their statements distributed to the press and interested public at the hearing should deliver 200 copies to the Subcommittee on Human Resources in room B–317 Rayburn House Office Building, in an open and searchable package 48 hours before the hearing. The U.S. Capitol Police will refuse sealed-packaged deliveries to all House Office buildings.

FORMATTING REQUIREMENTS:

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record, or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. Due to the change in House mail policy, all statements and any accompanying exhibits for printing must be submitted electronically to "hearingclerks.waysandmeans @mail.house.gov", along with a fax copy to 202/225–2610, in WordPerfect or MS Word format and MUST NOT exceed a total of 10 pages including attachments. Witnesses are advised that the Committee will rely on electronic submissions for printing the official hearing record.

2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.

3. A witness appearing at a public hearing, or submitting a statement for the record of a public hearing, or submitting written comments in response to a published request for comments by the Committee, must include on his statement or submission a list of all clients, persons, or organizations on whose behalf the witness appears.

4. A supplemental sheet must accompany each statement listing the name, company, address, telephone and fax numbers where the witness or the designated representative may be reached. This supplemental sheet will not be included in the printed record.

The above restrictions and limitations apply only to material being submitted for printing. Statements and exhibits or supplementary material submitted solely for distribution to the Members, the press, and the public during the course of a public hearing may be submitted in other forms.

Note: All Committee advisories and news releases are available on the World Wide Web at "http://waysandmeans.house.gov/".

The Committee seeks to make its facilities accessible to persons with disabilities. If you are in need of special accommodations, please call 202–225–1721 or 202–226–3411 TTD/TTY in advance of the event (four business days notice is requested). Questions with regard to special accommodation needs in general (including availability of Committee materials in alternative formats) may be directed to the Committee as noted above.

Chairman HERGER. Good morning, and welcome to today's Human Resources Subcommittee hearing on Teen Pregnancy Prevention. This hearing is a continuation of our review of welfare issues in preparation for next year's reauthorization of the Temporary Assistance for Needy Families (TANF) program at the heart of the 1996 Welfare Reform Law. Three of TANF's four basic purposes relate to preventing out-of-wedlock birth, and the law included several provisions encouraging States to address the problem of teen pregnancy.

The reasons are obvious. Recent decades of seeing teen childbearing in particular and out-of-wedlock childbearing in general become reliable predictors of welfare receipt. But there is more to this issue than just welfare. As Isabel Sawhill, President of the National Campaign to Prevent Teen Pregnancy puts it, "Almost no one thinks that teen unwed pregnancy and parenting is a good idea." I fully agree. There are important health consequences for young people who are sexually active as we will hear today.

As we head for reauthorization of TANF in 2002, a key issue will be what progress we have made in reducing out-of-wedlock births starting with births to teens, who as a group are the least equipped to support a baby. The good news is that the progress made to date has been impressive. In the 1999–2000 annual report of the National Strategy to Prevent Teen Pregnancy, the U.S. Department of Health and Human Services (HHS) reported that: "Teen pregnancy and birth rates in this country have declined to record low levels. Further, trends throughout the nineties have shown a steady reduction in teen birth rate that is now significant for all 50 States."

The bad news is that there is still a long way to go. The United States has one of the highest teen pregnancy rates in the industrialized world, but we are moving forward and are interested in building on the progress we have made to date. Thus, among other questions, today's hearing should help us focus on two specific questions. First, why are we making progress against teen pregnancy? And second, what further steps should we consider during next year's reauthorization of the 1996 Welfare Reform Law.

I look forward to exploring these issues with all of our witnesses today. Without objection, each Member will have the opportunity to submit a written statement and have it included in the record at this point.

Mr. Cardin, would you like to make an opening statement?

[The opening statement of Chairman Herger follows:]

Opening Statement of the Hon. Wally Herger, a Representative in Congress from the State of California, and Chairman, Subcommittee on Human Resources

Good morning and welcome to today's Human Resources Subcommittee hearing on teen pregnancy prevention. This hearing is a continuation of our review of welfare issues in preparation for next year's reauthorization of the Temporary Assistance for Needy Families program at the heart of the 1996 welfare reform law.

Three of TANF's four basic purposes relate to preventing out-of-wedlock births, and the law included several provisions encouraging States to address the problem of teen pregnancy. The reasons are obvious—recent decades have seen teen childbearing in particular and out-of-wedlock childbearing in general become reliable predicators of welfare receipt.

But there is more to this issue than just welfare. As Isabel Sawhill, President of the National Campaign to Prevent Teen Pregnancy, put it: "Almost no one thinks that teen unwed pregnancy and parenting is a good idea." I fully agree. There are

important health consequences as well for young people who are sexually active, as we will hear today.

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The bad news is there is still a long way to go. The United States has one of the highest teen pregnancy rates in the industrialized world. But we are moving forward, and are interested in building on the progress we have made to date.

Thus, among other questions, today's hearing should help us focus on two specific questions: First, why are we making progress against teen pregnancy and second, what further steps should we consider during next year's reauthorization of the 1996 welfare reform law? I look forward to exploring these issues with all of our witnesses today.

Mr. CARDIN. Well, thank you, Mr. Chairman.

First let me welcome our witnesses that are with us today, and I thank you for holding this hearing on an extremely important subject.

There is no question that reducing teenage pregnancy is a goal that enjoys broad bipartisan support here in Congress. Reducing teen pregnancy is not a panacea for every social program, but it will help promote better outcomes for family. In short, convincing young people to delay pregnancy will put them in a much better position to provide for and care for their children.

Mr. Chairman, I think you stated it accurately in that we are very pleased that we have been able to reduce teenage pregnancy, but we still have the largest teenaged pregnancy of any of the industrial nations of the world, developed nations of the world.

So the question is, what can we do to buildupon the success that we have had as we go to the next level of TANF and Welfare Reform? And to answer that I think we first need to try to understand why we have had the success that we have had in reducing teenage pregnancy, and I would suggest that there are multiple factors that have played a role in reducing the number of teenage pregnancies in our society. Clearly the rising fear of sexually transmitted diseases over the last decade decreased sexual activity and unprotected sex among teenagers. Second, increased access to contraception and more effective forms of long-term contraception reduced the number of unintended pregnancies. Third, local efforts to reduce teenage births through counseling and other methods have produced some positive results. While I have not seen any corroborative evidence for this presumption, I would guess that a decade of strong economic growth has had a positive impact on reducing teenage pregnancy because there is more hope out there, and that I think has led people to make more mature decisions about their family.

I might point out though that I am not sure there is any real evidence as to the direct actions that we took in the 1996 law, what impact that has had on our success in reducing teenage pregnancies. We need to take a look at that, Mr. Chairman. We need to take a look at what we should be doing on welfare reform.

In terms of what this means for the future, I would say that we should continue our focus on personal responsibility. We should do a better job of not only funding local efforts to combat teen pregnancy, but also highlighting successful programs, which should increase access to youth development and after-school programs that give teenagers productive activities to pursue, and we should promote the value of abstinence without undercutting our commitment to providing access to and information about contraception.

On this last issue, I think it is important to remember that discussing contraception has never been found to promote sexual activity among teenagers, but there is evidence that such discussion reduces unintended pregnancies. This means that we can tell teenagers that abstinence is always the best option, but if they do have sex, they should take precautions against pregnancy and sexually transmitted diseases.

I look forward to learning today from the witnesses that we have on the panel, and I will look forward to working with all my colleagues in developing the right policy to promote the goal of reducing teenage births.

[The opening statement of Mr. Cardin follows:]

Opening Statement of the Hon. Benjamin Cardin, a Representative in Congress from the State of Maryland

Mr. Chairman, I am pleased to be here today to discuss our Nation's effort to reduce teenage pregnancy—a goal for which there is broad bipartisan support.

Reducing teen births is not a panacea for every social problem, but it will help promote better outcomes for families. In short, convincing young people to delay pregnancy will put them in a much better position to provide and care for their children.

Fortunately, progress is being made on this important issue. Both teen pregnancy and teen birth rates have been falling since 1991—with the teen birth rate hitting a record low last year. However, even with this improvement, the United States still has the highest teenage birth rate among developed countries.

The question before this panel is how do we maintain the current progress on reducing teen pregnancy. To answer that inquiry, we first need to develop a consensus on what policy and societal changes prompted the improvement in teen pregnancy rates that have occurred over the last ten years.

As is so often the case, there is no single answer. Rather, there are mix of causes, some of which are linked to changes in public policy and some of which have nothing to do with any particular action taken by the government.

First, a rising fear of sexually-transmitted diseases over the last decade decreased sexual activity and/or unprotected sex among teenagers.

Second, increased access to contraception and more effective forms of long-term contraception, such as Depo-Provera, reduced the number of unintended pregnancies.

Third, local efforts to reduce teenage births, through counseling or other methods, may have produced some positive results.

Forth, while I have not seen any corroborative evidence for this presumption, I would guess that a decade of strong economic growth had a positive impact on reducing teenage pregnancies to the extent it reduced the sense of hopelessness and hardship that sometimes leads to unwise decisions.

And finally, a more general change may have occurred in young people's attitude towards sex. Many factors may have contributed to this last change, including government policies that stress personal responsibility, such as the provisions on promoting work and on enforcing child support obligations in the 1996 welfare law.

However, there is no evidence that any of the provisions in the 1996 welfare law that specifically targeted reducing teen and non-marital births have had any discernable impact.

In terms of what this means for the future, I would say that we should continue our focus on personal responsibility; we should do a better job of not only funding local efforts to combat teen pregnancy, but also of highlighting successful programs; we should increase access to youth development and after-school programs that give

teenagers productive activities to pursue; and we should promote the value of abstinence *without* undercutting our commitment to providing access to and information about contraception.

On this last issue, I think it is important to remember that discussing contraception has *never* been found to promote sexual activity among teenagers, but there is evidence that such discussions reduce unintended pregnancies. This means that we can tell teens that abstinence is always the best option, but if they do have sex, they should take precautions against pregnancy and sexually-transmitted diseases.

I look forward to hearing from our witnesses about their views on how best to continue our progress on reducing teen births. Thank you.

Chairman HERGER. Thank you, Mr. Cardin.

Before we move on to our testimony this morning, I want to remind our witnesses to limit their oral statements to 5 minutes. However, without objection, all the written testimony will be made a part of the permanent record.

To welcome our first witness today, I will turn to Mr. McCrery.

Mr. MCCRERY. Thank you, Mr. Chairman. Our first witness is Bobby Jindal from the U.S. Department of Health and Human Services. Bobby is from my home State of Louisiana, comes to HHS with a very distinguished resume. He started his career in my office as an intern, so a very distinguished record.

[Laughter.]

Mr. MCCRERY. He was an undergraduate at Brown. Went on to earn a Rhodes scholarship, furthered his studies overseas. Came back to the United States, became the Secretary of the Department of Health and Hospitals in Louisiana at a fairly young age of 24, I believe, something like that. And then became the executive director of the Medicare Reform Commission that was formed several years ago. When that work was completed, Bobby went back to Louisiana to become president of the Louisiana State Colleges and University system, and that is where we found him and brought him back to Washington to be the assistant secretary for planning and evaluation at HHS.

And we are indeed fortunate, Mr. Chairman, to have people of the quality of Bobby Jindal serving the public in Washington, D.C., and so I am very pleased to introduce our first witness, Bobby Jindal.

Chairman HERGER. Thank you, Mr. McCrery. And with that, Mr. Jindal, your testimony, please.

STATEMENT OF THE HON. BOBBY P. JINDAL, ASSISTANT SECRETARY FOR PLANNING AND EVALUATION, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. JINDAL. Thank you, Mr. Chairman.

Thank you, Representative McCrery for that kind introduction. I have often referred to the internship as the highlight of my career and resume as well.

[Laughter.]

Mr. JINDAL. Mr. Chairman, Members of the Subcommittee, I thank you for this opportunity. I thank you for inviting me to come discuss with you today the Department's teen pregnancy prevention activities, especially those since the passage of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996.

Like the Chairman and other Members have noted, I think this is a very important topic, and I do appreciate the opportunity to come and share some information with you this morning. The Welfare Reform Law highlighted the importance of addressing teen pregnancy prevention by recognizing the negative consequences of out-of-wedlock births particularly for teens. We know from the research that more than 80 percent of teens age 17 and younger who become parents ultimately require public assistance. Teen mothers face challenges when they become parents too early because they often drop out of school, have few skills to prepare them for work, have low rates of marriage, and are not adequately supported by the fathers of their children. The children born to unmarried teen mothers are at higher risk of having low-birth weights, have problems in their cognitive development and in school achievement, and are more vulnerable to child abuse. These children are also more likely to become teen parents themselves, to require public assistance as young adults, and are more likely to have trouble with the law.

In response to these findings, the 1996 Welfare Reform Law required the Department to establish a national Strategy to Prevent Teen Pregnancy. The Department's three annual reports to the Congress provide descriptions of our programs, technical assistance, research, evaluation activities, and surveillance activities that we have conducted to address this issue. The law also required the Department to ensure that at least 25 percent of communities have teen pregnancy prevention efforts. I am pleased to report that in 2001 the Department is supporting such efforts in at least 47 percent, almost half, of America's communities. This is likely a conservative estimate because it does not include activities funded under block grant programs to States for which data are not readily available. So this only includes direct grants to communities, not the many dollars expended to block grant programs.

I will shortly highlight some of the major activities taken by the Department to prevent teen pregnancies and especially to encourage adolescents to remain abstinent.

But first let me briefly describe the latest trends. We heard some references to these trends already. Let me briefly describe the latest trends in teen births and pregnancies.

Teen birth rates have been steadily declining according to the latest data compiled from the Department's Center for National Health Statistics. The overall birth rate for teenagers declined by 22 percent from 1991 to 2000, and is currently at its lowest rate ever.

However, we should be clear, as the Chairman and others have noted, that the U.S. teen birth rate is still too high, and of particular importance, it is still considerably higher than rates for other developed countries. The U.S. rate in 2000 was 48.7 births per 1,000 teens. This compares to rates under 30 births per 1,000 teens in nearly all the other developed countries reported by the Centers for Disease Control and Prevention (CDC), and rates fewer than 10 births per 1,000 teens in nearly one half of those countries.

The declines in U.S. teen birth rates cut across ages, States, races and ethnic groups. Specifically, the birth rate for younger teens, those aged 15 to 17 years of age, fell by 4 percent between

1999 and 2000, and 29 percent between 1991 and 2000. The 2000 rate is a record low for our country.

The rate for older teens, those aged 18 and 19 years of age, fell by 1 percent between 1999 and 2000, and is down 16 percent from its recent high in 1992.

Between 1991 and 1999, teen birth rates fell by 25 percent or more in nine States and the District of Columbia and the Virgin Islands, with declines in five of these States exceeding 30 percent. As the Chairman noted, the declines have happened in all 50 States.

The overall birth rate for black teens fell 31 percent from 1991 to 2000 to reach a record low, and for young black teens, those aged 15 to 17, it dropped by 40 percent. This drop is to a great extent the result of teen mothers delaying second births.

Among Hispanic teens declines in birth rates have been more modest, falling by 13 percent between 1994 and 1999, and actually increasing by 1 percent in 2000.

Rates among white non-Hispanic teens fell by 24 percent since 1991, and remain lower than rates among either black or Hispanic teens. Rates for Asian teens remain the lowest of all the different subgroups.

Birth rates for teens who are not married also declined in 1999, our most recent year of data. Since 1994 the rates for teens aged 15 to 17 years of age has fallen 20 percent, and the rates for teens aged 18 and 19 dropped 10 percent. However, despite these declines in birth rates, the proportion of teen births to unmarried teenagers continues to rise and remained very high in 1999. The majority of births to 15 to 19 years old were to unmarried teens. I think it was something over 75 percent over three quarters. The increase in the percentage of unmarried teens having children reflects in part the fact that birth rates for married teens have fallen considerably in recent years, and also the fact that many fewer teens are getting married.

The teen pregnancy rate has also fallen. This rate takes account of teen births, abortions and miscarriages. These data are less current and less detailed due to variability across States in collecting abortion data. We can measure U.S. teen pregnancy rates only since 1976 to 1997 due to that lack of consistent national data. In 1997 the rate was 94.3 pregnancies per 1,000 teen women.

I notice that I am getting close to the end of my time, so with the Chairman's permission, I will just take a minute to skip forward and get to the program descriptions.

My testimony does include much more detail on what we found. The quick summary is that teen pregnancy rates have also fallen, just as the birth rates have fallen.

Let me quickly describe what we know from the research, and I will refer you again to research in the written testimony from the National Institute of Health, both through longitudinal study and a Youth Risk Behavior Surveillance Study.

One of the things I want to stress in my testimony is that, as a Department, we think that the Congress's actions in instructing us and giving us the opportunity to do this research and evaluate programs is very important, and so we thank you for that oppor-

tunity, and we think that it will help inform the conversations we have going forward.

The research shows you several important things in terms of the likelihood for teens to engage in risky behavior, including sexual activity, as well as drinking and taking other chances.

What I do want to get to before I close, however, are what some of the evaluations are saying on programs and interventions. Studies show that those programs that include a youth development component are those that have demonstrated more success. For example, the way that it is commonly paraphrased, the more that we can allow students to say yes, not just say no, tends to improve our success rates. Specific findings also show that virginity pledges have been successful, in many instances, in convincing teens to delay their first sexual intercourse. It is most effective in schools where 30 percent of the student body also pledges. However, it also shows that if teens do become sexually active, they are less likely to protect themselves.

Let me close there just by saying in one sentence that the Department funds several programs, both abstinence-only and other programs, aimed at at-risk teens. The details are in your testimony. I will stop there since I am well over time, and I have submitted a more comprehensive set of written comments.

And I do know that on the panel, you also have somebody that is working directly with the Department to do the evaluation on Title V Abstinence Education Program. Rebecca Maynard is here. She is the investigator that was chosen through a competitive process to evaluate the abstinence programs funded by this Congress.

And I will just close where I started with saying this is obviously a very important issue. We are pleased that teen pregnancy and birth rates are declining. We have a lot more work to do, and we do think the evaluation components will be very important in informing the debate going forward.

Thank you, Mr. Chairman.

[The prepared statement of Mr. Jindal follows:]

Statement of the Hon. Bobby P. Jindal, Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services

Mr. Chairman and Members of the Subcommittee, thank you for inviting me to come today to discuss the Department's teen pregnancy prevention activities since the passage of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996. This welfare reform law highlighted the importance of addressing teen pregnancy prevention by recognizing the negative consequences of out-of-wedlock births, particularly for teens. We know from the research that more than 80 percent of teens age 17 and younger who become parents ultimately require public assistance. Teen mothers face challenges when they become parents too early because they often drop out of school, have few skills to prepare them for work, have low rates of marriage, and are not adequately supported by the fathers of their children. The children born to unmarried teen mothers are at higher risk of having low-birth weights, have problems in their cognitive development and in school achievement, and are more vulnerable to child abuse. These children are also more likely to become teen parents themselves and to require public assistance as young adults.

In response to these findings, the 1996 welfare reform law required the Department to establish a National Strategy to Prevent Teen Pregnancy. The Department's three annual reports to the Congress provide descriptions of our programs, technical assistance, research, evaluation, and surveillance activities we conduct to address this issue. The law also required the Department to ensure that at least 25 percent of communities have teen pregnancy prevention efforts. I am happy to report that in 2001, the Department is supporting such efforts in at least 47 percent of America's communities. This a conservative estimate because it does not include activities

funded under block grant programs to States for which data are not readily available.

I will shortly highlight some of the major activities taken by the Department to prevent teen pregnancies and especially to encourage adolescents to remain abstinent. But first, let me briefly describe the latest trends in teen births and pregnancies.

Trends in Teen Births and Pregnancies

Teen birth rates have been steadily declining, according to the latest data compiled from the Department's National Center for Health Statistics. The overall birth rate for teenagers declined by 22 percent from 1991 to 2000, and is currently at its lowest level ever.

However, we should be clear—the U.S. teen birth rate is still too high, and it is considerably higher than rates for other developed countries. The U.S. rate in 2000 was 48.7 births per 1,000 teens. This compares to rates under 30 births per 1,000 teens in nearly all the other developed countries reported by CDC, and rates fewer than 10 births per 1000 teens in nearly one half of those countries.

These declines in U.S. teen birth rates cut across ages, states, races, and ethnic groups. Specifically——

- The birth rate for younger teens (ages 15–17 years) fell by four percent between 1999 and 2000, and 29 percent between 1991 and 2000. The 2000 rate is a record low for the Nation.
- The rate for older teens (ages 18–19 years) fell by one percent between 1999 and 2000, and is down 16 percent from its recent high in 1992.
- Between 1991 and 1999, teen birth rates fell by 25 percent or more in 9 states and the District of Columbia and the Virgin Islands, with declines in five of these states exceeding 30 percent.
- The overall birth rate for black teens fell 31 percent from 1991 to 2000 to reach a record low, and for young black teens (age 15–17) it dropped 40 percent This drop is to a great extent the result of teen mothers delaying second births.
- Among Hispanic teens, declines in birth rates have been more modest, falling by 13 percent between 1994 and 1999, and actually increasing by one percent in 2000.
- Rates among white non-Hispanic teens fell by 24 percent since 1991, and remain lower than rates among either black or Hispanic teens. Rates for Asian teens remain the lowest of all.

Birth rates for teens who are not married also declined in 1999 (our most recent year of data). Since 1994, the rate for teens ages 15–17 years has fallen 20 percent, and the rate for teens ages 18–19 dropped 10 percent. However, despite these declines in birth rates, the proportion of teen births to unmarried teenagers continues to rise and remained very high in 1999. The majority of births to 15 to 19 year olds were to unmarried teens. The increase in the percentage of unmarried teens having children reflects in part the fact that birth rates for married teens have fallen considerably in recent years, and fewer teens are getting married.

The teen pregnancy rate has also fallen. This rate takes account of teen births, abortions, and miscarriages. These data are less current and less detailed due to variability across states in collecting abortion data. We can measure U.S. teen pregnancy rates from 1976 to 1997. In 1997 the rate was 94.3 pregnancies per 1,000 teen women. This is 19 percent lower than its peak in 1991, and its lowest point in the 20 plus years for which we have data. Declines in teen pregnancy rates reflect reductions in both teen births and teen abortions. The drop in teen pregnancy rates during this period occurred across age and ethnic groups——

- Between 1990 and 1997 teen pregnancy rates for younger teens fell by 21 percent and rates among older teens fell by 13 percent.
- Declines in pregnancy rates during this period were steepest for non-Hispanic white and black teens, falling by 23 and 26 percent respectively. Among Hispanic teens, abortion rates did not start falling until 1994, and have fallen by 11 percent between 1994 and 1997.

What We Know from the Research

Recent research from nationally representative surveys (such as the National Longitudinal Study on Adolescent Health (Add Health) and the Youth Risk Behavior Surveillance Survey (YRBSS)) gives us a great deal of information about how our young people are faring and what factors influence avoiding risky behaviors such as the initiation of early sexual activity. Add Health is a Congressionally-mandated study which asks students questions about their lives including their health, friendships, self-esteem, and expectations for the future. Twenty thousand students are being followed longitudinally and have already completed three waves of questions.

Since 1996 we have seen a number of published reports using the data collected from this study. The YRBSS is a CDC survey administered every two years that is used to measure the incidence of risk behaviors nationally, as well as at the state level.

While the studies show that most teens are doing well, they do confirm that a significant proportion of teens put themselves at risk. Let me highlight some of the interesting findings. We have learned from the YRBSS that in 1999:

- 27 percent of 9th graders and 51 percent of 12th graders reported having had sexual intercourse in the previous three months.
- 50 percent of all students reported drinking alcohol on one or more occasions in the last month.
- 27 percent of students reported having smoked marijuana in the last month.

Findings from Add Health have taught us that the home environment plays a major role in teen decisionmaking. They have shown that students' feelings of connection to school appear to protect them from health risks. Findings also show that teens who have strong ties to family and school are more likely than their peers to delay sexual intercourse and engage in less drug use, violence, and suicide. Conversely, Add Health also has shown that negative peer influences combined with poor parental supervision are associated with adverse health outcomes.

Specific findings from the Add Health study also included some related to virginity pledges Teens who have taken a public pledge to remain virgins until they are married are more likely to delay first sexual intercourse and to report that their parents disapproved of their having sex. Taking the pledge is most effective in schools where more than 30 percent of the student body also pledges. However, if there are no other pledgers, or if more than three-quarters of the students take the pledge, the pledge loses its power. In addition, if these teens become sexually active they are less likely to protect themselves from pregnancy or sexually transmitted diseases (STDs). Other studies are examining the best prevention methods for working with adolescents to help them protect themselves from risk.

In further support of what we have learned through Add Health, a new National Academy of Sciences study confirms that youth development strategies are critically important to the prevention of youth risk behaviors. The most effective youth development programs incorporate opportunities for physical, cognitive, and social/emotional development; opportunities for community involvement and service; and opportunities to interact with caring adults and a diversity of peers. Young people need a variety of experiences to develop their full potential and these experiences need to take place in an environment in which the family, school and community work together.

The Department's Major Teen Pregnancy Prevention Activities

Abstinence-only education programs are a major focus of the Department's activities to prevent teen pregnancies. The expansion of these programs was an important result of the 1996 welfare reform law. The law established the State Abstinence Education Block Grant Program (through Title V section 510 of the Social Security Act) and provided $50 million to be distributed annually to States to fund these activities. (Anecdotal evidence also suggests that some states are using Temporary Assistance to Needy Families (TANF) funds to support a broad range of teen pregnancy prevention activities, including abstinence-only education.) The authorization for this program, along with the other provisions of the law, is due to expire in FY 2002.

Under the Title V program, approximately 700 programs nationwide have been funded. The most frequently funded local program activities are social skills instruction, character-based education and assets building, public awareness campaigns, curriculum development and implementation, school-based abstinence programs, peer mentoring and education, and parent education groups. The two age groups most frequently served are 13–14 year olds and 9–12 year olds.

In addition, starting in FY 2001, a Community-Based Abstinence Education program was established. It follows the same legislative requirements as the Title V State program created under welfare reform. This program is funded at $20 million in FY 2001 and $30 million for FY 2002. Forty-nine communities were recently awarded grants.

The Adolescent Family Life Program awards approximately $10 million for abstinence education programs, also using the same legislative requirements as the Title V abstinence education program authorized under welfare reform.

Let me now mention other important efforts to prevent teen pregnancies within the Department. First, the Centers for Disease Control and Prevention (CDC) support 13 demonstration and evaluation sites funded through the Community Coali-

tion Partnership Programs for the Prevention of Teen Pregnancy. These programs are mobilizing and organizing community leaders to create an effective network of resources to demonstrate and evaluate the effectiveness of teen pregnancy prevention programs that are based on a youth development approach. These demonstrations do not fund individual programs to deliver services. Rather, they work with agencies in their communities to expand the scope and number of services that are provided to youth. Outcomes are being evaluated.

Second, the Administration for Children and Families funds 13 states to develop and support innovative youth development strategies. These state grants support efforts that focus on all youth, including vulnerable youth in at-risk situations. This grant program put into practice the new findings from the National Academy of Sciences report.

We believe it is critical that teen pregnancy prevention efforts should also focus on the teen boys and emphasize the importance of fathers in the lives of children. Living with both a mother and a father helps to protect teen girls and boys against the risks associated with early initiation of sex and to slow the rate at which teenagers become sexually active. A number of our grant programs have especially targeted teen boys and work with young fathers to prevent subsequent unplanned pregnancies. Many projects that received abstinence education grants work with teen boys. Also, an HHS-funded male involvement initiative works with community-based organizations that provide health, education, and social services and integrates them with pregnancy prevention efforts directed to young men.

When teens are provided with educational opportunities, supportive environments, skills, and motivation, they make healthy choices. The Administration has been clear that it believes that providing these opportunities combined with a consistent abstinence-only message is the surest approach to preventing pregnancies or STDs. The Department funds programs that provide other services in addition to abstinence-only education. Teens do have access to family planning programs through either the Title X Family Planning Program or Medicaid, which provide assistance for all ages. Title X guidelines require grantees to discuss abstinence with all teen clients. The Administration is committed to pursuing funding parity between abstinence-only education and contraception services that go to teens.

Evaluation Efforts

Evaluating the impact of teen pregnancy prevention efforts is critically important to determining and documenting what works. Efforts to evaluate teen pregnancy prevention programs to date have shown mixed success, and the quality of many evaluations has been inconsistent. Sound rigorous evaluation is costly, time consuming, and requires high methodological standards such as random assignment. As a consequence, it is often avoided. In addition, depending upon the outcomes of interest, the results are often not available immediately.

This Committee clearly understood the importance of rigorous evaluation. A year after the 1996 welfare reform law was enacted this Committee authorized funding to conduct a rigorous evaluation of a selected number of programs funded under the Title V State Abstinence Education Program, with the final report due in FY 2005. This is a large and complex evaluation of the effectiveness of certain approaches to abstinence education, which my office manages for the Department. The study will allow us to take an empirical look at the differential effectiveness of several types of abstinence programs, but will not be a comparison of abstinence programs with other pregnancy/STD prevention programs. A competitive contract was awarded to Mathematica Policy Research to conduct this study and Dr. Rebecca Maynard is the Principal Investigator for the study. The findings will not be available in time for welfare reauthorization next year.

In addition to the Title V Abstinence Education Evaluation, Congressman Istook included an evaluation component when he added funds in FY 2001 Labor, Health and Human Services, Education appropriations bill to create community-based abstinence education programs. My office is also responsible for managing this evaluation effort, and we are now in the planning stages for developing evaluation design options. We are interested in making sure that these evaluation efforts are complementary to the State evaluation efforts. We also are committed to evaluating a range of teen pregnancy prevention approaches, including family planning. As we proceed with our feasibility study, we intend to consult with many key stakeholders, including researchers, advocates, program administrators, policy officials, and members of Congress.

We in the Department believe that sound, rigorous evaluation is what is needed to advance our knowledge of what works to prevent teen pregnancies.

Conclusion

I commend you, Mr. Chairman, for calling this hearing and recognizing the importance of looking at the risks our young people face and the impact they have on our welfare system. The Department looks forward to working with you as we reauthorize PRWORA.

Chairman HERGER. Thank you, Mr. Jindal, and your full testimony will be submitted for the record. With that, the gentleman from Louisiana, Mr. McCrery to inquire.

Mr. MCCRERY. Thank you, Mr. Chairman.

Mr. Jindal, based on what we know about trends involving teen pregnancy and the early effects of the 1996 Welfare Reform Law, are there any changes or new provisions that your Department is ready to recommend as we start the process of reauthorizing TANF next year?

Mr. JINDAL. Two things. First, we are certainly working very closely with Wade Horn at the administration for Children and Families (ACF) internally in the Department looking at reauthorization. I know that the administration is going to begin its series of consultations with Members of Congress and congressional leadership. Currently Wade is engaged in a series of national listening tours across the country to get input from representatives to find out more about what has worked and what might need tweaking as we go forward. Overall, certainly, I think the Secretary, it would be fair to say, views Welfare Reform both in Wisconsin and across the country as a success and would like to build on that success.

It would be too early for me to comment at this time on the administration's perspectives on particular aspects of Welfare Reform in terms of changes or not making changes, but I do know that process has started. I know the national listening tours are taking place and I do know the administration is going to start coming up to the Hill literally over the next few days to start consulting with Members as it does these national listening tours.

The second piece that I would emphasize is the importance of evaluation activities. Rebecca can talk more about this. Next year will be the final year that they will be collecting data. Some of those results will therefore be coming out in the next couple of years.

There is also another evaluation component on the community-based programs that is only now just starting. We will soon release the competitive request for proposals, and so the only thing I would emphasize is that we do believe the evaluation is an important component of moving forward.

Mr. MCCRERY. So it is safe to say that Welfare Reform reauthorization is on your radar screen, it is on the radar screen of the administration, and you are going to be working with us to fashion the reauthorization next year?

Mr. JINDAL. Yes, sir, and we do look forward to working with you to get that input.

Mr. MCCRERY. Thank you, Mr. Jindal. Thank you, Mr. Chairman.

Chairman HERGER. Thank you, Mr. McCrery. The Ranking Member from Maryland, Mr. Cardin.

Mr. CARDIN. Thank you, Mr. Chairman.

And thank you very much for your testimony. It is a very comprehensive report as to current status and a blueprint to move forward. In your written testimony, and you mentioned it very briefly, you highlighted the importance of developing constructive activities for young people so that they could avoid risky activities, such as after-school programs and other ways in which young people can work together, become more responsible rather than being at risk.

We have certain funding that is available at the Federal government for abstinence programs, and I am just wondering what your position would be, considering that we want to give flexibility to local governments to be able to develop the best types of programs. It seems to me that if constructive activities are a good remedy for putting children at risk, shouldn't those types of programs be qualified for Federal abstinence dollars, even if there isn't a direct educational component to the use of those funds?

Mr. JINDAL. Let me start by setting the larger context, and then talk in particular about abstinence dollars. The Department is very interested in promoting rigorous comprehensive research on what works and doesn't work. The early trends certainly suggest, as you have said, that those interventions that include adolescent development components are going to be the more successful programs. I do want to put in a huge caveat, that we are still in the early stages of learning about what works and what doesn't work, and we do believe there needs to be more rigorous comprehensive work across the country. There have been isolated studies. I think you can find studies to say a wide range of things, looking at very, very particular local programs, but we want to make sure there is rigorous research with control groups that look across a variety of programs.

To answer your particular question, the Department has many funding sources for teen pregnancy programs and adolescent programs in its Maternal and Child Health Bureau, in ACF, and certainly with the block grants to States. The administration is very committed to parity between the abstinence-only programs and the other programs, and is working toward reaching that parity. The administration believes that the abstinence programs are an important component of that overall range of programs that are available to communities. However, knowing that there are these other funding sources, I think it is important that there be dollars available for abstinence programs.

Mr. CARDIN. And that is a good point. But let me, one of the real changes for the 1996 law was to give flexibility to the States within broad Federal guidelines of goals that we wanted to achieve, and States have really developed some very innovative programs. I guess I am concerned that if you pigeonhole too tightly for abstinence by itself and don't allow States to be able to use those types of funding source to develop comprehensive solutions, we might lose an opportunity. So I would just urge you to carry out the real policy that was developed by the Congress on giving flexibility to the States to not to be so prescriptive that it becomes difficult for States to do innovative programs.

You mentioned a balance, and that is a very good point. I would just caution again the virginity pledges, there is no—one of my con-

cerns is that it may very well just postpone activity and that when the adolescent becomes sexually active, that person may not have the education necessary to make the right decisions. So I would just also urge, as you look at balance, again not to pigeonhole so much. I think there is general agreement that abstinence is a value that we want to instill in our children but we also want them to understand the consequences of sex, and we want them to understand contraception. We want them to understand sexually transmitted diseases. And if you pigeonhole it too tightly, you end up maybe postponing but not avoiding some undesired consequences. And it is important, I think, to try to combine these rather than pigeonholing.

Mr. JINDAL. And I appreciate the suggestion to look into giving States more flexibility. Two quick comments. I know Congress set up some requirements in the law in terms of what requirements these abstinence programs would have to meet, and so we are very interested in making sure we are compliant with congressional intent. And in terms of giving States more flexibility, that is consistent with the Department's overall direction, and certainly, given the multiple funding sources, I think we would encourage States and communities to make those choices consistent with their own values and norms. But again, the point is well taken, and certainly we will consider ways we can give States and communities more flexibility.

Mr. CARDIN. I thank you. Thank you, Mr. Chairman.

Chairman HERGER. Thank you, Mr. Cardin. And now the gentlelady from Connecticut, Mrs. Johnson to inquire.

Mrs. JOHNSON. Thank you. And thank you for your testimony, Mr. Jindal. It was very complete and very impressive that we are making progress in reducing teen pregnancy.

You mentioned a couple things that were particularly important to me. One, you mentioned that you are finding if you connect students to other activities that that helps, very logical, very simple. I would hope that just because we do not have some of the evaluations done, that we do not miss this opportunity, when we reauthorize Welfare Reform, to deal with this issue of connectivity, because what we are finding in my hometown of New Britain, which is an old manufacturing center going through all the processes of losing its major employees and having intense pockets of poverty and isolation, which Welfare Reform now has impacted by bringing people into the workforce, you have a desperate need to connect kids into stable situations. And what we are finding with teen pregnancy prevention is, that it is not just about teen girls or teen boys—and I am glad you mentioned teen boys—it is about family systems. And we do have a program with 8½ years experience, and only two pregnancy events, one by a male—maybe both by a male, I do not know that, I am not up to date on that. But the fact is, this is essentially 100 percent over 8½ years. But it is through family systems. Yes, it is through children and connecting them into, and particularly with their mothers gone now for work. But what we are finding is, you have got to reach down. You can't wait till they are teenagers.

So some of that money has to enable us to enlarge these programs that have had at least Robert Wood Johnson review, to

reach down so that they can get the third and fourth grade sisters and brothers of the kids who in the program, and you can impact the whole family. We are seeing family change, and in the end, since these kids are mostly the product of teen pregnancies, if you don't get family change, you don't get system reform.

Now, if we are going to bring women into the workforce with young children, we have to think about how do we make sure that those children don't become teen parents. And we do have models of teen pregnancy prevention. But I am as concerned, as is my colleague, Mr. Cardin, about the narrowness of the funding smokestacks or pipes, because if we judge a program by its outcome, did its outcome result in abstinence? Can you tell by its outcome that the teens were abstinent? Then we ought to honor that, and we ought not to look at whether they accomplished that by teaching kids about responsible contraception, because if they teach kids about responsible life living skills and one of those is contraception, right now we don't give them any money. But if their outcomes are close to 100 percent, far better than most pledge programs or lower-level interventions, and we see family system change, isn't that what we want?

Mr. JINDAL. Thank you for the questions, Mrs. Johnson. And also I want to thank you, before I get to the question. I know that you were personally involved in some of the evaluation components of this, and I absolutely appreciate and support that. Again, if you look at the written testimony, I think it covered this. When you look at the programs most likely to be funded, because there is quite a bit of discretion in both the abstinence and the non-abstinence funding; a wide-range of approaches. They do involve teaching life skills, and they involve bringing in the parents and siblings as well. That is something we find very common among successful grant recipients.

And, again, I agree. I think the administration agrees with the need for flexibility and for a multiple number of approaches. And the good news is, if you look at communities, you will see that they are in—and I am not familiar with this program in particular in Connecticut; I am happy to learn more about it and will do so—but you will see that the States are using a variety of funding sources from HHS. There is $90 million in the abstinence programs. There is over $135 million in the other types of programs. You will see that communities have done a good job of using those multiple sources of funding to provide programs that are consistent with their local community values, the local norms and local desires.

Mrs. JOHNSON. Right. And I think just as in Welfare Reform, we found that if we gave States flexibility, they were much more creative in getting people off welfare. In this next kind of welfare reform, as the author of last year's, co-author with Mr. Cardin of last year's Fatherhood Bill, in many ways it is outdated. We need to integrate the education of fathers of children on welfare into welfare reform, just as we need to integrate teen pregnancy prevention into Welfare Reform, because we have to make whole family change if Welfare Reform is to achieve its ultimate goal of economic viability of families. So I would hope that the Department, as we move into Welfare Reform, will think with us about systems change rather

than about grants for fatherhood, grants for teen pregnancy, and how do we reach the real problem, which is as mothers go to work, family systems disintegrate because there is no parental oversight, and we are sort of dealing with that as a day care subsidy issue. It is not just a daycare subsidy issue.

So I look forward to working with you, and I thank you for your good testimony.

Mr. JINDAL. Thank you. We look forward to working with you as well.

Chairman HERGER. Thank you, Mrs. Johnson. Now we turn to the gentleman from Washington, Mr. McDermott, to inquire.

Mr. MCDERMOTT. Thank you, Mr. Chairman.

It always gives me pause to be here as a sort of middle-aged man with a bunch of other middle-aged people deciding how teens are not going to get pregnant.

But one of the questions that I have, in looking at this, where you have 600,000 failures every year, I mean 750,000 kids get pregnant, 80 percent are unintended. So that is about 600,000 young women get pregnant. I am very eager to hear how somebody can call that a successful program. And what I have trouble with in these two pots of money is how you look at a young woman and say, "Well, you are one that abstinence is going to work in, so we are going to put you in this pot. And you, you abstinence won't work with you, so we are going to put you over here where we will also tell you about birth control."

I can't see why you have an abstinence-only program unless you have some magic marker on young women that they are going to somehow show up and you can spot them and say, "Well, now there is one we have got to do this abstinence program on." How do you select these people? Because, obviously, if you had all 600,000 who got pregnant and put them in the abstinence program, it wouldn't do a bit of good. So what is the reason for having an abstinence program? Why don't you just have a sex education program, which is what the Kaiser Family Foundation says 73 percent of adults in this country say is the right thing to do?

Mr. JINDAL. Thank you for the question, Representative, and it is certainly good to see you again after the Commission.

The very simple reason why these programs exist is they were set up and required in the Welfare Reform Act, so we are required to give those dollars for abstinence-only programs. But going beyond that, again, we are only now at the beginning of the research—and you will hear more from Rebecca Maynard on the research into abstinence-only programs, plus the Department's intent when it looks at the community-based programs. We are only now at the beginning of doing rigorous research to understand the impact of all these programs. The administration does believe that the abstinence-only programs do play an important role.

To answer your particular question, though, in terms of who decides where these programs go, which individuals go into which particular program, that is a decision that is made at the local level, the States and the local communities getting these dollars, and again, there are multiple programs, multiple pots of money they can apply to within HHS. If States want to, they can certainly access these other dollars as well, and currently there are more

dollars outside of the abstinence-only programs for preventing teen pregnancies.

So the answer to your question in terms of who decides which interventions to direct at a particular teenager would be up to the State and the local communities. That is not a decision the Federal Government is making on their behalf, but I think Congress correctly decided to leave it to local communities and States to decide how best to intervene on behalf of their communities, on behalf of their teenagers in a way that is consistent with their norms, with their values, in a way that they judge will be most successful. And Welfare Reform gives them a tremendous amount of flexibility to decide how best to do that.

Mr. MCDERMOTT. And so if they have a reduction in the area, do you get more money the next year, or how do you measure success, or are we just shoveling money out there? Well, first of all, let me ask a more important question: who gets this money? Who are the—I mean the programs? Are they all faith-based?

Mr. JINDAL. Again, there are a large number of programs. The $50 million in Welfare Reform for abstinence goes in a block grant to the State. In terms of the dollars that were added by Congress, $20 million is now going to many organizations as part of a competitive grant process through Health Resources and Services Administration (HRSA). I don't know right now, and I can certainly get it to you, how many of those are faith-based organizations. I would imagine a good portion of them are. I don't know what portions of those are faith based.

Mr. MCDERMOTT. Do you have such a listing so that somebody could find out who gets this money?

Mr. JINDAL. I can find out from HRSA and get back to you after today.

[The information was subsequently received:]

HHS FISCAL 2001 ABSTINENCE EDUCATION IMPLEMENTATION GRANTS

Organization	City	State	Amount
State of Alabama Department of Public Health	Montgomery	Ala	$661,902
Mid-South Christian Ministries	West Memphis	Ark	277,179
Fayetteville Public Schools	Fayetteville	Ark	465,631
Arkansas Department of Health	Little Rock	Ark	800,000
Westcare Arizona, Inc.	Bullhead City	Ariz	239,951
Teen Awareness, Inc.	Fullerton	Calif	239,645
The Await and Find Project	Union City	Calif	285,000
Bay County Health Department	Panama City	Fla	131,000
Empowering the Vision	Miami	Fla	156,297
United Students for Abstinence/Pinellas Crisis	Pinellas Park	Fla	223,642
Economic Opportunity FHC	Miami Springs	Fla	698,169
Choosing the Best, Inc.	Marietta	Ga	593,422
Family Centered Educational Agency	Phoenix	Ill	279,807
St. Vincent Hospital and Health Services	Indianapolis	Ind	578,022
YMCA of Cumberland	Cumberland	Md	251,338
Michigan Department of Community Health	Lansing	Mich	800,000
Freedom Foundation of New Jersey, Inc.	Newark	NJ	515,481
Catholic Charities Diocese of Syracuse/Neighborhood Centers	Syracuse	NY	442,086
Greenburgh-Graham Union Free School District	Hastings on Hudson	NY	800,000
Catholic Charities of Buffalo, New York	Buffalo	NY	800,000
Tri-County Right to Life Education Foundation	Springfield	Ohio	386,095
Pregnancy Decision Health Centers	Columbus	Ohio	500,000
Abstinence Educators, Inc.	Mason	Ohio	800,000
Women's Care Center of Erie County	Erie	Pa	262,357

HHS FISCAL 2001 ABSTINENCE EDUCATION IMPLEMENTATION GRANTS—Continued

Organization	City	State	Amount
Heritage Community Services	North Charleston	SC	800,000
AAA Women's Services, Inc./Why Know Abstinence Education Program.	Chattanooga	Tenn	254,530
Fort Bend Independent School District	Sugarland	Texas	351,815
Worth the Wait	Pampa	Texas	371,691
Scott and White Memorial Hospital	Temple	Texas	625,970
McLennan County Collaborative	Waco	Texas	800,000
Teen-Aid	Spokane	Wash	751,352
Rosalie Manor Community and Family Services	Milwaukee	Wis	630,797
Community Actions of South Eastern West Virginia	Bluefield	W.Va	433,599
TOTAL			16,206,778

HHS FISCAL YEAR 2001 ABSTINENCE EDUCATION PLANNING GRANTS

Organization	City	State	Amount
Boys and Girls Club of East Central Alabama	Anniston	Ala	$88,500
The Crisis Pregnancy Centers of Greater Phoenix	Phoenix	Ariz	76,913
Roseland Christian Health Ministries	Chicago	Ill	98,048
YWCA of Greater Baton Rouge	Baton Rouge	La	99,362
Lao Family Community of Minnesota	St. Paul	Minn	74,920
New Jersey Family Policy Council	Parsippany	NJ	92,650
Several Sources Foundation	Ramsey	NJ	75,000
Action for a Better Community, Inc.	Rochester	NY	99,903
Community Services of Stark County	Canton	Ohio	75,000
Citizen Potawatomi Nation	Shawnee	Okla	62,358
Municipality of Caguas	Caguas	PR	99,295
Christ Community Medical Clinic	Memphis	Tenn	74,578
Centerstone Community Health Centers	Nashville	Tenn	74,067
S.A.G.E. Advice Council	Alvin	Texas	99,725
Catholic Charities of the Diocese of Fort Worth	Fort Worth	Texas	65,654
Shannon Health System	San Angelo	Texas	75,000
Boys and Girls Club of Murray/Midvale and Coalition	Murray	Utah	84,238
Spokane School District #81	Spokane	Wash	74,500
Youth Health Services, Inc.	Elkins	W.Va	85,000
AIDS Resource Center of Wisconsin	Milwaukee	Wisc	91,690
TOTAL			1,666,401

Mr. MCDERMOTT. I would appreciate it. I think it would be useful for the Committee to understand who it is that applies for this abstinence-only money, because certainly people like Planned Parenthood would not, because they recognize that they have got a broader problem here. And the American Medical Association and the American Pediatric Association, the American Nursing Association, every responsible medical organization says you ought to teach people about both. There is no reason to say, "We are just here going to tell you about contraception. We say the best thing is abstinence, but." And if you have got 600,000 young women last year who didn't want to get pregnant, got pregnant, it seems to me that there is falling through the cracks everywhere.

Mr. JINDAL. If I can make—I know we are running out of time, but I would like to offer two quick pieces of information. In terms of who does apply for this money, again, I don't know the particular organizations. I do know there are some organizations who

participate in other programs within the Department. For example, some of the applicants do receive money for non-abstinence programs. There are successful applicants that also get money for other programs.

Mr. MCDERMOTT. How do you keep the dollars separated in an organization?

[The information was subsequently received:]

U.S. Department of Health and Human Services
Washington, DC 20201

When applying for SPRANS Community-Based Abstinence Education grants, applicants are required to provide an assurance that any discussion of other forms of sexual conduct or provision of services will be conducted in a setting different from where and when the abstinence-only education is being conducted.

Mr. JINDAL. Again, we can give you the information. It will be important for that program that it is separate, but second, I would just close by saying we do think that the abstinence-only programs play an important role, and it is not that communities have to do one or the other. There are multiple programs within the Department. We think, given the wide range of services, the abstinence-only programs do play a very important role as a part of that range of services that are available from the Department.

Chairman HERGER. Thank you very much for your testimony. The gentleman's time has expired.

Mr. Jindal, I understand that HHS also reviewed programs in State and local areas that provide maternity group homes of second-chance homes. This was an important provision in the Welfare Reform Law aimed at ensuring that teen parents have a structured and supervised environment in which to raise their children. Can you please tell me how many such programs are operating and what the Department has learned from its review of these programs?

Mr. JINDAL. I think there are approximately 130 such homes operating in roughly 20 States, and I think in our current budget we have asked for $33 million for these second-chance or maternal group homes, depending on what you would like to call them. When I say there is $33 million, please understand there are other areas they can get funding from within our Department and Housing and Urban Development, so those would not be the only dollars that are available to them, and I will be happy to provide that information to the Committee or to you, Mr. Chairman. There are a couple of documents that the Administration for Strategic Planning and Evaluation has produced on these group homes and on sources of funding available to those providers in case they are interested in accessing the Department's various opportunities for partnership.

[The information was subsequently received:]

U.S. Department of Health and Human Services
Washington, DC 20201

Second Chance Homes

WHAT ARE THEY?

Second Chance Homes are adult-supervised, supportive group homes or apartment clusters for teen mothers and their children who cannot live at home because of abuse, neglect or other extenuating circumstances. Second Chance Homes can also offer support to help young families become self-sufficient and reduce the risk of repeat pregnancies. They provide a home where teen mothers can live, but they also offer program services to help put young mothers and their children on the path to a better future. Several federal resources are available to help state and local governments and community-based organizations create Second Chance Homes that provide safe, stable, nurturing environments for teen mothers and their children.

"I have to say Visions (a Second Chance Home in Massachusetts) helped me quite a bit, I loved them. I wanted to go somewhere [with my life], and the staff respected me for that."

TARA, AGE 18

"When I was younger I said, 'I'm never going on welfare. I'm going to college' (but) school was just too much. . . . I know I need help for me and my son. I always wanted to be a lawyer when I was a kid, but now with a kid and all, I just want to go one step at a time—be a paralegal, and then college and law school."

SABRINA, AGE 19

• Second Chance Homes programs vary across the country, but generally include:
- An adult-supervised, supportive living arrangement
- Pregnancy prevention services or referrals
- A requirement to finish high school or obtain a GED
- Access to support services such as child care, health care, transportation, and counseling
- Parenting and life skills classes
- Education, job training, and employment services
- Community involvement
- Individual case management and mentoring
- Culturally sensitive services
- Services to ensure a smooth transition to independent living

WHY ARE THEY IMPORTANT?

Second Chance Homes offer a nurturing home for society's most vulnerable families B teen mothers and their children with nowhere else to go. Almost half of all poor children under six are born to adolescent parents. Children of teen mothers are 50 percent more likely to have low birthweight, 33 percent more likely to become teen mothers themselves, and 2.7 times more likely to be incarcerated than the sons of mothers who delay childbearing. Teen mothers are half as likely to earn their high school diplomas or GEDs and are more likely to be on welfare than mothers who are older when they give birth.[1] In addition, research shows that over 60 percent of teen parents have experienced sexual and/or physical abuse, often by a household Member.[2] Limited early findings indicate that residents of Second Chance Homes have fewer repeat pregnancies, better high school/GED completion rates, stronger life skills, increased self-sufficiency, and healthier babies.[3]

Second Chance Homes help teen mothers and their children comply with welfare reform requirements. Under the 1996 welfare law, an unmarried parent under 18 cannot receive welfare assistance unless she lives with a parent, guardian or adult relative. However, if such a living arrangement is inappropriate (for example, if her family's whereabouts are unknown or if she was abused), states may waive the rule

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[1] Rebecca Maynard, *Kids Having Kids,* Robinhood Foundation's Special Report on Cost of Adolescent Childbearing, 1996.

[2] Debra Boyer and David Fine, *Victimization and Other Risk Factors for Child Maltreatment among School Age Parents: A Longitudinal Study,* US Department of Health and Human Services, 1990.

[3] Evaluation of Programs for Teen Parents and Their Children, Boston University School of Social Work, June 1998.

and either determine her current living arrangement to be appropriate, or help her find an alternative adult-supervised supportive living arrangement such as a Second Chance Home. Also, in states where alternatives such as Second Chance Homes are currently not available, teen mothers could be forced to choose between inappropriate living arrangements and losing their cash assistance. Making Second Chance Homes available to teen mothers in need could provide these teens with stable housing, case management, and preparation for independent living.

Second Chance Homes can support teen families who are homeless or in foster care. State foster care systems may not have the capacity to place the teens and their children together, and frequently, homeless shelters, battered women's shelters, and transitional living facilities cannot accept teen parents under age 17. Unfortunately, homelessness poses the threat of separation in young families. For vulnerable families with no safe, stable places to go, Second Chance Homes can help fill the gap.

WHO IS ELIGIBLE?

Eligibility criteria for Second Chance Homes vary from program to program. Some programs are targeted for adolescent mothers (between the ages of 14 to 20, for example), mothers receiving welfare assistance, or homeless families. Other programs are open to any mother in need of a place to live—regardless of age, income or the assistance program for which she qualifies. Teen mothers can be referred to Second Chance Homes through welfare agencies, homeless shelters, or foster care programs, or by community organizations, schools, clinics, or hospitals. Mothers may also self-refer.

WHERE ARE THEY?

Nationwide, at least 6 states have made a statewide commitment to Second Chance Home programs: Massachusetts, Nevada, New Mexico, Rhode Island, Texas and Georgia. In statewide networks, community-based organizations operate the homes under contract to the states and deliver the services. States share in the cost of the program, refer teens to homes, and set standards and guidelines for services to teen families. In addition, there are many local Second Chance Home programs operating in an estimated 25 additional states. For a directory of programs, please visit: http://www.span__online.org/seeking__supervision.html.

WHAT FEDERAL RESOURCES ARE AVAILABLE?

State legislatures may allocate Temporary Assistance to Needy Families (TANF) block grant funds for Second Chance Homes. Like TANF, state maintenance-of-effort (MOE) funds and the Social Services Block Grant (SSBG) are flexible, and largely under states' discretion in terms of how they are spent. States and communities may also explore other sources of funding from HHS and HUD (see the attached chart). Additional state and private sources of funding are available to fill in funding gaps, help providers acquire or rehabilitate Second Chance Homes, or develop specialized Second Chance Homes for foster care and homeless teens.

WHERE CAN I LEARN MORE?

The attached chart contains detailed information on the major sources of Federal funding for Second Chance Homes that are available from HHS and HUD. In addition to the Federal sites that are included in the chart, more general information about the Administration for Children and Families (the agency that oversees most of the programs within the Department of Health and Human Services) and the Department of Housing and Urban Development can be found at http://www.acf.dhhs.gov and http://www.hud.gov respectively. An HHS paper describing Second Chance Homes and some things that decisionmakers at the state and local levels may want to consider as they start or implement a Second Chance Home program can be accessed online at http://www.aspe.hhs.gov/hsp/.

There are a number of non-governmental organizations that have been actively assessing Second Chance Homes and providing technical assistance to states. The Social Policy Action Network (SPAN) has been a leader in documenting existing programs, identifying best practices and developing guides and a directory of homes. For more information about SPAN, call 202–434–4767 or online at http://www.span-online.org. Other organizations that can provide useful information about providing services to teen parents in need include The Child Welfare League of America, Florence Crittenton Division http://www.cwla.org, the Center for Law and Social Policy (CLASP) http://www.clasp. org and the Center for Assessment and Policy Development (CAPD) http://www.capd.org.

WHAT MAJOR RESOURCES ARE AVAILABLE?

	What Aspects of SCH Can These Funds Pay For?	Restrictions on Funding	Who Receives Funds?	Where can I get more information?
		HHS Sources of Assistance		
Temporary Assistance for Needy Families (TANF) Block Grant and State Maintenance of Effort Dollars (MOE).	Planning & operating costs; cash assistance to teens; parenting & life skills classes; child care; job training & placement; counseling; case management; follow-up services. Also, anything else that reasonably meets the four broad purposes of TANF. For MOE all of the above.	Cannot be used for facility construction or medical care except family planning; ''assistance'' such as housing and cash aid can only go to needy teens. For MOE, all funds must be spent on needy families. States define who is needy.	States, in the form of formula block grants; states decide how funds are spent within context of a TANF plan that must be reviewed and certified by HHS. For MOE, state decides how funds are spent.	State contacts for this funding stream are provided through this site: www.acf.dhhs.gov/programs/ofa/
Child Care Development Fund (CCDF)	Child care assistance for low-income families who are working or attending training/education; quality improvement efforts such as grants or training for child care providers.	CCDF cannot be used for construction or major renovation (except for Indian Tribes). Families receiving subsidies must meet income eligibility requirements and have children under age 13 (or age 19 if not capable of self care).	States, Territories, and Indian Tribes in the form of formula block grants.	State contacts for this funding stream are provided through this site: www.acf.dhhs.gov/programs/ccb/
Social Services Block Grant (SSBG)	Planning & operating costs; parenting & life skills classes; child care; job training & placement; counseling; case management; follow-up services.	Cannot be used for facility purchase, construction renovation; medical care except family planning; cash aid; unlicensed child care; drug rehab; public education; room and board; services in hospitals, nursing homes, or prisons.	States, in the form of formula block grants; states must report to HHS on how funds are spent and who is served.	State contacts for this funding stream are provided through this site: www.acf.dhhs.gov/programs/ocs/ssbg
Child Welfare Services Title IV–B Subpart 1 and 2 Funds.	Child welfare services, family preservation and reunification, family support, adoption promotion and support.	All children receiving State or Federal foster care funds must also receive certain protections under Title IV–B.	States and Indian Tribes receive Title IV–B subpart 1 and 2 funds on a formula basis.	www.acf.dhhs.gov/programs/cb/programs/index.htm

WHAT MAJOR RESOURCES ARE AVAILABLE?—Continued

	What Aspects of SCH Can These Funds Pay For?	Restrictions on Funding	Who Receives Funds?	Where can I get more information?
		HHS Sources of Assistance		
Independent Living Program	Room and board (for youth aged 18–21 only); education; life skills training; counseling; case management.	Funds must be spent on youth between the ages of 18 and 21 to assist them in making the transition from foster care to independent living.	States, on a formula basis	www.acf.dhhs.gov/programs/cb/programs/index.htm
Transitional Living Program for Homeless Youth	Housing, life skills training, interpersonal skills building, education, job training, health care.	Funds can only be used to serve youth aged 16–21 for up to 18 months who are: homeless, including those for whom it is not possible to live in a safe environment with a relative; and who do not have an alternative safe living arrangement.	HHS awards 3-year competitive grants to multi-purpose youth service organizations.	www.acf.dhhs.gov/programs/fysb/programs/pgm__tlp.htm
		HUD Sources of Assistance		
Community Development Block Grant (CDBG)	Facility purchase, construction, renovation; planning operating costs; parenting & life skills classes; child care; job training & placement; counseling; case management; follow-up services.	At least 70 percent of funds must benefit low and moderate income families; states and communities must prepare action plan with community input.	States, major cities, urban counties, in the form of formula block grants.	Contact your local HUD office. A listing is available at: http://www.hud.gov /local.html

WHAT MAJOR RESOURCES ARE AVAILABLE?—Continued

	What Aspects of SCH Can These Funds Pay For?	Restrictions on Funding	Who Receives Funds?	Where can I get more information?
		HUD Sources of Assistance		
HUD Supportive Housing Program	Facility purchase, construction, renovation; new or increased services to the homeless; operating expenses; some admin costs.	Funds must be spent on homeless persons only; 25 percent set aside for families with children; 25 percent set aside for disabled; 10 percent set aside for supportive services not provided with housing. Homeless minors may be eligible to receive services under this funding source unless they are considered wards of the state under applicable state law.	HUD awards 3-year, renewable competitive grants to states, tribes, cities, counties, other governmental entities, private non-profits, community mental health associations.	Contact your local HUD office. A listing is available at: http://www.hud.gov/local.html.
HUD Emergency Shelter Grants	Facility renovation; operating costs; homelessness prevention; employment, health, drug abuse, education services.	Funds must be spent on the homeless or those at risk of being homeless; only 5 percent of funds can be used for admin costs, and 30 percent for prevention and services. Homeless minors may be eligible to receive services under this funding source unless they are considered wards of the state under applicable state law.	States, major cities, urban counties, in the form of formula grants.	Contact your local HUD office. A listing is available at: http://www.hud.gov/local.html.

WHAT MAJOR RESOURCES ARE AVAILABLE?—Continued

	What Aspects of SCH Can These Funds Pay For?	Restrictions on Funding	Who Receives Funds?	Where can I get more information?
		HUD Sources of Assistance		
Rental Assistance Vouchers	In general, the voucher pays the landlord the difference between 30 percent of a renting family's gross income and the price of the rental unit, up to a local maximum.	Teenage mothers may be eligible for vouchers. However, the voucher program requires that a lease be signed by the renter, and in some states minors may not sign a lease. Individual PHAs determine whether a shared housing facility is an acceptable use for the voucher. The PHA must approve the renter and the unit according to various eligibility criteria.	In order to receive a voucher, a renter must apply to his/her local Public Housing Authority.	Contact your local Public Housing Authority.
HUD's Dollar Homes Program	Property acquisition		Local governments (cities and counties) can purchase HUD owned homes for $1 each, plus closing costs, to create housing for families and communities in need. Local governments can purchase these homes and then convey them to non-profit organizations for use.	http://www.hud.gov/dollarhomes Also, the full text of Housing Notice 00–7 (''Implementation of $1 Home Sales to Local Governments Program'') can be downloaded at http://www.hudclips.org (Click on ''2000 Housing Notices'')

WHAT MAJOR RESOURCES ARE AVAILABLE?—Continued

	What Aspects of SCH Can These Funds Pay For?	Restrictions on Funding	Who Receives Funds?	Where can I get more information?
		HUD Sources of Assistance		
HUD's Non-Profit Sales Program	Property acquisition	Direct sales of properties foreclosed by the Federal Housing Authority. Discounts of 30 percent off the list price are offered if the property is not eligible for FHA insurance and is located in a HUD-designated ''revitalization'' area. Other properties are offered at 10 percent discounts off list price (or 15 percent if five or more properties are purchased and closed in a single transaction). These discounts apply to sales in both restricted and general property listings.	Non-profit organizations can purchase properties at a discount through this program.	www.hud.gov/goodneighbor/nonprofitsales/index.html
		HUD Sources of Assistance		
McKinney Act Title V Program	Property acquisition	Properties are leased without charge for a period of 1 to 20 years, but the entity providing homeless services must pay for operating and repair costs..	Surplus properties can be made available to States, local governments and non-profit organizations for use to assist the homeless. Available properties are listed in the HUD Federal Register notice listing property availability HHS handles the application portion of the program.	Within HUD: at the Office of Special Needs Assistance Programs (202) 708–1234 From HHS: (301) 443–2265
Military Base Closures	Property acquisition		When a military base is being closed, a Local Redevelopment Authority is designated to redeploy the assets of the base.	Contact your Local Redevelopment Authority

Early indications are that we do see some positive results in terms of not only outcomes for the mother, but also for the child. We do see some early positive trends in terms of the likelihood that the mother will get work force skills and education. Going back to the points made by previous questions, we do see early indications that the child is also more likely to have positive health care outcomes. I say "early indicators" because it is still early and there isn't comprehensive or rigorous research. Part of the challenge has been that these programs are fairly small, they serve a small number of people, there hasn't been a very good control group to compare the results with, but the early indicators are certainly very positive that in giving a structured environment for these women who may not otherwise have had structured environments, you can accomplish good things both for the mothers and for the children. Combined with Welfare Reform, as you know, which allows States to require teen mothers to live with adult supervision or in a structured environment, these group homes can play an important role. And that is why the administration has asked for $33 million in the 2002 budget.

Chairman HERGER. Thank you very much, Mr. Jindal, and I thank you for your outstanding fine testimony.

Mr. JINDAL. Well, thank you, Mr. Chairman. Thank you, Members of the Committee.

[Questions submitted from Chairman Herger to Mr. Jindal, and his responses follow:]

1. In your testimony, you mention that teen boys ought also to be the focus of teen pregnancy prevention efforts. Can you describe the types of programs that are effective in encouraging teen boys to remain abstinent?

The Department recognizes that boys and girls have a shared responsibility in the prevention of teen pregnancy. Many abstinence programs target both girls and boys and recently, providers have begun developing curricula aimed specifically at addressing the concerns of boys. Unfortunately these programs are too new to have been fully evaluated. The national evaluation of abstinence education will provide gender specific outcome information for the mixed gender programs it is studying.

2. Please compare Federal and State funding for family planning, including contraception, with funding for abstinence education for each year since 1996.

1. FAMILY PLANNING SERVICES TO ALL WOMEN OF ALL AGES [1]

Funding (in millions dollars)

Progarm	1996	1997	1998	1999	2000	2001
Federal and State funding for family planning, including contraception, to women of all ages [2]						
Title X [3]	192.6	198.5	203.5	215	238.9	253.9
Medicaid:						
Federal Share	454.7	394.3	393.4	483.8	535.5	925.4
State Share	45.5	39.4	39.3	48.4	53.6	92.5
Total	692.8	632.2	636.2	747.2	828	1,271.8
2. Abstinence Education Funding [1]						
Adolescent Family Life Program	[4] 1.8	[4] 10.2	[4] 10.8	[4] 10.4	10.5	10.4
Title V section 510:.						
Federal Share [5]	.....	.....	50	50	50	50
State Match [6]	37.5	37.5	37.5	37.5		
SPRANS [7]	.....	.....	.....	.....	.....	20
Total	1.8	10.2	98.3	97.9	98	107.5

[1] This represents Federal programs that we know states use to fund these activities. States may be using other funds, but we do not have the reporting capability to know.

[2] Several other Federal programs fund family planning services, including Title V MCH Block Grant, Title XX SSBG, TANF and TANF bonuses for reduction in illegitimacy rates.

[3] An estimated 90 percent of the total expenditures goes for services.

[4] Includes projects that also have a care component for pregnant and parenting teens.

[5] This is the total amount of Federal funding available. Not all states and territories have applied for funding in each year. In 2001, the total amount awarded was $43.5 million.

[6] The required state match is $3 for every $4 Federal dollars. The total amount will vary with the amount of Federal funds awarded.

[7] This is the Special Projects of Regional and National Significance community-based abstinence education grant program. The FY 01 budget included an advance appropriation of $30 million for the SPRANS program for 2002. The FY 02 Labor/HHS appropriation included an additional $10 million for a total of $40 million in FY 2002.

3. Do you feel the funding streams for abstinence, family planning, and adolescent life programs are sufficiently flexible to provide opportunities for a broad array of program approaches that address teen pregnancy prevention and teen sexuality?

Through the abstinence, family planning and adolescent life programs, along with other programs at HHS, a range of teen pregnancy prevention activities are funded. While the uses of abstinence funding through the Title V state program, the SPRANS community-based program and the Adolescent Family Life program, have been Congressionally prescribed, the Department's health agencies have a variety of funding streams for the prevention of adolescent risk behaviors. States and communities can use these funds quite flexibly to improve overall adolescent outcomes. In addition states receive Federal block grant funding, such as TANF, that can be used to provide a range of pregnancy prevention services.

Chairman HERGER. And at this time if the witnesses for our second panel would please have a seat at the table.

On the second panel this morning, we will be hearing from Gale Grant, director of the Virginia Abstinence Education Initiative in Richmond, Virginia; Elayne Bennett, president of Best Friends Foundation, which is the subject of a recent "Washington Times" article that I would like included in the hearing record.

[The Washington Times article follows:]

D.C.'s Best

Cheryl Wetzstein
The Washington Times
Published 11/6/01

Asriel-Janifer wants to go into the Air Force and fly jets. Derrenzo Hines wants to play football. Their friend Ryan Vaughn isn't quite sure where his destiny lies.

For now though, these three 13-year-old D.C. boys are pursuing something else—good reputations.

"We don't want people to mess with the Best Men," said Derrenzo.

The three boys, all eighth-graders at Jefferson Junior High School in Southwest Washington, are Members of the fledgling Best Men program, a companion to the highly praised Best Friends for girls.

Like Best Friends, which was founded in 1987, Best Men uses an in-class study program, physical exercise and mentoring to teach teens how to say no to smoking, drugs, alcohol and sex—and yes to self-respect and healthy lifestyles.

Best Men also stresses an ideal of manhood: Its logo carries the image of an eagle as a symbol of vision, a lion as a symbol of strength, an anchor as a symbol of courage and strength, and a gavel as a symbol of truth and justice.

Boys learn "how to carry themselves as gentlemen, how to conduct themselves and have respect for themselves, women, young ladies and authority figures in general," said Alan Holt, dean of students at Southwest Washington's Amidon Elementary School, which has had all its sixth-grade boys in the program last year and this year.

Best Men started in the 2000–2001 school year at Jefferson and Amidon, and in several Milwaukee public schools. This year, the program is in the same schools, plus others in Texas and New Jersey.

It teaches boys "how to choose good friends, how to make the right decisions, and why you stay away from dangerous activities, such as sex, drug use and alcohol use," said DeLeon Ware III, a math teacher who helps lead the program at Jefferson.

Elayne Bennett, founder of Best Friends, said Best Men was created "because every time we would talk about what we're doing for the girls, someone would say, 'But what about the boys?' "

Despite concerns that Best Men would siphon off resources from the rapidly growing Best Friends program—which now has 5,000 girls in 99 public schools in 14 states, the District and the U.S. Virgin Islands—Best Friends Foundation leaders decided "we just have to try," Mrs. Bennett said.

Evidence of the Best Men's positive impact could be seen after the first year in the District, said Mrs. Bennett, who is married to former Education Secretary William J. Bennett and is the mother of two sons.

In a survey taken at the beginning of the Best Men program, 31 percent of some 60 teen-age boys said they had had sexual intercourse in the past 3 months. By the end of the year, 20 percent of the boys said they had had sexual intercourse in the previous 3 months.

It was especially heartening that eight of the previously sexually active boys said they would abstain from sex either until they graduated or got married, said Mrs. Bennett.

Hundreds of abstinence-education programs are in place nationwide, but few target boys exclusively, according to the Abstinence Clearinghouse in Sioux Falls, S.D.

A program introduced this year—the Game Plan Abstinence Program—by Miami Heat basketball star A.C. Green and Project Reality of Golf, Ill., uses a sports motif, but can be used with both boys and girls.

Abstinence researchers say single males face formidable obstacles in sexual self-control—the popular culture has exploded with permissive sexual imagery, while social messages to stay chaste and marry have weakened.

As a result, many teen-pregnancy-prevention programs stress sexual abstinence with young teen males, but later, "assuming that most older teen boys and young men will be sexually active," focus on contraception, the National Campaign to Prevent Teen Pregnancy said in a 1997 publication, "Not Just For Girls: The Roles of Boys and Men in Teen Pregnancy Prevention."

Still, studies in the 1990s indicate that boys were hearing abstinence messages. According to the Federal Youth Risk Behavior Survey, in 1991, 57.4 percent of high school males had sexual intercourse. This figure dropped to 48.8 percent in 1997 and upticked to 52.2 percent in 1999.

The number of sexually active high school girls fell also, but less dramatically: In 1991, 50.8 percent of girls had sexual intercourse. This figure was 47.7 percent in both 1997 and 1999.

The District's Best Men program involves 30 boys at Amidon and 60 boys at Jefferson, program leaders said. The boys have monthly meetings, where they study the Best Men curriculum and delve into such things as manhood, decision-making and relationship skills.

The boys learn that girls have pickup lines—like "Come on, prove you're a man"—and how to resist them, said Mrs. Bennett. "We also teach boys that their role is to protect and take care of the girl," and realize, that for a teen-age girl, "pregnancy would not be in her best interest," she said.

Best Men Members meet weekly for martial arts, which builds fitness and mental discipline, and have frequent contact with male mentors at their school. There are

also field trips, sports activities, tutoring and community-service projects. Adult females are welcomed and appreciated, but the goal is to connect young men to strong male role models, program leaders said.

Derrenzo said that joining Best Men has helped him with self-control. "I had self-respect, but if an adult would say something to me that I didn't like, I would just say something back," said the youth, who lives with his parents and an older brother. "Since I've been in the program, I've been able to catch myself before I say something."

"When I was in elementary school, I had just a little, tiny attitude problem," said Ryan, who grinned as Mr. Holt, his former teacher, shot him a knowing look.

"When I heard about Best Men," continued Ryan, whose parents have recently reunited, "I thought that this would help me to have some self-control and bring a brighter future for me."

"I wanted to be in Best Men because I heard it was like Best Friends, and they're so disciplined and have a good reputation," said Asriel, who lives with his parents and two sisters. "Best Men helped me learn about drug abuse," he added. "There are messages 'about just say no,' but really, you just can't say no. [Best Men] teaches you the real thing, what to do when somebody tells you to take some drugs."

In Best Friends, girls graduate into the Diamond Girls program in high school; many are eligible for college scholarships from the Best Friends Foundation. A companion program for high school boys, called the Iron Men, is being discussed, said Lori Anne Williams, the Best Friends cultural-arts director.

Chairman HERGER. Rebecca Maynard, university trustee professor of education and social policy at the University of Pennsylvania in Philadelphia.

And, Mrs. Johnson, would you like to introduce the next witness?

Mrs. JOHNSON. I certainly would, Mr. Chairman, and thank you very much for this opportunity.

There is not very many of us that really change people's lives, and I am please to introduce RoseAnne Bilodeau, who really has changed the lives of so many kids in my hometown. She came into a neighborhood that was gang-ridden, one of the most dangerous, one of the poorest neighborhoods in a city with a lot of problems, and she has created opportunity for those kids. Over 8½ years only two instances in which one of those young people was involved in a pregnancy.

You know, I have visited a lot of young parents' programs. And who is there? The girls with their babies. I visit this program, and who is there? The girls and the boys. They did a poetry book. Most of the poems were written by the boys.

So we can do it. We can take this opportunity to help families in our society grow in such a way that they don't become at risk and into the Department of Children and Families and all the family agencies. But we have to be smarter. And I just am so thrilled to have RoseAnne Bilodeau here, who has done such a wonderful job of impacting the lives of young people and their parents. Thank you for being here.

Chairman HERGER. Thank you, Mrs. Johnson.

We also have Dr. Joe McIlhaney, president of the Medical Institute for Sexual Health in Austin, Texas; and Sarah Brown from the National Campaign to Prevent Teen Pregnancy in Washington, D.C.

Again, I would like to welcome each of you, and if we could begin with the testimony. Ms. Grant.

STATEMENT OF GALE E. GRANT, DIRECTOR, ABSTINENCE EDUCATION INITIATIVE, VIRGINIA DEPARTMENT OF HEALTH, RICHMOND, VIRGINIA

Ms. GRANT. Good morning, and thank you, Chairman Herger and other Members of the Committee for allowing me to be here today. I am Gale Grant, director of the Virginia Abstinence Education Initiative which operates through the Virginia Department of Health.

Having been involved in teen pregnancy prevention for quite a number of years for personal reasons, primarily because I was born to a 15-year-old. And also when I went to graduate school I focused on human development, and have really studied the life span from infancy to older age to elderly. I focused in though on the adolescent period, preadolescence and adolescence, because I had particular interest in that, and particularly adolescent sexuality and the issues related to that.

During my work in teen pregnancy prevention I saw grueling work, and I love the work, trying to work with girls and their families, and young men, to have some impact on what would happen to those young people as they were being parented, either as a girl emancipated herself or if she stayed in the home with other family Members. And I found that I just felt like I was spinning my wheels. So many times it was so difficult to prevent the second pregnancy. And I decided to take a step back and look at how did we get here? And that led me to much more emphasis in primary prevention and actually started hearing about abstinence education and looking into what that was all about. I realized that until we deal with teens engaging in sexual activity, we truly cannot have an impact on teen pregnancies. We must deal with the source and the sexual activity, young people engaging in sexual activity that leads to pregnancies and other consequences of that activity.

Consequently, I felt very prepared, after spending pretty much most of the 1980s training people in abstinence education around the State for this job as Director of the Abstinence Education Initiative for Virginia. And in Virginia we took a different approach with our monies. We decided that we wanted to look at the impact of teaching abstinence until marriage education. So we designed a large quasi-experimental longitudinal study. We did receive some flack around the State for doing that because we just didn't take our dollars and throw them out there, let people apply and do good as people want to do a lot of times with monies like this. They want to help kids, which is of some merit, but we really wanted to take an empirical approach to this.

So we had a request for proposal process, which was competitive, and funded six agencies to provide abstinence until marriage education. We provide a great deal of training to those agency staff. We provide technical assistance. And consequently, we have what we believe is the foundation for a very strong quasi-experimental evaluation, because we don't have random assignment to control and treatment groups, but we do have match comparisons.

And what we are finding right now, we are looking at our preliminary data, first year, and annual follow-up, and we are finding that we have very strong linkages between our pre- and post-test, we are not losing kids from the time that they take our pre-test to the time they take our post-test. We have fairly good strong link-

ages from year one to year two, from when kids take that post-test that first year they are in our programs, and then when they take their annual follow-up, which we give them every year, along with a booster session after they have left that primary year, the first year they come in, we provide booster sessions for young people each subsequent year, and we are finding that we have good strong compatibility between our program and our comparison group, and that our scales on our survey are very reliable and strong.

One of the major findings I wanted to share with you right now is that two of our four projects with our longitudinal data are showing significant pre-post movement on most or all of our short-term predictors, and I have those predictors listed in my written testimony, as compared to our comparison group which showed no change at all. The other two projects did not show short-term change on our short-term measures.

It is interesting to us in Virginia, as we look at our data and start to analyze, because with respect to our prediction model and our evaluation model, we would expect that those programs would show change in the short-term predictors if they really, really are good predictors of behavioral intent, to show change in our short-term predictors. If they really are good predictors to also show change in the longer term in terms of our behavioral data. And I feel, I would like to say, that what we are finding with our model is that those factors that predict behavioral intent for young people leaning toward sexual activity were showing that our construct, our picking up those factors, and that right now from year one to year two—and we have other years to follow with these kids—that we are showing some change in terms of kids not transitioning from a virgin to non-virgin status. And I hope that wasn't confusing, but that is our dependent variable in Virginia. We are trying to keep kids from moving from virginal to non-virginal status in terms of our design.

Thank you.

[The prepared statement of Ms. Grant follows:]

Statement of Gale E. Grant, Director, Abstinence Education Initiative, Virginia Department of Health, Richmond Virginia

Introduction

In general, evaluation research and its findings serve three primary functions:
1. to judge merit or worth
2. to improve programs and policies
3. to generate knowledge.

Research should never be undertaken to "prove" something—research probes. A substantive finding or hypothesis is one that repeatedly survives such probing. A single piece of work should never be looked upon as either complete or conclusive. In order to make any kind of conclusive statements about the function, efficacy, and/or contributions of abstinence education, there must exist a body of literature.

The literature on the effectiveness of abstinence education programs is meager at best. None of the small number of published studies have demonstrated reductions in sexual activity levels, but each study suffers design flaws that prevent conclusions about either positive or negative effects. Thus, we presently have no scientific basis for judging the merit or worth of such programs, for improving these programs, or for developing policies related to these programs.

Is Rigorous Evaluation of Abstinence Education Programs Possible?

The strength or rigor of any program evaluation research is dependent in large part upon the following contributing factors:

1) The strength and integrity of the program that is being evaluated
2) The strength of the research design/methodology
3) The use of assessment instruments whose measures are both reliable (consistent) and valid (accurate)
4) The replicability of the research findings

Each of these contributing factors are controllable, thus making rigorous evaluation of abstinence education programs theoretically possible.

What are the Challenges to the Rigorous Evaluation of Abstinence Education Programs?

By its very nature, human subjects research occurs outside of a controlled laboratory environment. Programs are rarely implemented exactly as they are intended, unanticipated outside influences often come into play, etc. The accuracy and completeness of documentation of the processes and events that took place during the period of the study are crucial for the interpretation of research data.

The use of strong research designs is often hampered by lack of resources (evaluation is expensive), political pressures (rarely do people want to serve as the control/comparison group and not receive the intervention), structural limitations (class assignments and student schedules), and poor planning (in most cases, evaluation is an after-thought). There are four primary designs for measuring program outcomes and impacts. The first two are the only ones which allow for true assessments of program outcomes/impacts:

1) Random Assignment/Experimental Design
—This is the strongest design available because it eliminates all sources of bias.
—This design must be developed prior to program implementation
2) Comparison Group with Pre and Post Measures/Quasi-Experimental Design
—Next strongest design
—The primary limitation to this design is that it does not control for pre-existing differences in unmeasured attitudes/values/behaviors/risk factors
3) Comparison Group with Post Measures Only
—Has serious limitations since it runs the risk of peer group selection biases and does not control for pre-existing differences in measured or unmeasured attitudes/values/behaviors/risk factors
4) Pre-post test with Program Participants Only
—Has serious limitations because it does not control for maturation

The definition of abstinence and abstinence education is often confusing/ambiguous. In addition, consensus regarding program goals and outcomes is not always easy to come by. For example, decreases in sexual activity or delays in the initiation of sexual activity are definitely seen as positive outcomes. However, the definition of sexual activity (intercourse versus other forms of sexual involvement) is frequently a subject of debate.

Different types of knowledge are generated based on the type of evaluation research being conducted. For example, formative evaluation research assists programs with the documentation of program processes and their implementation. This leads to programs that are more effective. Summative evaluation research, on the other hand, assists sponsors with information about program success/effectiveness. This leads to greater accountability for resources and more effective policy decision-making.

It has been said by opponents of abstinence education that the efficacy of it has not been demonstrated. In fact, opponents have attempted to say that it does not work. The truth is that the literature on the efficacy of abstinence education programs is meager at best, and that the jury is still out on whether or not it is effective. Where there is literature on the efficacy of abstinence education programs, that literature has historically been replete with methodological weaknesses. Many of these methodological problems were due to compromises of program integrity from weak or poor program design/implementation resulting from inadequate funding.

History

The Virginia Abstinence Education Initiative is a five-year, multi-component effort to implement new approaches that will help adolescents develop the attitudes and skills necessary to delay sexual involvement until marriage, and to evaluate systematically the effectiveness of those approaches. Unlike many of the evaluation of abstinence education efforts around the country both past and present, systematic evaluation of the program was built into the Virginia Abstinence Education Initiative (VAEI) from the very beginning. Due to the criticisms thrown at abstinence

education programs, the VAEI sought two things as a priority: 1) adequate funding to support strong program design and integrity of program implementation and 2) adequate funding to support formative and summative program evaluation.

Consequently, the Virginia Department of Health (VDH), which has the responsibility for VAEI program administration, built evaluation expectations into its Request for Proposals. In addition, VDH established an Evaluation Consortium comprised of faculty from five public universities in Virginia (University of Virginia, George Mason University, James Madison University, Virginia Commonwealth University, Christopher Newport University) with expertise in program evaluation and one national expert on the evaluation of abstinence education programs. The Evaluation Consortium provides technical assistance to local program sites, provides guidance around the design of data collection and evaluation methodology, and data analyses and interpretation. In addition, VDH has subcontracted with the Survey and Evaluation Research Laboratory (SERL) at Virginia Commonwealth University to design and implement a data reporting system to support evaluation and monitoring activities.

Overview

The VAEI evaluation system is comprised of both formative and summative evaluation components. Data for the VAEI evaluation system is collected using the the following five tools:

1. Quarterly Implementation Progress Reports (QIPRs): The QIPR serves as a qualitative report on each program's activities and barriers related to achieving the overall program goals. The QIPR is used to record the history of the program, including any events that occur in the school or community that may influence the participants in the program.

2. Community Education Information Reports (CEIRs): The CEIR serves as a way to capture basic information on activities and audiences that are very diverse in nature. Community education is defined as a one-time or short-term program where it is impractical or unfeasible to capture attendance data (or for short series of sessions where there is no expectation that the same participants will return for each session).

3. Intervention Project Attendance Reports (IPARs): Intervention projects are defined as projects where there is an expectation that individuals will be "enrolled" into a planned approach or curriculum that includes multiple contacts where the information in each subsequent session builds upon information that has been covered previously.

4. Survey of Youth Attitudes and Behaviors: The purpose of the survey is to capture the attitudes and behaviors of youth related to marriage, sex, and sexual abstinence. This questionnaire is administered to all participants at the first or second session (pre-) and at the final session (post-) to assess the level of impact of the program's activities. The questionnaire is also administered to program participants annually over the course of program funding (longitudinal design). This longitudinal design allows for the capturing of both long and short term changes. Additionally, in order to attribute any change to the program's activities, the same survey is also administered to a comparison group within two weeks of the participant administrations. This quasi-experimental design helps to insure that any changes noted pre-to-post program can be attributed to the intervention and not due to normal maturation or other events that may happen in the environment. Since this initiative is implemented over five years, the longitudinal and quasi-experimental nature of the design creates a rather complex but rich source of data. (see Table 1).

5. Other Methods as needed as determined cooperatively between the program site, the evaluation consortium member assigned to that site, in consultation with all members of the Evaluation Consortium.

Preliminary Findings

Six program sites were selected to receive VAEI funding during the first year of the initiative. By nature of human subjects research that is outside of a controlled laboratory environment, there will never be a perfect study. However, results from the first year of a five-year study show strong scale reliability and strong comparability between program and control groups in all but one of the six sites. Having accurate and complete recording of processes and events that take place during the period of the study, a strong design/methodology from the very beginning, and the use of reliable/valid assessment instruments establishes a good foundation for a strong study.

In addition, during the first year, three of the six funded sites had enough participants and strength and integrity of program implementation to warrant some in-

depth analyses about short-term program effects. Of the three sites, one had very strong statistically significant short term treatment effects in the desired direction, one had moderate statistically significant short term treatment effects in the desired direction, and one showed little significant short term treatment effects in the desired direction. These types of outcomes are generally not attainable in the first year of a pilot project since first year projects generally have weak program elements and problematic rates of participation. On the flip-side, three of the six sites did experience the expected problems related to weak program implementation or less than optimal participation rates. However, it is anticipated that with the feedback and lessons learned from the first year, these already positive findings will become increasingly so over the next three years.

The strength of the VAEI design not only shows great promise in its ability to contribute to the body of knowledge about the efficacy of abstinence education programs, but has also attracted national attention and recognition. Due to the groundwork laid by the VAEI, one of the six VAEI program sites has been selected by Mathematica Policy Research (MPR) as a model program site for their federally funded national evaluation of abstinence education programs.

Data Summary for Years 1 and 2 of 5

- Year 1 data showed very strong pre- and post-test linkages in 3 of 6 programs. Year 2 data showed very strong pre- and post-test linkages in all programs being evaluated.
- Year 1 and Year 2 data show strong comparability between program and control groups in more than half of the programs being evaluated. Some work remains to be done to increase group comparability in two of the sites.
- Year 1 and Year 2 data show that there is very strong scale reliability on all measures.
- Year 1 data showed moderate to very strong program effects in the majority of programs. Year 2 data showed moderate program effects, but also showed similar movement in the desired direction among comparison group youth.
- Two of the four projects with longitudinal data showed significant pre-post movement on most or all of the short-term predictors as compared to the comparison groups, which showed no change. The other two projects did not show short-term change on the short-term measures. This is interesting to us for several reasons. With respect to our evaluation model, we would expect those programs which show change in short term predictors, if they really are good predictors, to also show change in short term predictors, if they really are good predictors, to also show change in the longer term—on the behavioral data.

Highlights

Virginia has been selected to be one of only four states to present their evaluation study at the national abstinence evaluator's workshop in July 2000. Selection criteria included strength of design, positive progression of the study, and availability of data.

The Association of Maternal and Child Health invited Virginia to participate as a panelist for a teleconference on abstinence program evaluation.

Most recently, we presented at both the American Public Health Association and the National Organization of Adolescent Pregnancy Parenting and Prevention conferences.

TABLE 1: THE VIRGINIA ABSTINENCE EDUCATION INITIATIVE SURVEY ADMINISTRATION AND LONGITUDINAL TRACKING TIMETABLE

Year	Pre-test	Post-test	Annual	Annual	Annual
1998–1999	Post(Cohort 1— .... Program and Comparison).	Pre(Cohort 1— ..... Program and Comparison).			
1999–2000	Pre(Cohort 2— ..... Program and Comparison).	Post(Cohort 2— .... Program and Comparison).	Annual (Cohort 1— Program and Comparison).		
2000–2001	Pre(Cohort 3— ..... Program and Comparison).	Post(Cohort 3— .... Program and Comparison).	2nd Annual (Cohort 1—. Program and Comparison).	1st Annual (Cohort 2—. Program and Comparison).	

TABLE 1: THE VIRGINIA ABSTINENCE EDUCATION INITIATIVE SURVEY ADMINISTRATION AND LONGITUDINAL TRACKING TIMETABLE—Continued

Year	Pre-test	Post-test	Annual	Annual	Annual
2001–2002	Pre(Cohort 4— ..... Program and Comparison).	Post(Cohort 4— .... Program and Comparison).	3rd Annual (Cohort 1—. Program and Comparison).	2nd Annual (Cohort 2—. Program and Comparison).	1st Annual (Cohort 3— Program and Comparison)

TABLE 2: KEY PREDICTORS OF BEHAVIOR INTENTIONS (1ST YEAR DATA)

First order	Second order
•Peer environment	•Future orientation
•Opportunity	•Reasons to wait
•Sexual values	•Love justifies sex
•Personal efficacy	•Value of marriage
•Prior experience	•Religiousness
	•Parental respect and approachability

Chairman HERGER. Thank you very much for your testimony, Ms. Grant. Now Mrs. Bennett.

STATEMENT OF ELAYNE G. BENNETT, PRESIDENT AND CHIEF EXECUTIVE OFFICER, BEST FRIENDS FOUNDATION

Mrs. BENNETT. Thank you so much for inviting me here.

Chairman Herger and Congresswoman Johnson, my name is Elayne Bennett. I am the President, founder, chief executive officer, instructor, chief cook and bottle washer, I guess, of the Best Friends Foundation.

I want to tell you how we at Best Friends have found a way to reduce sexual activity and pregnancies among teenage girls. We have accomplished through a long-term program that is presented during the school day. It is initiated, operated and financed at the local level, and it teaches abstinence. That is the message we believe young girls want to hear.

When Marian Howard of Atlanta's Emory University asked 1,000 teenage mothers what they wanted to learn in sex education, 82 percent of them said how to say no without hurting my boyfriend's feelings. Best Friends' girls learn how to say no, and we don't particularly care whether they hurt their boyfriends' feelings.

A recent survey conducted—that is actually something you can laugh at I hope.

[Laughter.]

Mrs. BENNETT. A recent survey conducted by the American Association of University Women—it is the foundation of AAUW—survey conducted on 2000 11- to 17-year-old girls found that the vast majority said that sex and how to say no in emotionally-charged relationships was their number one concern. And the National Campaign to Prevent Teen Pregnancy found that 93 percent of teens said that, "It is important for teens, for us, to be given a strong message from society that we should abstain from sex until we are at least out of high school."

The abstinence message, as everyone knows, is hard to get across when much of the popular culture, movies, magazines, television, and in many cases sex ed. in public schools is giving the opposite view. Of the 58 television shows monitored by "U.S. News & World Report" almost half contain sexual acts or references to sex. A study by Robert Lichtner & Associates found a sexual act or reference occurred on average of every 4 minutes on shows during prime time. Media Research Center found portrayals of premarital sex outnumbered sex within marriage by eight to one on television. So is it any wonder that between 1960 and the early nineties there was a 450 percent rise in out-of-wedlock births, that among industrialized nations the U.S. has the highest teen birth rate and one of the highest child poverty rates, which is related to high poverty rates among single mothers, and particularly those who became mothers as teenagers. Teenage pregnancies are costing our economy more than 7 billion annually and 49 billion is going to families begun by unwed teenage mothers.

Now I recently added a page here because I know the issue is funding for abstinence and abstinence-only education, so I am going to quickly just cite a few things. The press is obviously on an alarmist campaign regarding Federal expenditures on abstinence education. A case in point was an article in "New York Times" a few months ago. The article compared Federal funding for abstinence education with Federal funding for HIV prevention education. It notes that beginning in 1996 Congress set aside 250 million for 5 years to fund abstinence education programs. But what it doesn't make clear is that the 250 million is a cumulative 5-year figure, not an annual expenditure of 250 million. This was, I believe, intentionally confusing to the reader. It accuses this administration of allocating to abstinence education, "A figure which dwarfs contraceptive education expenditures." This again is gratuitously misleading. In fact, the 50 million from Title V and the 17.1 million from Maternal and Child Health or SPRANS, Special Projects of Regional and National Significance, totals 67 million for abstinence education. This is dwarfed by the 274 million spent on Title X Family Planning Clinics. This 274 million, coupled with the 220 million a year spent on 1,000 school-based health clinics, which either dispense contraception or refers students to community clinics which do. This is 500 million on two relatively small programs and does not even count the millions allocated within the States. Twenty-three States require that sex ed. be taught; 47 recommend or require—either recommend or require, and all 50 require AIDS education programs.

One of the things I would also just like to add, that——

Chairman HERGER. If you could sum up your testimony.

Mrs. BENNETT. I will. I will sum it up right now. Sorry.

Chairman HERGER. Thank you.

Mrs. BENNETT. I would just like to tell you quickly how we have been successful because we focus on a character-building in-school curriculum with an abstinence-only philosophy, an intensive peer support structure, and long-term adult involvement. We address the issue of sexual abuse, by emphasizing that sexual abuse is wrong and never the victim's fault. We do know that many young girls, their first sexual experience is by adult men 21 and older.

But we foster self respect by promoting self control and telling girls they have a place to go, they have someone to talk to, and that they can stop if they have begun sexual activity. And most sexual activity among middle-schoolers, particularly in the inner city, is not by the young girl's choice.

Chairman HERGER. I thank you for your testimony.

Mrs. BENNETT. That is it.

Chairman HERGER. And your full testimony will be submitted for the record.

Mrs. BENNETT. We have copies of 10-page testimony showing our research, which is quite impressive. Thank you.

[The prepared statement of Mrs. Bennett follows:]

Statement of Elayne G. Bennett, President and Chief Executive Officer, Best Friends Foundation

I. INTRODUCTION

For the past 14 years, the Best Friends Foundation has been reaching out to adolescents throughout the United States with a very simple message: enjoy adolescence by abstaining from sexual activity, drugs and alcohol. While this message may not be new to young people, the method in which it is delivered is profoundly different, and its impact is unsurpassed by traditional youth development models. The model is unique. It combines the elements of intensity, duration, and saturation.

The Foundation reaches over 5,500 girls each year through its Best Friends program and this year will reach about 500 boys through the new Best Men program. These programs operate in 26 cities and 14 states, plus the District of Columbia and the U.S. Virgin Islands. Sexual activity among youth in the program is almost nonexistent. In 1999, an independent evaluation of the Washington D.C. Best Friends program showed that 4.2 percent of 7th and 5.6 percent of 8th grade girls were sexually active. This is in comparison with the Youth Risk Behavior Survey data for Washington D.C. 7th and 8th grade girls, where 18.5 percent of 7th grade and 34.7 percent 8th grade girls indicated that they were sexually active.

The Best Friends and Best Men programs are successful through a very consistent message and approach.

- **Adolescents are not provided mixed messages.** The program teaches that abstinence is the best and most effective way of preventing teen pregnancy and STDs. Many programs and schools teach abstinence as an option along with contraception. Best Friends/Best Men staff members do not support this dual philosophy, and as a result, youth are not confused by conflicting messages.
- **Saturation.** Many programs are expensive to implement and take place after school when children are involved in other responsibilities. Best Friends/Best Men recognizes that the school is the surest way to reach the maximum number of youth and their peers. All curriculum sessions are provided at school, and most sessions take place during the school day. School principals view the Best Friends/Best Men curriculum as important for young people as core academic courses. The Best Friends/Best Men model is the most effective way to saturate an entire region with the abstinence message.
- **Duration.** Youth may join the Best Friends and Best Men as early as 5th grade. The program leaves abstinence as the only option. Curriculum and support are provided each and every month of the school year and continues through middle and high school. A trustworthy mentor is always there to help youth with difficult decisions.
- **Intensity.** Each youth receives more than 110 hours of program services each year. (1) Youth participate in monthly 90-minute core curriculum and peer discussion sessions during the school year. This is augmented by (2) weekly one-on-one meetings with volunteer school mentors, (3) male and female role model presentations from the community, (4) culturally enriching field trips, (5) weekly fitness and nutrition classes, (6) participation in community service projects, (7) and a Family and School Recognition Ceremony to honor students and parents for their commitment and accomplishments.

II. DOCUMENTATION OF NEED/STATEMENT OF THE PROBLEM

A. Teen Pregnancy

The United States has the highest rates of teen pregnancy and births in the western industrialized world, more than double that of the United Kingdom, which has the second highest rate. Every state in the nation has a higher pregnancy rate than the UK. In 1998 in the U.S., there were 51.1 births for every 1,000 teen girls aged 15–19; in 1998, there were 97 pregnancies per 1,000 girls in that age group. More than 4 of 10 young women become pregnant at least once before they reach the age of 20—nearly one million a year; 8 of 10 of these pregnancies are unintended and 90 percent are to unmarried teens. Over $7 billion is spent annually on more than 500,000 out-of-wedlock babies born to teenage mothers with an estimated cost to the economy in lost productivity of at least $29 billion a year.

Each year the Federal government alone spends about $40 billion to assist families which began with a single, teenage mother, initiating or perpetuating the poverty cycle which underlies most major social problems in the United States. The median income for a single mother is less than $20,000 a year. Daughters of single parents.

Research has consistently shown that children growing up with a single mother are more likely to drop out of school, to give birth out of wedlock, to divorce or separate, and to be dependent of welfare (Garfinkel, I. and McLanahan, S.S., 1986). Seventy-two percent (72 percent) of America's adolescent murderers, 70 percent of long-term prison inmates and 60 percent of rapists come from fatherless homes. Numerous recent studies document the importance of fathers in the lives of their children. Even if a marriage fails, children born into a married couple family have advantages over those born to unmarried women (Popenor, David, 1996).

Each year the Annie E. Casey Foundation tracks the well being of children in its *Kids Count* publication. The data shows that while programs in the 1990s have successfully addressed the reduction of teen pregnancy, there has not been a corresponding reduction in children born out of wedlock. In fact, there has been a disturbing increase. The nationwide percent of total births to unmarried women increased from 41 percent in 1990 to 43 percent in 1998. In Washington D.C., the target area for this proposal, the percent of births to unmarried mothers was an alarming 63 percent in 1998. Moreover, the likelihood of a child receiving a child support award reflects the marital status of parents at the time of birth. Only 22 percent of never married single parents received child support payments in 1997, compared with 47 percent of divorced single parents. Further, only 10 percent of mothers ages 15 to 17 received child support payments in 1997.

B. Teen Birthrates

Child Trends reports that preliminary data for 1998 from the National Center for Health Statistics show that the teen birth rate has declined since the early 1990s. In 1998, there were 51.1 births per 1,000 to teen girls age 15–19. However, the number of teen births since 1991 represents a 7 percent decline compared with an 18 percent decline in the rate of teen births since 1991. Despite a decrease in the teen birthrate, the total number of births to teens increased slightly between 1997–99 due to an increase in the number of teen females in the 1990s.

Researchers have begun to acknowledge that the decline in teen birthrates is directly linked to fewer teens having had sex. KIDS COUNT reports that in 1999, 50 percent of the nation's high school students reported having had sex, compared with 54 percent in 1991. Public acceptance and support of teens abstaining from sex is credited for the recent success. Abstinence has gained credibility among foes; opponents no longer disparage abstinence as an unrealistic method of preventing teen pregnancy.

C. Birthrates by Marital Status

Seventy-nine percent (79 percent) of all births to teenagers occur outside of marriage. Among mothers ages 15–17, the proportion that are unmarried more than doubled, from 43 percent in 1970 to 87 percent in 1997. The proportion of unmarried mothers, ages 18–19, has more than tripled—from 22 percent in 1970 to 72 percent in 1997. Birthrates of married teens declined 23 percent between 1990–1997. Unmarried teen birthrates peaked in 1994. In 1998, 79 percent of teen births occurred outside of marriage (up from 71 percent of births in 1992). According to the Annie E. Casey *KIDS COUNT Report,* 97 percent or births to teens in Washington D.C. were to unmarried teens in 1996. The majority of teen mothers choose to keep their children rather than put them up for adoption.

Today's teen parents face very different circumstances than that of their counterparts in the 1960s. In the 1960s, more than two-thirds of births to teens occurred within the context of marriage, even when conception occurred beforehand. Mar-

riage was viewed as a goal to strive for, offering social and financial stability. Even though the stigma has lessened since the 60s, it is clear that children in single parent homes do not have the same economic resources as those growing up in two parent households.

Sociologists Sara McLanahan and Gary Sandefur examined family structure and its impact on whether a child will succeed. They examined a decade worth of data and found, "Compared with teenagers of similar background who grow up with both parents at home, adolescents who have lived apart from one of their parents during some period of childhood are twice as likely to drop out of high school, twice as likely to have a child before age twenty, and one and a half times as likely to be 'idle'—out of school and out of work—in their teens and early twenties."

There is reason to be hopeful. According to *KIDS COUNT*, after peaking in 1996, the nationwide percentage of children living in single parent families fell to 27.8 percent in 2000. This can, in part, be credited to the Landmark Welfare Reform legislation of 1996, which began to encourage states with financial incentives to lower their proportion of single parent households. Programs like Best Friends and Best Men will contribute to a continued reduction.

D. Birthrates and Abortion

While still perceived as an epidemic by public health officials and still at the highest rate of all industrialized nations, the teen pregnancy rate, birthrate and abortion rate have all declined slightly in the past several years. Thus, the decline in the birthrate is NOT due to an increase in abortion. However, it should be noted that the total number of births to teens increased slightly between 1998–1999.

According to the Allan Guttmacher Institute, the teen pregnancy rate declined by 16 percent between 1991–96, while the abortion rate declined by 22 percent between 1991–96. The District of Columbia had the highest rate of abortion per 1,000 women (155) of any state, more than triple that of Nevada (44), the next highest state. The easy availability of abortions clearly has not had a significant effect on reducing the birthrate.

E. Contraceptive Use

Data from the National Survey of Family Growth show different trends in contraceptive use *at first and most recent sexual encounter among teens.* There is an increase in the percentage of adolescent females who report using any contraceptive method at *first sex* from 48 percent in 1982 to 76 percent in 1995. However, and more importantly, there has been a decline in contraceptive use at *most recent sex* among sexually active teen females (those who had sex in the last three months). The proportion of sexually active females who use contraception at most recent sex declined from 77 percent in 1988 to 69 percent in 1995. This data does not support the argument that increased contraceptive use resulted in decreased teen birth rates because it is obvious there is a much higher risk of pregnancy with repeated sexual intercourse. Although advocates of contraceptive education may claim that increased contraceptive use is a major cause of the decrease in teen pregnancy and birth rates, these data demonstrate quite the opposite.

F. STDs

Another devastating result of increased promiscuity by our teens is the increase in sexually transmitted diseases (STDs). There are 3 million new cases of STDs diagnosed in teenagers in the United States each year, requiring more than $2 billion in direct treatment costs annually. Teenagers are far more susceptible to STDs than adults. For example, a 15-year-old girl has a one in eight chance of contracting a STD if she has sex, while a 21-year-old woman has a one in eighty chance under the same circumstances. Moreover, the AIDS virus is also on the rise among our youth. Nearly 20 percent of all AIDS patients are in their 20s, which means many of them were infected as adolescents. Today teenage sex is not only harmful; it is deadly. Surpassing even homicide, AIDS is the number one killer of African-American men ages 24–45 in the U.S. It is the number two killer of African-American women of the same age. Condoms offer little or no protection for a number of STDs (including HPV—human papilloma virus which causes genital warts). In a single act of unprotected sex with an infected partner, a teenage girl has a 1 percent risk of contracting HIV, a 30 percent risk of infection with genital herpes (HPV) and a 50 percent chance of contracting gonorrhea (Allan Guttmacher Institute—*Facts in Brief: Teen Sex and Pregnancy, 1998*).

G. Oral Sex

Oral sex is a gateway behavior to other sex, alcohol and drug use. Oral sex is highly dangerous because of the physical risk, STDs (HPV virus is easily transmitted through oral sex). In the last seven years, it appears that girls are having

sex at an earlier age. The proportion of girls engaged in sex before age 15 rose from 11 percent to nearly 20 percent. For most of these girls, oral sex was their first sexual experience. Recent news stories about the prevalence of oral sex among middle-schoolers points to the dire need for guidance and clear-cut standards of behavior.

H. Consequences for Young Mothers

The Casey Foundation report also speaks to the consequences for young parents. A young woman who has a child before graduating from high school is less likely to complete school than a young woman who does not have a child. About 64 percent of teen mothers graduated from high school or earned a GED within 2 years of their scheduled graduation date, compared with 94 percent who did not give birth. **Best Friends has a 100 percent graduation rate for girls who stick with the program in high school.**

Nearly 80 percent of teen mothers eventually go on welfare and end up in the child support system. According to Child Trends, more than 75 percent of all unmarried teen moms went on welfare within 5 years of the birth of their first child. An alarming 55 percent of all mothers on welfare were teenagers at the time their first child was born.

I. Consequences for Young Fathers

Consequences also exist for teen fathers. They are more likely to be in the criminal justice system, use alcohol, deal drugs, or quit school. Among married men, those who were teen fathers had the least schooling and earned lower wages than those who fathered children with mothers who were 20 or 21 (Casey Foundation, *KIDS COUNT*).

Data from the March 2000 Current Population Survey show that only 58 percent of males ages 16 to 19 have any earned income in 1999 and that the average annual income for those who worked was less than $6,000 annually. Teen fathers are unable to provide the required financial support for their children. This causes an added strain between the relationship of the teen mother and father.

III. STRATEGIES THAT WORK

The Casey Foundation summarized in brief, without endorsing specific programs, strategies that work at preventing teen pregnancy. **All of the essential elements they highlighted are contained within Best Friends/Best Men programs.**

A. **Unwavering Commitment by Families—**Best Friends/Best Men parents give permission for his/her child to participate in the program. Each school holds a parent information meeting at the beginning of the school year. The Best Friends/Best Men introduction video is shown and parents ask questions of the Best Friends/Best Men staff. In the 15 years of program operation, only two parents did not allow their children to participate. Once enrolled, not a single parent has ever removed his/her child from the program. Families celebrate the commitment of their children at the Family and School Recognition Ceremony. 80–90 percent of parents attend this event. Each Best Friend/Best Men participant acknowledges his/her parent with a symbol of gratitude at the Recognition Ceremony.

B. **Services must be holistic, comprehensive and flexible—**Best Friends/Best Men is not sex education. The eight-step curriculum discussion sessions look at the "whole" person. The curriculum examines the life and social skills needed to resist the negative pressures that lead to teenage pregnancy. The support system is comprehensive—mentors, role models, teachers, parents, peers and the community at large learn how to support the youth's very important decision of abstaining from sex. The program is flexible to meet each child's needs. Best Friends/Best Men curriculum is taught during the school day. Children who have after-school responsibilities do not miss out on the program. Diamond Girls who are in high school meet at times convenient to their busy schedules. The needs of the youth dictate how the program is delivered.

C. **The information is revised and updated yearly—** Founder Elayne Bennett, her staff, lead research consultant, and medical experts have examined volumes of research. Through peer review, only the most credible findings have been used to develop the curriculum. All curriculum materials have gone through numerous peer reviews and are updated annually to ensure the most up-to-date information. The message to adolescents is accurate and consistent. The participants are the most knowledgeable spokespersons for the program. They present end of the year essays titled, "What Best Friends Means to Me," and these essays are a testimonial to the accuracy and consistency of the message.

D. **Teens need to be provided with more targeted academic and job information—**Graduation from high school and post secondary education is a major tenet of Best Friends and Best Men. Elayne Bennett felt so strongly about the importance of showing young girls that there is a very promising future ahead of them,

that she created a generous scholarship program. Each program participant who stays with the program through high school is offered the opportunity for a college scholarship. Since 1993, more than 70 young women have attended college with Diamond Girl Scholarships, attending top universities. Girls who are not collegebound receive career counseling and choose careers such as the military.

E. **Teens need information about how their bodies work and how to keep them safe—**Staying healthy and protecting one's body from physical harm are key ingredients to the Best Friends/Best Men programs. Girls and boys participate in weekly group fitness classes. Girls exercise, dance and discuss health and nutrition. Boys participate in martial arts and discuss health and nutrition. Through the curriculum, youth learn skills to avoid physical confrontations with peers and adults.

F. **Messages from adults must be clear—**The coordinators and facilitators attend training conferences in the utilization of a carefully designed curriculum in which abstinence from sex, drugs and alcohol is clearly conveyed.

G. **Discussions must be frank to "deglamorize" the barrage of sexual images provided through the media—**To counter the glamorization of sex, Best Friends has glamorized abstinence. Girls earn jewelry, t-shirts, and other incentives that they wear to symbolize as a peer group that abstinence is attractive. Girls learn that one can be attractive without being sex symbols, something that many have thought as being one and the same. Boys learn that they can be cool when they do not drink, do drugs and have sex. Male role models reinforce that abstinence is cool. Videos, theme songs and dance performances reinforce that Best Friends/Best Men is cool.

H. **Students learn techniques in making good decisions, communication and work skills to prepare for the adult world—**Best Friends/Best Men has an entire curriculum session dedicated to decision-making skills. Youth learn how to make good decisions and to take responsibility for their actions. Communication skills are addressed in every aspect of the program. Most participants have teacher/mentors who utilize their mentor guides with specified discussion activities. Role-plays are used to simulate difficult decisions. Peers give feedback on how they would handle difficult situations.

Best Friends utilizes the social learning theory (Bandura,1977) that explains human behavior in terms of continuous reciprocal interaction between cognitive, behavioral and environmental influences. Best Friends/Best Men is structured to provide adolescents with 100–200 hours of interaction with responsible adult leaders who serve as role models of behavior that we wish to develop in our youth. Our cognitive input is reflected through the messages presented in the curriculum units, which are repeated throughout the program year. Social and environmental influences are brought about through community service and culturally enriching field trips. The Family and School Recognition Ceremony is an opportunity for the participants to express their appreciation while showcasing their talent through essay reading, song and dance. As girls and boys mature with the program, they become role models for their younger classmates.

Bill Mosher and Stephanie Ventura of the National Center for Health Statistics co-authored a study released in February 2000 by the Center for Disease Control. The study found that the number of births, abortions and miscarriages in the United States declined by half a million in just six years. Much of the drop can be attributed to a change in teenagers' behavior. Among other factors, they cite "the message of abstaining from sexual intercourse has gotten across to a good number of teenagers." In fact, recent survey data show that 51 percent (both boys and girls) are choosing to abstain from sexual activity (*KIDS COUNT).*

The Adolescent Health Study (ADD Health), which surveyed over 90,000 middle school students, clearly demonstrated that a protective factor in delaying the onset of first sexual behavior as well as the prevention of pregnancy was the perceived parental disapproval of adolescent contraception and adolescent sex. It is surprising to the Best Friends Foundation that the advocates of comprehensive sex education that involve condom distribution are not rethinking their position based on this significant research study.

IV. BEST FRIENDS/BEST MEN PROGRAM DESIGN/METHODOLOGY

Elayne Bennett founded the Best Friends Program in 1987, when she was a faculty member of the Georgetown University Child Development Center. Elayne continues as the President of the Foundation, teaches curriculum in Washington D.C. schools, and has trained more than 1,000 educators in 26 cities in 14 states, including the District of Columbia and the U.S. Virgin Islands. Nationally, the Best Friends program serves almost 5,500 girls as well as nearly 500 boys in the recently piloted Best Men program.

Students may enter as early as the 5th grade and continue through middle school. Girls who continue in the program in high school enter the Diamond Girls program; boys enter Iron Men in high school.

Best Men Messages

The primary goal of Best Men is to provide boys with the tools and the environment needed to help them develop into responsible young men. This goal is accomplished with the implementation of a multi-faceted program which:

- Defines manhood.
- Teaches boys that to abstain from sex in high school is a good decision and to abstain from sex until marriage is the best decision.
- Provides boys with positive adult male mentors to support and encourage them in their goal to become men worthy of respect.
- Develops positive peer support.
- Encourages ongoing parental support, especially fathers.

Best Friends Messages

Best Friends is designed to reach girls in early adolescence when their attitudes toward life are forming, when they need to discuss their personal concerns and receive support from friends and respected adults. The following messages permeate the Best Friends program:

- The best kind of friend is one who encourages you to be a better person.
- Friends help each other make good decisions.
- Without self-respect, it is difficult to say "no" to anyone or anything.
- Boys and girls often have different agendas in their romantic relationships.
- Sex is never a test of love.
- The decision not to have sex in high school is a good one. The decision to wait until marriage is the best one.
- Children deserve to begin life with married adult parents.
- The decision not to take drugs is a good one. It is illegal to take drugs.
- The decision not to drink alcohol in high school is a good one. In most jurisdictions, it is illegal to drink alcoholic beverages before the age of 21.
- Tomorrow is the first day of the rest of your life. Past mistakes do not mean that one must continue the same pattern.

Operational Structure

Best Friends/Best Men is a school year program. Girls and boys may enter as early as 5th grade and participate in an eight-step school year curriculum program, augmented by mentors, role models, fitness program, cultural activities/field trips and a Family and School Recognition Ceremony. Best Friends/Best Men succeeds because it is an ongoing education and support system. Each girl and boy is invited back to the program at the start of the school year. Those who graduate from high school may qualify for educational scholarships funded through the program.

Recruitment

Best Friends/Best Men coordinators and grade level teachers recruit youth into the program. Special efforts are made by school staff to recruit students who demonstrate risk factors, such as poor school attendance, drinking, smoking, physical aggression, etc. Experience has shown that a blend of students consisting of high and average achievers, along with those who fall below the mark, provides a productive learning environment. Youth connect with both the positive and negative experiences of peers and draw from these experiences to make positive changes in their lives.

Curriculum/Discussion

The most important component of the Best Friends curriculum are the group discussions conducted by a Best Friends/Best Men instructor at least once a month for 90 minutes. The group sessions provide opportunities for students to discuss topics important to adolescents—**(1) friendship, (2) love and dating, (3) self-respect, (4) decision-making, (5) alcohol abuse, (6) drug abuse, (7) physical fitness and nutrition, (8) AIDS and sexually transmitted diseases.** Participants record their thoughts in a *Best Friends/Best Men Student Journal.* The Best Friends instructor uses the *Best Friends/Best Men Program Guide* to lead discussions. The instructor uses a combination of lectures and discussion, videos, news clips and journal writing. Each session always concludes with the Best Friends Theme Song and the Best Men Chant.

1. **Friendship:** participants learn that the best kind of friend is one who encourages you to be a better person and that friends help each other make good

decisions. They learn skills and techniques for saying "no" in response to peer pressure.

2. **Relationships/Love and Dating:** This session addresses the difference between love and infatuation and that sex is never a test of love. It is reassuring to young people to realize that the pressures that they are experiencing are shared by many adolescents. They learn that the decision not to have sex in high school is a good one and the best decision is to wait until marriage.

3. **Self-Respect:** Participants learn that respecting oneself is very important. Without self-respect, it is difficult to say "no" to anyone or anything. They learn to take responsibility for their decisions and that these decisions have an impact on their lives. Each student is encouraged to be in control of his or her life, to set positive goals to look forward to the future.

4. **Decision-Making:** Best Friends/Best Men boys and girls learn skills for making good decisions, taking responsibility for their own behavior, and evaluating the messages in the media. Best Friends safety rules are discussed.

5. **Alcohol Abuse:** Participants learn why drinking alcoholic beverages before the legal drinking age is dangerous. We teach techniques for avoiding alcohol and riding in cars with drivers who have been drinking. Youth learn that drinking alcohol makes them more vulnerable to sexual advances. Videos, news articles and role-plays are particularly useful in this session.

6. **Drug and Tobacco Abuse:** The Best Friends Program conveys a clear "no use" message. Boys and girls learn the dangers of experimenting with drugs, how drugs can steal their goals and dreams and hurt their family and friends. Youth learn that drugs contribute to sexual activity.

7. **Physical Fitness and Nutrition:** Good health helps adolescents gain self-respect and have a more positive outlook on life. Once a week, all Best Friends participants have a one-hour fitness class where they exercise, dance, discuss the importance of health and nutrition and have fun with their friends. Best Men participate in self-defense classes.

8. **AIDS and STDs:** Participants learn that abstinence from sexual activity and drug use is the only guaranteed protection against sexually transmitted diseases and the HIV virus. Candid information is shared about the most common STDs, the symptoms, treatment and consequences.

Fifteen years of experience in curriculum development and direct instruction in hundreds of schools with thousands of adolescent girls and most recently adolescent boys, has convinced me that our youth want to hear the abstinence message. Students will respond when it is presented in a developmentally sound approach that involves positive peer pressure and promotes a sense of connection to their school.

We urge the committee here today to understand that by setting the expectations of abstinence until marriage we are at the very least promoting a standard that has been a part of our traditional moral values for centuries.

It is especially important at this time of crisis in our country that we not compromise the values that have been time honored in our society. Our children deserve no less than our highest expectations.

In summation, Best Friends believes that as adults "If we give our children our best, they will surely respond with their best."

Chairman HERGER. Thank you very much, Mrs. Bennett. Now our next witness will be Sarah Brown, director of National Campaign to Prevent Teen Pregnancies. Ms. Brown.

STATEMENT OF SARAH S. BROWN, DIRECTOR, NATIONAL CAMPAIGN TO PREVENT TEEN PREGNANCY

Ms. BROWN. Good morning, Chairman Herger, Ranking Member Cardin, and Members of the Subcommittee. Let me greet in particular Congresswoman Nancy Johnson, who is a wonderful leader of our congressional bipartisan House Advisory Panel, and we are very grateful to you for your interest in our work.

My name is Sarah Brown. I am the director of the National Campaign to Prevent Teen Pregnancy, and on behalf of Isabel Sawhill,

our president, and former governor Tom Kean of New Jersey, our chairman, I want to thank you for inviting me here today.

We commend this Subcommittee for focusing on teen pregnancy prevention in the context of welfare reform. As many of you well know, reducing teen pregnancy is a highly effective way to make progress on a number of related social issues: child poverty, welfare dependency, out-of-wedlock childbearing and responsible fatherhood.

Written testimony and many of the documents and citations referred to in the testimony back up these points I am going to cover, and I hope they will be entered into the record.

The good news, as we have heard this morning already, is that teen pregnancy and birth rates have declined steadily over the past decade. They are now at record low levels. But as many people have pointed out, we still have a long, long way to go. Four in 10 girls in this country become pregnant before they turn 20. Two in 10 go on to become single mothers, therefore, obviously, contributing to our high levels of out-of-wedlock childbearing. So there is no reason for complacency.

Why are the rates of teen pregnancy going down? Chairman Herger, you posed that question at the beginning of this hearing. Basically there are only two possible explanations: a smaller proportion of teens are having sex and/or contraceptive use among sexually active teens has increased. Unfortunately, the exact contribution of these two factors just can't be nailed down precisely, but a reasonable conclusion supported by all of us is that both less sex and more contraception are making an important contribution to the decline.

Another important question: what community-level programs actually prevent teen pregnancy? Fortunately, we now have some answers here, and having been in this field for a long time, it is lovely to be able to sit in front of this Subcommittee and offer some good news. This past May, the National Campaign released a comprehensive research review entitled "Emerging Answers: Research Findings on Programs to Reduce Teen Pregnancy." Let me give you a very few of the highlights.

First, there are some programs that work. Interestingly, some focus on sex and some don't at all. There are three types found to be effective. One cluster includes a variety of sex and HIV education programs that have been shown to delay sex and/or increase contraceptive use for up to 30 months. These effective programs have some very definable, well-described characteristics, and as a number of people have already said, the evidence is clear that teaching young people about sex and sexuality does not increase sexual activity. It was a reasonable important question to ask, but the jury is now "in" on this question: It does not.

A second cluster includes two youth development programs (which we also talked about this morning), that offer opportunities for community service, adult mentoring and so forth. They are very impressive in their results. It is not exactly clear why they are so effective, but we can talk about that later if you would like.

A third category of programs found effective combine good sexuality education, family planning services, and a vigorous youth de-

velopment program. I think we are going to hear from one such model from New Britain, Connecticut, in just a minute.

Having this array of effective programs gives us another piece of good news. Communities now have choices. When they want to reduce teen pregnancy, they can look at a rich array of options, and they can pick ones to suit their budgets, their local values and their situation.

What do we know about abstinence education? Our review finds in this case that the jury is "out" on abstinence-only or abstinence-until-marriage education, and this is for two particular reasons: very little rigorous research of these programs have been completed, and the few studies that do show positive effects are really not capturing the rich array of programs that are currently offered. I know that Dr. Maynard, who is testifying next, is going to be talking about her important work in this area.

I would like to add that I think it is critically important that our evaluations of abstinence programs answer two questions. First, do they delay first sexual intercourse? And for those program participants who do become sexually active, are they less likely to use contraception?

Although some may find this second question beside the point, I would argue that it is no different than asking whether sex education programs might actually encourage young people to have sex. Our first goal must always be to do no harm. Now, having said this, remember, there is enormous public support for abstinence messages for school-age youth in particular. Remember too, the reality is that many teens in high school become sexually active, whether we like it or not. At present, about 65 percent of high school seniors have had sex, so we need to offer services for them and information, but all in a context of abstinence as their first and best choice.

One final comment. What are the implications for Welfare Reform reauthorization in all of this? As a general matter, States and communities need adequate resources to prevent teen pregnancy. They need access to good information about what works. They need a clear signal from the Federal Government that teen pregnancy prevention is important and is directly linked to the other goals of Welfare Reform. And they need flexibility to design strategies that suit their local situations and cultures. This is consistent with the devolution philosophy underlying the rest of Welfare Reform, and it is consistent with the view that family and community values rather than Federal mandates should be the primary influence regarding what we should do about such sensitive issues as teen sexuality.

Thank you for inviting me here today.

[The prepared statement of Ms. Brown follows:]

Statement of Sarah S. Brown, Director, National Campaign to Prevent Teen Pregnancy

SUMMARY

Chairman Herger, Ranking Member Cardin, and Members of the Subcommittee:

My name is Sarah Brown. I am the Director of the National Campaign to Prevent Teen Pregnancy, a nonpartisan, nonprofit organization dedicated to the goal of reducing the teen pregnancy rate by one-third over a ten-year period. I also want to recognize Congresswoman Nancy Johnson who we are so fortunate to have as one

of the leaders of the Campaign's bipartisan House Advisory Panel. On behalf of Isabel Sawhill, our President, and former Governor Tom Kean of New Jersey, our Chairman, thank you for inviting me to testify today. We commend this subcommittee for focusing on teen pregnancy prevention. As many of you recognize, reducing teen pregnancy is a highly effective way to make progress on a number of related social issues: child poverty, welfare dependency, out-of-wedlock childbearing, and responsible fatherhood. Said another way, reducing teen pregnancy is one of the most effective single steps we can take to improve the life prospects of young women and men, and most important, their children. My full written testimony goes into the points I am about to make in more detail, and contains citations for additional information.

Good news but still more work to be done

The good news is that teen pregnancy and birth rates have declined steadily over the past decade and are now at record-low levels. However, we still have a long way to go: four in ten girls become pregnant at least once before age 20, the U.S. still has the highest rates of teen pregnancy in the fully industrialized world, and every year teen childbearing costs U.S. taxpayers at least $7 billion. We must not let the good news lull us into complacency and must redouble our efforts to help more young people avoid becoming parents too soon.

What's behind the good news?

A commonly asked, and hotly debated, questions is "Why are the rates of teen pregnancy going down?" Basically, there are only two possible explanations: a smaller proportion of teens are having sex, and/or contraceptive use among sexually active teens is improving. The exact contribution of each of these factors—less sex and more contraception—is difficult to determine precisely. A reasonable conclusion supported by all recent analyses is that *both* less sex *and* more contraception are making important contributions to the decline.

Understanding what *motivates* young people to choose either of these paths is also critically important. That is, why are teens being more prudent? Most experts believe it is some combination of more cautious attitudes among young people about sex, fueled in part by fear of AIDS and other sexually transmitted diseases and by growing support for the value of abstaining from sex *at least* until teens have finished high school; greater public and private efforts to reduce teen pregnancy; the availability of more effective forms of contraception; the strong messages about work and personal responsibility (including child support) in welfare reform; and perhaps the strong economy in recent years. As this subcommittee knows, there are a number of provisions in the 1996 welfare reform law aimed at reducing teen pregnancy and out-of-wedlock childbearing. While there is little evidence that any one of these provisions on its own has had an effect on teen pregnancy rates, we believe that they have, in the aggregate, sent a powerful message to both young women and men about the importance of waiting to become parents until they are grown up, preferably married.

What works to prevent teen pregnancy?

Fortunately, I have good news here. I've been involved in this field for nearly 30 years, and, frankly, for most of that time it has been discouraging work—the rates of teen pregnancy and childbearing were high, often increasing, and we didn't know what to do about it.

Finally, we have some answers. This past May, the National Campaign to Prevent Teen Pregnancy released a comprehensive research review called *Emerging Answers: Research Findings on Programs to Reduce Teen Pregnancy*. Let me briefly summarize what this review found. Most importantly, there are a variety of programs that are effective—some that focus on sex and some that do not. The review identified three particular types:

- Several sex and HIV education programs have been shown to delay sex or increase contraceptive use for up to 30 months. The effective programs share ten clearly definable characteristics. It is also important to point out that the overwhelming weight of research evidence clearly shows that sex and HIV education programs such as these do not increase sexual activity, as some people have reasonably feared.
- Two youth development programs that give young people opportunities to do community service and have mentoring relationships with adults have the strongest evidence of any intervention that they actually reduce teen pregnancy while the youth are participating in the program. It is not clear exactly why these programs are so successful, but keeping empty hours filled with useful activities is certainly one plausible explanation.

- The third category of programs includes both sexuality education and youth development. One such program combines family life and sex education with tutoring, work and sports-related activities, and comprehensive health care—and it substantially reduced teen pregnancy and birth rates among girls.

These findings offer leaders around the country some encouraging news, but more importantly, communities now have a list of effective, credible programs to choose from to suit local needs, values and culture, which is particularly important when dealing with an issue as complex and sensitive as teen pregnancy. As we all know, one size doesn't fit all.

What do we know about abstinence education? Our review finds that the jury is still out on abstinence-only or abstinence-until-marriage education. This is true for two reasons: (1) very little rigorous evaluation of abstinence-only programs has been completed and (2) the few studies that show no positive effect do not reflect the great diversity of abstinence-only programs currently offered. Fortunately, Dr. Maynard (who is also testifying today) is conducting a very rigorous study of several abstinence-only programs that I expect will shed more light on this important group of interventions.

I would add that I think it is critically important that our evaluations of abstinence programs answer two questions: (1) do they delay first sexual intercourse? and (2) for those program participants who do become sexually active, are they less likely to use contraception? Although some may find this second question beside the point, I would argue that it is no different than asking whether sex education programs actually encourage young people to have sex. Our first goal should always be to do no harm. Having said this, let me be very clear that there is great value in, and public support for, a strong abstinence message, especially for young people. In fact, our polling data on this point are quite dramatic.

But even if the number of teens who choose abstinence grows significantly—and even if some sexually active teens make a conscious decision to refrain from sexual intercourse—the reality is there will still be many teens who are sexually active (for example, 65 percent of all high school seniors have had sexual intercourse at least once). Therefore, preventing teen pregnancy requires that contraceptive services and information be available. The analogy here is that we urge young people not to drink, but if they do, not to drive. In this same spirit, we can give a strong "abstinence-first" message, especially for school-age teens, and also offer critically important information and health care.

A final point about "what works": while we now know that effective programs to reduce teen pregnancy exist, it would be unrealistic to rely exclusively on such programs to address teen pregnancy. Most teens aren't in programs, and many programs are small, fragile, and poorly funded. Other forces, such as parents, the media, moral and religious values, and especially popular culture, play critical roles as well. The Campaign works actively on each of these fronts and so should we all.

Implications for Welfare Reform Reauthorization

What are the implications of all this for welfare reform reauthorization? As a general matter, states and communities need: (1) adequate resources to prevent teen pregnancy; (2) access to good information about what works so they can make informed choices about the best way to invest their resources; (3) a clear signal from the federal government that teen pregnancy prevention is important and is directly linked to the other goals of welfare reform; and (4) flexibility to design strategies to reduce teen pregnancy that respect diverse local values and cultures. Consistent with the devolution philosophy underlying the rest of welfare reform, family and community values, rather than federal mandates, should prevail, especially on such sensitive issues as teen sexuality.

Conclusion

In conclusion, all of us committed to reducing teen pregnancy need not get bogged down in strident arguments about abstinence versus contraception. Both approaches are important, both have contributed to the recent progress in reducing teen pregnancy, and we need more of both to make additional progress. Our survey data indicate that large majorities of adults and teens agree that policymakers should place greater emphasis on encouraging teens not to have sex *and* greater emphasis on contraception for those who do. Survey data also confirm that this common sense, combined approach is not seen by teens or adults as a "mixed message." As outlined more fully in my written statement, welfare reform offers Congress and the nation an important opportunity to do even more to prevent teen pregnancy, and by doing so, achieve the goals that we all want: strong, stable, self-sufficient families.

FULL WRITTEN STATEMENT

Teen Pregnancy's Link to Other Critical Social Issues

Teen pregnancy is closely linked to a host of other critical social issues—welfare dependency and overall child well-being, out-of-wedlock childbearing, child poverty, responsible fatherhood, and workforce development, in particular. There is compelling evidence that progress on *all* of these issues can be materially advanced by reducing teen pregnancy.[1] Teen mothers and their children experience a number of adverse consequences in the areas of education, health, and income.[2] For example, compared to similarly situated women who delay childbearing until age 20 or 21, teen mothers are less likely to complete high school and their children have more problems in school. This puts them at a disadvantage for obtaining the higher education necessary to qualify for a well-paying job and support their families. Teen childbearing also has important economic consequences for society: U.S. taxpayers shoulder at least $7 billion each year in direct costs and lost tax revenues associated with teen pregnancy and child-bearing. Helping young women avoid too-early pregnancy and childbearing—and young men avoid premature fatherhood—is easier and much more cost effective than dealing with all of the problems that occur after the babies are born. Simply put, if more children in this country were born to parents who are ready and able to care for them, we would see a significant reduction in a host of social problems afflicting children in the United States, from school failure and crime to child abuse and neglect. Therefore, we urge those interested in achieving one or more of these goals to give serious attention to teen pregnancy prevention.

The Good News: Teen Pregnancy and Birth Rates Are Declining

Fortunately, there is much good news to report about teen pregnancy. After years of high and often increasing levels, the teen pregnancy and birth rates have both steadily declined during the 1990s, in all states and among all ethnic groups.[3] These encouraging declines show that we can make progress on what once seemed an intractable social problem. Nonetheless, the United States still has the highest rates of teen pregnancy and birth in the fully industrialized world. And, it remains the case that close to one million teenagers get pregnant annually and that 4 in 10 girls become pregnant at least once before turning 20. Almost all of these teen pregnancies are unintended and nearly eight of ten births to teenage mothers are now out-of-wedlock.

Why Are the Rates Declining?

One of the questions we are most frequently asked at the Campaign is, "why have the rates been declining?" There is a short answer and a long answer to this question. The short answer is that teen pregnancy rates are declining because of less sex and more contraception. That is, a smaller proportion of teens are having sex, and those that are sexually active are using contraception more consistently. Because of data limitations, however, it is difficult to determine what the *precise* contribution of each of these factors is to the good news of declining teen pregnancy. Our own analysis suggest that each of these two factors probably accounted for between 40 and 60 percent of the decreased teen pregnancy rates. A reasonable conclusion, supported by all recent analyses, is that both less sex and more contraception are making important contributions to the decline, and more of both should be encouraged.[4] Interestingly, public opinion about how to reduce teen pregnancy supports such a two-part strategy. For example, several polls conducted by the National Campaign reveal a strong preference—among both adults and teens—for school-aged teenagers especially to avoid sexual intercourse altogether, coupled with a practical view that those young people who are sexually active should have access to contraception.[5]

Now, for the long answer. Given that teenagers are already being more careful (having less sex and using contraception more), the interesting question is: *why* are

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[1] The National Campaign to Prevent Teen Pregnancy. (2001). *Not Just Another Single Issue: Teen Pregnancy's Connection with Other Important Social Issues (forthcoming).* Washington, DC: Author.

[2] The National Campaign to Prevent Teen Pregnancy. (2001). *Halfway There: A Prescription for Continued Progress in Preventing Teen Pregnancy.* Washington, DC: Author.

[3] Ibid.

[4] Flanigan, C. (2001). *What's Behind the Good News: The Decline in Teen Pregnancy Rates During the 1990s.* Washington, DC: The National Campaign to Prevent Teen Pregnancy.

[5] The National Campaign to Prevent Teen Pregnancy. (2001). *With One Voice: America's Adults and Teens Sound Off About Teen Pregnancy.* Washington, DC: Author. http://www.teenpregnancy.org/april2001/chrtbook.pdf

they doing so? Presumably, if we could pinpoint the reasons that have motivated teens to act more prudently, we could build on those insights to accelerate the decline. Most experts believe that teen pregnancy rates have declined over the past decade because some combination of the following:

- Greater public and private efforts to prevent teen pregnancy. States have dramatically increased their efforts to reduce teen pregnancy—in 1990 only 16 states had an official policy requiring or encouraging pregnancy prevention programs in public schools; by 1999 this had increased to 28.[6] Similarly, at present there are some 41 teen pregnancy coalitions at the state level, up from 32 in 1995.[7]
- Fear of AIDS and other sexually transmitted diseases. In conversations with the Campaign, teens say time and again that fear of STDs, and AIDS in particular, factors heavily into their decisions about sex.
- More conservative attitudes among the young. An Urban Institute study shows that the proportion of adolescent males approving of premarital sex decreased from 80 percent in 1988 to 71 percent in 1995.[8] And, the proportion of college freshmen who agree that "it's all right to have sex if two people have known each other for a short time" declined from 52 percent in 1987 to a record low 40 percent in 1999, according to an annual survey conducted by UCLA.[9]
- Better and more consistent contraceptive use as well as more effective contraceptives. For example, contraceptive use at *first* sex has improved dramatically in recent years (although there has been a downward trend in contraceptive use at most *recent* sex).[10] Depo-Provera, a new long-acting and highly effective contraceptive method, has also been quite popular among some teens.
- New messages about work and child support embedded in welfare reform. The 1996 welfare reform law contained several important messages. To young women, it said, "if you become a mother, this will not relieve you of an obligation to finish school and support yourself and your family through work or marriage. And any special assistance you receive will be time-limited." To young men, it said, "if you father a child out-of-wedlock, you will be responsible for supporting that child." It may be the case that these messages may be far more important than any specific provisions contained in the welfare reform legislation.[11]

What Works to Prevent Teen Pregnancy?

What do we know about what works to prevent teen pregnancy? Fortunately, there is some good news here, too. For decades, those involved in the teen pregnancy field have been discouraged by the fact that the rates of teen pregnancy and childbearing remained high, were sometimes increasing, and we didn't know what to do about it. The research was just not there to tell us what programs worked to help teens avoid sex or to use contraception effectively.

Finally, we have some answers. This past May, the National Campaign to Prevent Teen Pregnancy released *Emerging Answers: Research Findings on Programs to Reduce Teen Pregnancy*, a comprehensive research review by the well-respected researcher, Douglas Kirby, Ph.D.[12] To summarize what this review found: (1) the overwhelming weight of research evidence clearly shows that sex and HIV education programs *do not* increase sexual activity, as some people had feared, and (2) there are a variety of programs that seem to work. Some focus on sex and some do not. Kirby identified three particular types:

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[6] Wetheimer, R., Jager, J., & Moore, K. (2001). *State Policy Initiatives for Reducing Teen and Adult Nonmarital Childbearing. Policy brief.* Washington, DC: Urban Institute.

[7] Flanigan, C. (2001). *What's Behind the Good News: The Decline in Teen Pregnancy Rates During the 1990s.* Washington, DC: The National Campaign to Prevent Teen Pregnancy.

[8] Ku, L., Sonenstein, F., et al. (1998). Understanding changes in sexual activity among youth metropolitan men: 1979–1999. *Family Planning Perspectives 30(6): 256–262.*

[9] UCLA. 27 Jan. 1999. College freshmen: Acceptance of abortion, casual sex at all-time low. *Kaiser Daily reproductive health Report* online. http://report.KFF.org/archive/repro/1999/01/kr990127.6/html

[10] Terry, E. & Manlove, J. (2000). *Trends in Sexual Activity and Contraceptive Use Among Teens.* Washington, DC: National Campaign to Prevent Teen Pregnancy.

[11] Sawhill, I. (2001). *What Can Be Done to Reduce Teen Pregnancy and Out-of-Wedlock Births? Policy Brief.* Washington, DC: The Brookings Institution. *http://www.brookings.edu/wrb/publications/pb/pb08. htm*

[12] Kirby, D. (2001). *Emerging Answers: Research Findings on Program to Reduce Teen Pregnancy.* Washington, DC: National Campaign to Prevent Teen Pregnancy. *http://www.teenpregnancy.org/053001/emeranswsum.pdf*

• Several sex and HIV education programs have been shown to delay sex or increase contraceptive use for up to 30 months. The effective programs share ten clearly definable characteristics.

• Two youth development programs that give young people opportunities to do community service and have mentoring relationships with adults may actually have the strongest evidence of any intervention that they reduce actual teen pregnancy rates while the youth are participating in the programs. Among the programs with the best evidence of effectiveness are the Teen Outreach Program and Reach For Health service learning program. The research does not indicate why these youth development programs are so successful, although the review suggests several possible explanations: participants develop relationships with caring adults, they gain a sense of autonomy and feel more competent in their relationships with peers and adults, and they feel empowered by the knowledge that they can make a difference in the lives of others. Taken together, all these factors may help increase teenager's motivation to avoid pregnancy. In addition, of course, participating in supervised activities reduces the opportunities for teens to engage in risky behavior.

• The third category of programs includes *both* sexuality and youth development components. The Children's Aid Society-Carrera Program combines family life and sex education with such things as tutoring, work and sports-related activities, and comprehensive health care. Research shows that the program has *substantially* reduced teen pregnancy and birth rates among girls. In fact, according to the research in *Emerging Answers,* the Carerra Program and the Teen Outreach Program reduced pregnancy rates among girls by as much as half.

Together, this information offers leaders around the country encouraging news and the opportunity to choose an intervention that best fits the needs and values of their own communities. Having a variety of options is particularly important when dealing with an issue as complex and sensitive as teen pregnancy.

What do we know about abstinence education? Our review finds that the jury is still out on abstinence-only or abstinence-until-marriage education. This is true for two reasons: (1) very little rigorous evaluation of abstinence-only programs has been completed, and (2) the few studies that show no positive effect do not reflect the great diversity of abstinence-only programs currently offered.[13] Fortunately, Dr. Rebecca Maynard is now conducting a very rigorous study of abstinence-only programs that should shed more light on this important group of interventions.

I would add that I think it is critically important that our evaluations of abstinence programs answer two questions: (1) do they delay sexual intercourse? and (2) for those program participants who do end up having sex, are they less likely to protect themselves from disease and pregnancy? Although some may find this second question beside the point, I would argue that it is no different than asking whether sex education programs inadvertently encourage young people to have sex. Our first goal should always be to do no harm.

Programs Can't Do It All

While it is true that effective programs to reduce teen pregnancy exist and should be expanded, it is unrealistic and unfair to assume that community programs alone will solve this problem entirely. Not all teens are enrolled in programs and many community-based programs are small, fragile, and often given too little money to do their important job as well as they would like.

But there is another reason why community programs can't shoulder the burden alone: teen pregnancy is rooted in broad social phenomena, including the images portrayed in the entertainment media, the values articulated by parents and other adults, and popular teen culture most of all. Simply put, it's fine to work with states and communities to make their efforts better—more research-based, more media savvy, more tolerant of differing views, and offering a wide variety of ways to act. But doing so will be a hollow exercise if the entire culture, especially popular teen culture, is sending kids messages that getting pregnant at a young age is no big deal, that having sex "early and often" is just fine, that contraception is not all that important, that refraining from sex is square and unrealistic, and that parents can't do anything about their children's sexual attitudes and behavior.

The research assessing the effectiveness of media campaigns to prevent teen pregnancy is not nearly as extensive as the research evaluating community-based teen pregnancy prevention programs. There is, however, some encouraging research that indicates media campaigns can be effective. One meta-analysis of 48 different

[13] Ibid.

health-related media campaigns—from smoking cessation to AIDS prevention—found that, on average, these types of campaigns caused seven to 10 percent of those exposed to the campaign to change their behavior (compared to those in a control group).[14] Given how hard it is to actually change behavior, these findings are encouraging.

From its inception, the National Campaign to Prevent Teen Pregnancy has recognized that reducing teen pregnancy requires, among other things, a change in social values and standards; that the entertainment media has a major influence on popular culture; and that conveying important messages through the entertainment media is both powerful and efficient. The Campaign works in two primary ways with the entertainment media: influencing the content of television shows and magazines and placing PSAs in both print and broadcast media. To encourage media leaders to weave prevention messages into the content of their work, we offer specially tailored face-to-face briefings to key editors, script writers, and producers about the problem of teen pregnancy and its solutions. We discuss with them selected messages well suited to their shows or magazines and talk about different ways that these messages can be presented in their media. To date, the National Campaign has worked with over 57 media partners on messages that have reached millions of teens and their parents.

Implications for Welfare Reform Reauthorization

The National Campaign to Prevent Teen Pregnancy believes that preventing teen pregnancy should be a central focus in reauthorizing welfare reform. Sustained progress in reducing teen pregnancy could contribute significantly to the continued success of welfare reform. Welfare caseloads have declined dramatically since 1996, millions of low-income parents have moved into the labor force, child poverty has declined, teen birth rates have declined, and out-of-wedlock birth rates have leveled off. However, this good news could be short-lived if every welfare recipient who goes to work and begins moving toward self-sufficiency is replaced by a pregnant younger sister or daughter who is not prepared to support a family.

Moreover, teen pregnancy prevention is closely tied to the goal of reducing out-of-wedlock childbearing and increasing the number of children growing up with married parents. Three out of ten out-of-wedlock births in the U.S. are to teenagers and nearly half of all *first* out-of-wedlock births are to teen mothers. Furthermore, 80 percent of teen births are out of wedlock. Welfare caseloads are disproportionately made up of women who had their first birth as a teen. The teen years are frequently a time when unmarried families are first formed. Teenagers who have a non-marital birth are less likely to get married later and even if teen parents do get married, teen marriages are highly unstable and far more likely to fail than marriages between older individuals.[15]

Specific ideas

1. As a general matter, provide states and communities with adequate resources to prevent teen pregnancy, access to good information about what works so they can make informed choices about the best way to invest their resources, and a clear signal from the federal government that teen pregnancy prevention is important and is directly linked to other goals of welfare reform. They also need flexibility in deciding how best to reduce teen pregnancy, given local circumstances. Setting performance goals and expectations is a good idea. Rigidly prescribing how to achieve these goals is not. Consistent with the devolution philosophy underlying the rest of welfare reform, family and community values, rather than federal mandates, should prevail, especially on such sensitive issues a teen sexuality.

2. Strengthen the monitoring of and reporting on state efforts to reduce teen pregnancy. States are already required to include their goals and strategies for reducing teen pregnancy in their TANF plans but this information is not widely available and has received little attention within states or at the national level. In order to enhance accountability and visibility, we believe there is more that could be done by the federal government to shine a light on the portion of state TANF plans that address teen pregnancy. Similarly, the federal government should more closely monitor states progress in meeting their teen pregnancy prevention goals. This would encourage states to continue their work on this issue and inspire other states to do more.

3. Establish a national resource center to collect and disseminate information about what works to prevent teen pregnancy. Until very recently, little high quality

[14] Snyder, Leslie B. (2000). How Effective Are Mediated Health Campaigns In *Public Communication Campaign*, edited by Ronald E. Rice and Charles K. Atkin. Thousand Oaks, CA: Sage.
[15] Sawhill, I. (2001). Op Cit.

information was available to states and communities about the best ways to prevent teen pregnancy and they had no way of learning about each other's efforts. A national resource center would provide easy access for people to get information about the latest research evidence, as well as promising practices. We believe the scope of this resource center should be defined broadly to include information about programs, as well as strategies on how to work through the media to promote responsible messages and content related to teenage sexuality. Helpful ideas should also be available about engaging parents, schools, and faith communities in teen pregnancy prevention.

4. Maintain or increase present funding levels for the TANF block grant in order to preserve resources and flexibility for states to expand their teen pregnancy prevention initiatives, while carrying out other important functions of TANF. The latest federal data show that states are spending less than one percent of TANF funds on pregnancy prevention. There are many competing priorities for TANF dollars, and these demands are likely to grown in the current economic downturn.

Additional ideas for welfare reform reauthorization include: make preventing teen pregnancy an explicit purpose of the TANF program; reward states that make the most progress in reducing teen pregnancy or teen births (without increasing abortion); and, retain in the overall welfare reform legislation a very strong abstinence message accompanied by support for information about and access to contraception. Both approaches help to reduce teen pregnancy and both merit support.

[The attachments are being retained in the Committee files.]

Chairman HERGER. Thank you very much, Ms. Brown. And I would like to again remind all our witnesses, as well as our Members, that we do have 5 minutes. All of your testimony, without objection, will be submitted for the record.

And with that, we would like to hear from Dr. Rebecca Maynard, university trustee professor of education and social policy, University of Pennsylvania, Philadelphia, Pennsylvania. Dr. Maynard.

STATEMENT OF REBECCA A. MAYNARD, PH.D., UNIVERSITY TRUSTEE CHAIR PROFESSOR, UNIVERSITY OF PENNSYLVANIA, AND DIRECTOR, NATIONAL TITLE V ABSTINENCE EDUCATION PROGRAM EVALUATION

Dr. MAYNARD. Thank you, Chairman Herger and Members of the Committee for giving me the opportunity to submit testimony on this important issue.

I am both professor of education at the University of Pennsylvania, and the director of the National Title V Abstinence Education Program Evaluation being conducted by Mathematica Policy Research under a contract to the U.S. Department of Health and Human Services.

I am going to talk about three topics. The, first very briefly, is the need for scientifically rigorous research to improve policies and practice. The second is the ways in which the Federal support for abstinence education has changed the local conversations and approaches to reducing teen sexual activity. And third, I want to talk about what the National Title V Program Evaluation evaluation is going to contribute to our knowledge.

You have heard the evidence of why we need to continue to invest in careful research. What I would tell you is that the 1996 Welfare Reforms have really heightened public awareness about the nature and the extent of these problems that you have heard about, and it has fostered a number of efforts to address them, including the provision of $50 million annually in support for the

Title V abstinence education programs. And while we don't yet have definitive evidence linking this specific reform or any other specific reform to the favorable trend in the teen birth rate, what we do know is that Title V has fostered three major changes at the State and local level that I want to talk a little bit about.

First, Title V has expanded and changed the conversation about the role of abstinence education in local communities and schools. The most striking evidence of this is the tenfold increase in the proportion of high schools in this country that are requiring the teaching of abstinence as the sole way to prevent pregnancy and sexually transmitted diseases.

The second is that Title V has fostered the development of many new strategies for promoting abstinence and expanding the concept of abstinence education. Abstinence programs are no longer "just say no." The earliest grass roots abstinence education programs tended to be classroom based, short term, and emphasized the benefits of abstinence and the negative consequences of sex. But many of the current programs, including the Best Friends program you heard about here in Washington, D.C., and nationwide, take a much broader approach, often including extensive mentoring components, including educational and cultural enrichments, and teaching about healthy friendships and marital relationships—things that many of you have been alluding to. We also have a number of abstinence-only initiatives that are community wide systemic change efforts.

Third, Title V has been a huge boost to the abstinence-until-marriage movement. The Federal funds have leveraged at least $50 million again in local funds to support more than 700 abstinence-until-marriage programs nationwide. And, if additional funds were available, it is really clear that many current programs would grow and that new programs would emerge, particularly in communities that have these more intensive, youth development focus abstinence programs. There are lines at the door, and people are ready to expand and to add new programs.

All of this is happening because Congress identified the promotion of abstinence education as an important strategy for preventing teen sexual activity and non-marital pregnancies and births. And, the evaluation of Title V is going to provide the much needed scientific evidence about which of these program models are effective, for whom and under what conditions. I want to emphasize our focus on, which programs are effective, for whom, and under what condition?

I want to note six features of the study that we are conducting that are central to the credibility and the utility of the findings we are going to be able to share with you beginning in about another year. First, we are measuring program impacts using scientifically rigorous experimental design methods. This is the only means of insuring with any degree of certainty how successful the programs are overall, and for key subgroups of youth.

Second the impact evaluation is examining five quite different programmatic strategies geared in part to the needs of the communities in which they are operating, so we are respecting local autonomy and values.

Third, we have designed our student surveys to ensure that program and control youth apply common definitions when answering question about sexual activity. This is really important because the abstinence education programs have changed how people think about sexual activity.

We're using interviewers who are independent of the programs to collect all of our student data, which is important because we need to avoid problems of under reporting of sexual activity due to students' linkages with the program staff.

Fifth, we are following youth for between 18 and 36 months after sample enrollment to allow us to observe more of them as they reach the age when they are making these critical decisions about whether to engage in sex.

And sixth, we are using large samples in all of our sites to protect against the possibility that we would fail to detect true program impact simply because we have low statistical power.

We are going to release our first results in 2003 when we will have follow-up data for the entire study sample.

The one final statement, I want to make a plea to Congress to continue to support youth risk avoidance and pregnancy prevention initiatives, but I also want to encourage you to support other scientifically rigorous studies to complement what we are learning. We are going to learn something very important, but it is a small piece of what we need to know.

Thank you.

[The prepared statement of Dr. Maynard follows:]

Statement of Rebecca A. Maynard, Ph.D., University Trustee Chair Professor, University of Pennsylvania, and Director, National Title V Abstinence Education Program Evaluation, and Amy Johnson, Ph.D., Senior Researcher, Mathematica Policy Research, Inc.

Thank you for giving us the opportunity to submit testimony on this important issue and to share some information based on our experiences from the national evaluation of Title V abstinence education programs being conducted by Mathematica Policy Research, Inc., under contract to the U.S. Department of Health and Human Services. We will focus our remarks on three main topics. First, we will discuss the need for scientifically rigorous research to improve future policies and practice aimed at reducing teen sexual activity and its adverse consequences, including nonmarital childbearing and sexually transmitted diseases (STDs). Second, we will discuss important ways in which federal support for abstinence education has changed local conversations and approaches to reducing teen sexual activity. Third, we will describe what the national evaluation of Title V abstinence education programs will contribute to our knowledge base and when we will report study findings.

The Need for Investing in Careful Research

Teen pregnancy and birth rates have declined steadily since the early 1990s. However, five years after passage of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA), teen sexual activity and its consequences remain important issues, particularly nonmarital and unintended births and sexually transmitted diseases. We need to pay close attention to some of the significant efforts launched in recent years to combat these problems. We need to build on their successes. We also need to learn about and respond to those areas where efforts are not achieving their intended goals.

• Despite the steady decline in the teen birth rate between 1991 and the present—from a high in 1991 of 62 births per 1,000 females age 15 to 19, to 49 births per 1,000 last year [1] many concerns persist:

• Nearly half of all high school students and more than two-thirds of graduating seniors in this country have had sexual intercourse.[2]

• One in five high school seniors reports having had sex with four or more partners.[2]

• More than 40 percent of teens failed to use any protection against STD infections during their last sexual encounter.[2]

• An estimated 25 percent of sexually active teens will contract a sexually transmitted disease this year.

• Nearly 500,000 babies are born each year to teens, more than 80 percent of whom are not married.[3]

The 1996 welfare reforms heightened the public's awareness of the nature and extent of problems associated with teen sexual activity, teen childbearing, and nonmarital childbearing. The reforms also fostered targeted efforts to discourage sex among teenagers, to reduce teen pregnancies and births, and to promote stronger family relationships. Specifically, the reforms did the following:

• Required state welfare plans to focus on out-of-wedlock and teen childbearing and offered a total of $20 million in bonuses to states that were especially successful in reducing their nonmarital birth ratio.

• Increased the emphasis on statutory rape laws and required minor parents to live in supervised settings.

• Allowed use of federal Temporary Assistance to Needy Families (TANF) funds to support family planning services.

• Provided $50 million annually in federal support for Title V abstinence education programs, which is matched by roughly $38 million in state and local funds.

At this point, we have no definitive evidence linking any of these provisions with favorable trends in teen pregnancies and births. However, we have abundant evidence that the federal support of abstinence education, in particular, has focused attention at the state and local level on the problems of teenage sexual activity and nonmarital childbearing, and that this focus has led to expansion in the number and variety of abstinence education programs. An important complement to these policy and program initiatives is the investment by the U.S. Department of Health and Human Services in a rigorous research study of Title V abstinence education programs. The study will fill a small, but very important, portion of the knowledge gap by helping us understand how best to design and implement abstinence programs that are successful in reducing nonmarital sexual activity and childbearing.

Changes at the Local Level as a Result of Abstinence Education Funding

The federal government's commitment of $50 million annually to support abstinence education through the Title V Block Grant Program has had three major impacts. First, it has expanded and changed the conversation about the role of abstinence education in local communities and schools. Second, it has fostered the development of new strategies for promoting abstinence among youth. Third, it has increased significantly the number of abstinence education service providers and the number of youth they serve.

One only needs to read the newspapers to be aware of the heightened focus, at both the state and the local level, on health, sex education, and abstinence education policies. However, the numbers provide more concrete evidence of change. In 1988, only 2 percent of school districts reported teaching abstinence as the sole way to prevent pregnancy and sexually transmitted diseases; by 1999, 23 percent reported such policies.[4] Today, 23 states incorporate contraception into their curricula,

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[1] Child Trends. *Facts at A Glance,* Washington, DC: Child Trends, August 2001. The original data are from National Center for Health Statistics, Centers for Disease Control and Prevention, Hyattsville, MD.

[2] Centers for Disease Control. "Youth Risk Behavior Surveillance—United States, 1999." *CDC Mortality and Morbidity Weekly Report Summaries,* vol. 49, SS05, June 9, 2000 and vol. 47, no. 36, September 18, 1998 (www.cdc.gov/mmwr/PDF/SS/SS4905.pdf and www.cdc.gov/mmwr/PDF/wk/mm4736. pdf, respectively).

[3] Child Trends. *Facts at A Glance,* Washington, DC: Child Trends, August 2001.

[4] Darrroch, J.E., D.J. Landry, and S. Singh. "Changing Emphases in Sexuality Education in the U.S. Public Secondary Schools, 1988–1999." *Family Planning Perspectives,* vol. 32, no.5, September/October 2000, pp. 204–211.

and 26 states teach abstinence.[5] In part, this increased emphasis on abstinence reflects the fact that, in many communities, it is the only strategy for reducing teen pregnancies that is consistent with local norms and values. In other cases, abstinence education programs are viewed as important complements to other existing strategies focused on curbing high rates of sexual activity, pregnancies, and nonmarital births.

Title V funding has fostered the development of myriad new strategies for promoting abstinence and expanded the concept of abstinence education. The earliest grassroots abstinence education programs tended to be more homogeneous, classroom-based programs focusing on the benefits of abstinence and the negative consequences of sex outside of marriage. In contrast, many of the current programs—including Best Friends here in Washington, DC, and ReCapturing the Vision in Miami, Florida—take a broader approach, linking abstinence and other healthy behavioral choices for young people. The major quality distinguishing them from many other youth development initiatives in our country is their clear, consistent message that abstinence is the healthiest choice and the only way to prevent unintended pregnancies and sexually transmitted diseases.

Contrary to popular opinion, the vast majority of current Title V abstinence education programs offer much more than a "just say no" message. As noted previously, many have extensive youth development and mentoring components; they often include educational and cultural enrichments; and they frequently incorporate curricula and experiences designed to teach about healthy friendships and marital relationships.

The majority of the Title V abstinence education programs target most of their services on identifiable groups of youth. The following table illustrates the range of such programs:

TABLE 1: ILLUSTRATIVE TARGETED TITLE V ABSTINENCE EDUCATION PROGRAMS

Program and location	Entry grade/setting/curriculum/other services/other features
Teens in Control, Clarksdale, MS	Grades 5 and 6. School-based. 30 curricula sessions, possibly repeated once. Minor peer mentor component. Extremely poor, rural community.
ReCapturing the Vision, Miami, FL	Grades 6–8 and 9–12. School-based. Daily, year-long curriculum. Monthly home visits and referrals to other services; school uniforms. Urban setting; diverse student population.
Heritage Keepers Community Services, Edgefield, SC.	Grade 6 and 7 and grades 9 and 10. School-based. Character clubs added to a five-session abstinence curriculum. 18 or more sessions annually over multiple years. Rural, middle- to lower-middle-class population.
My Choice, My Future, Powhatan, VA	Grade 8. School-based. 36-session curriculum. 9th and 11th grade boosters. Lower- to middle-income community.
Families United to Prevent Teen Pregnancy, Milwaukee, WI.	Grades 4–6. After school. Two hours daily throughout the school year for multiple years. Summer program; parent involvement; peer mentors. Poor, inner-city neighborhoods; mixed race/ethnic groups.

Other programs are using Title V monies to increase public awareness, shape attitudes, and change behavior throughout the community. Many community-wide programs also complement their public education and messaging efforts with more targeted services to provide particular groups of youth with the skills and values needed to remain abstinent. The following are examples of such efforts:

[5] Wertheimer, R., J. Jager, and K. Moore. "State Policy Initiatives for Reducing Teen and Adult Nonmarital Childbearing: Family Planning to Family Caps." *New Federalism Issues and Options for States,* Series A, No. A–43. Washington, DC: Urban Institute, November 2000.

TABLE 2: ILLUSTRATIVE TITLE V COMMUNITY-WIDE ABSTINENCE EDUCATION PROGRAMS

	Sponsoring agency	Principal program components	Target population
Cedar Rapids, IA	Not-for-profit/ public school district coalition.	Abstinence curriculum for 5th graders; *Young Parent Network* for abstinence training; community resource library; School assemblies in middle and high schools; workshops for parents and educators; support groups for transition from middle school; volunteer teens writing and producing messages; mentoring and adult supervision; Baby Think It Over dolls.	All county youth; emphasis on middle school youth.
South Carolina [1]	Heritage Keepers Community Services.	Abstinence education curriculum (450 minutes); weekly or biweekly character clubs; parent training; mentors; assemblies; training of medical providers.	Grades 6–10; 11th and 12th grade boosters.
Toole, UT	Counth health department.	Abstinence curriculum, with some *Teen Aid* et al. in family life classes at middle schools (typically 2 weeks or so); *Love and Logic* parenting class (2 hours per week for 10 weeks); self-esteem ays for 5th—8th graders; Baby Think It Over dolls; FACT student self-esteem classes for high-risk youth; peer educators; school fairs; billboards and newsletters; merchang involvement; faith-based linkages.	9–18 year olds; strongest focus on 10–14 year olds.
Waco, TX	Newly formed community-based organization.	Abstinence curriculum (6 weeks as part of health class); *Aim for Success* assemblies; Reality Check (''I'm Worth Waiting For''); character education in elementary schools; youth mentors; medical provider training; faith-based partners; resource library; media spots.	10–14 year olds, with a heavy emphasis on 8th and 9th graders.
Fort Bend, TX	Newly formed community-based organization.	Wings youth development for girls; *Change-Makers,* community training; peer education (STARS); *GOLDCLUB,* social group for high school youth; parent education programs; parent resource center; propellor group for boys (under development); Aim for Success Assemblies; school-based abstinence curriculum; community events (e.g., fairs).	9–18 year olds, with a heavy focus on middle school youth.
Monroe County, NY ...	County health department and New York agency (advertising).	Abstinence curriculum; parent guides; paid TV ads, radio spots, and posters; *Kids Advisory Panel* for media efforts; interactive web site for parents, youth, and community educators.	Youth aged 9–14.

The $50 million annual federal investment in abstinence education through Title V has been a huge boost to the abstinence-until-marriage movement. Federal program funds have leveraged at least that much again in local matching funds to support more than 700 programs nationwide. And, funds for abstinence education through the Special Projects of Regional and National Significance (SPRANS) grant program administered by the Health Resources and Services Administration recently added another $20 million to support 49 additional grantees operating a similar range of programs.[6]

If additional funds were available, it is clear that many current programs would grow and that new programs would emerge. Particularly in communities with the more intensive youth-development programs, demand for abstinence programs frequently exceeds current capacity, as evidenced by program waiting lists and requests for programs to expand to new sites. Many communities with classroom-based programs are interested in beginning them earlier and/or running them longer. One of the biggest future challenges is knowing which models and delivery

[6] Lawler, Michele. "Abstinence Education Grant Program, Health Resources and Services Administration, U.S. Department of Health and Human Services." Presentation at the *Abstinence Clearinghouse International Conference,* Miami, FL, July 26, 2001.

strategies will work best for a particular community or with a particular group of youth—issues that are central to the ongoing evaluation of Title V abstinence education programs we are conducting.

What Will the National Evaluation of Title V Abstinence Education Programs Contribute?

Congress identified the promotion of abstinence education as an important strategy for preventing teen sexual activity, nonmarital pregnancies and births, and sexually transmitted diseases. The central focus of the Congressionally mandated study of the Title V programs is to provide much-needed, scientifically rigorous evidence about which program models are effective, for whom, and in what local contexts. The study will measure the success of different program models in altering youths' attitudes and intentions about nonmarital sex, reducing sexual activity among teens, convincing youth who have had sex to become abstinent, and lowering exposure to sexually transmitted diseases and nonmarital births.

The Title V program evaluation findings should have much greater credibility than findings from previous research, because of critical features of the study design and implementation:

1. We are measuring program impacts using scientifically rigorous, experimental design methods. This is the ONLY means of measuring with a known degree of certainty how successful the programs are overall and for key subgroups of youth. Findings based on any other evaluation design could be readily dismissed for their weak study design and the potential for "selection bias." This would include results based designs that relied on comparisons of pre- and post-program outcomes for program youth; comparisons of outcomes for program youth with those for youths in the program site who, for some reason, do not participate in the program; and comparisons of outcomes for program youth with those for youth in another school or district.

2. The impact evaluation is examining five quite different programmatic strategies geared, in part, to the needs of the communities in which they are operating. For example, the programs in two sites serve mainly youth from single-parent households; these programs are intensive and include strong components on relationship development and maintenance, and appreciation of the institution of marriage. In another site, many youth live in large, multi-generational households often isolated from the broader community. The program in this community is delivered through the schools and emphasizes both basic knowledge development and peer pressure management components. Youth in another two sites live in communities that mirror "middle America." The program in one of these sites is a low-cost, school-based intervention, while that in the other site is a more comprehensive and intensive youth development initiative. By measuring impacts for a range of program models we promote the goal of identifying and documenting effective abstinence education strategies appropriate to varied local needs and contexts.

3. We have designed student surveys to ensure that program and control youth apply common definitions when answering questions about sexual activity and abstinence. Participation in abstinence education programs sometimes leads youth to change their definitions of what constitutes sexual activity and abstinence. Failure to address such program-induced changes in definitions could result in a downward bias in the reporting of abstinence by program youth relative to control youth and thereby limit our ability to detect true program impacts. It is, therefore, essential that we clearly ask about the specific behaviors of interest.

4. We use interviewers who are independent of the programs to collect all student survey data for the study. Research shows that youth are especially likely to underreport sexual activity and other risk-taking behaviors on surveys linked to or administered by program staff. Reporting accuracy can be improved through carefully designed surveys administered by independent professionals in neutral settings.

5. We are following youth for between 18 and 36 months after sample enrollment. This follow-up permits the study to measure behavior changes, not just changes in reported intentions. It also allows us to observe more youth as they reach the age when they are at substantial risk of engaging in sexual activity.

6. We have enrolled samples of 400 to 700 youth per site. Large sample sizes protect against the possibility that we would fail to detect true impacts of the programs, simply because the study lacked statistical power. Small samples have a very high probability of missing all but very large program impacts.

7. We are establishing a foundation for longer-term assessment of systemic change resulting from community-wide programs. Changing community norms and values is a cumulative process that takes time. As part of the Title V program evaluation, we are documenting the operational strategies of a select

group of such programs. However, it may take many years to reliably link operational success to changes in community norms and youths' behaviors. Fortunately, some of these projects have instituted indicator-tracking systems that will support their ongoing efforts to gather evidence of cumulative changes in local behaviors beyond the period when the national evaluation of Title V programs is ongoing.

We are committed to conducting a scientifically rigorous, responsible evaluation that will inform future decisions about effective intervention strategies and policies to support and promote them. Results based on only part of our study sample are susceptible to missing all but very large program impacts. Thus, evidence on the short-term effects of the various program strategies in changing norms, attitudes, and behaviors will not be available until we have data for the full study sample, early in 2003. The final impact findings will be available early in 2005. Throughout the study period, we are monitoring program operational experiences and the local community context, as well as other related research that emerges.

The Title V program evaluation will generate some very important information to guide future policy and program initiatives. It is important, however, that there be other similarly rigorous studies to fill other critical knowledge gaps about the causes of youths' risk-taking behaviors, about ways we can promote healthier life choices among youth, and about strategies to mitigate the adverse outcomes youth encounter.

Chairman HERGER. Thank you very much, Dr. Maynard. And now Ms. RoseAnne Bilodeau, Greater New Britain Teenage Pregnancy Prevention, Incorporate, New Britain, Connecticut. Ms. Bilodeau.

STATEMENT OF ROSEANNE BILODEAU, EXECUTIVE DIRECTOR, GREATER NEW BRITAIN TEEN PREGNANCY PREVENTION, INC., NEW BRITAIN, CONNECTICUT

Ms. BILODEAU. Good morning, Mr. Chairman, and honorable Committee Members. It is with a deep sense of honor that I appear before you today to share our teen pregnancy prevention findings from Connecticut's Sixth District, Congresswoman Johnson's hometown of New Britain.

My name is RoseAnne Bilodeau, and I am the founder and executive director of Greater New Britain Teen Pregnancy Prevention, Incorporated, which is more commonly known as the Pathways/Senderos Center.

We originated 8½ years ago as a neighborhood-based coed teen pregnancy prevention youth and family center. We are an independent private, non-for-profit organization. Our mission is to eliminate teen pregnancy by addressing its root causes, assuring high school graduation and promoting adult self-sufficiency. We provide long-term comprehensive holistic services by creating a parallel family structure with neighborhood youth and parents. Our motto is "diplomas before diapers."

Our board of directors is comprised mostly of successful businessmen, bankers, lawyers and a few other community stakeholders, such as the superintendent of the schools, the director of Family Planning, local clergy and leadership from both the Democrat and Republican parties. Almost 60 percent of our board of directors are men.

Our annual evaluation, conducted by Philliber Research Associates, documents that only two of our participants have ever created a pregnancy, which 100 percent of our participants remain in school, and only 25 percent of our kids have ever been involved in

a physical fight, only 4 percent have ever carried a weapon, and only 8 percent have tried cigarette smoking.

Our program population is 50 youth. They range in age from 10 to 18 years old, and as Congresswoman Johnson indicated, we are one of New Britain's greater poverty-stricken areas. All of our children are Latino, most are Puerto Rican, while the others come from Peru, Colombia, Mexico, and Panama. For most, English is a second language. At least 80 percent of our preteens come from families that were started by teen parents. Some of the children are being raised by their biological parents, while others are raised by single grandmothers or mothers who may be married to a stepfather, single or living with a boyfriend.

Our TANF-dependent families were affected by the first wave of Connecticut's welfare reform. All of our parents are currently employed in low-paying entry-level jobs, many as certified nursing assistants. Our families are Members of the working poor, people who run out of food frequently while trying to make ends meet. At Pathways/Senderos we provide clothing and food pantries. We distribute at least a bag of groceries a day.

Our program model and philosophy are based upon the work of Dr. Michael Carrera and the Children's Aid Society, which was recently identified as being an extremely effective intervention by the National Campaign's "Emerging Answers" report. We believe that by participating in a safe environment with a parallel family structure every day after school and during the summer, that young vulnerable teens can develop the skills and inner fortitude necessary to avoid negative, risk-taking behaviors, and instead engage in activities that encourage academic success, making the right choices, and eventually attaining self-sufficient adulthood. We provide a pathway of hope.

Ours is a child-focused family systems intervention which involves us with families for years. Our primary service components emphasize education, career, vocational exploration, community service projects, family life and sex education, arts and lifelong sporting activities. We have also started a business of our own, titled Barcodes aRe Us, which is a bulk-mailing service. We train and employ our age-eligible youth who maintain at least a C average in school. Our business also provides a source of revenue for our program.

Our board of directors is finalizing a year-long strategic planning process which will identify an expansion of our scope of services to include additional children from the elementary grades. Currently we recruit from the sixth grade. Our intake data, since welfare reform, indicates that the children now spend less time with their parents and have greater exposure to and involvement with risk-taking behaviors than did their peers prior to welfare reform. We would like to reach out to these younger children who might not be properly supervised when they are out of school. We would like to involve children at an earlier age with our philosophy of hard work, cooperation, making the right choices and team effort.

Although we currently save the youth who are most likely to fall between the cracks, we believe we could be so much more successful in moving poverty-stricken children and their families forward if we had the resources to serve more children at an earlier age.

Pathways/Senderos assists vulnerable families by providing intensive long-term multi-faceted services. Over time we have seen many families slowly overcome the barriers created by undeveloped education, limited skill training and lack of English language skills. With our daily involvement the children flourish and prosper. As they grow in this positive manner, the rest of the family follows, including parents and extended family.

Pathways/Senderos is also credited by the local clergy with contributing to the stabilization of our highly-transient inner city neighborhood. When we first arrived local gangs controlled the area and neighborhood teens either joined a gang for protection or stayed in their apartments for safety. The police cleaned out the gangs and Pathways/Senderos replaced them as an option of choice for the neighborhood teens.

We have created a positive peer group which carries on when we are not there on some of the weekends and during school hours. Our youngsters bond as a family and strive together to become responsible civic-minded self-sufficient citizens. It is this long-term holistic approach which not only averts teen pregnancy, but does so much more, that has persuaded our inner city poverty-stricken children to make the right choices and aspire to a life of success.

Thank you for your time and attention.

[The prepared statement of Ms. Bilodeau follows:]

Statement of RoseAnne Bilodeau, Executive Director, Greater New Britain Teen Pregnancy Prevention, Inc., New Britain, Connecticut

Good morning Mr. Chairman and honorable subcommittee members. It is with a deep sense of honor that I appear before you today to share our teen pregnancy prevention findings from Connecticut's Sixth District, Congresswoman Johnson's home town of New Britain.

My name is RoseAnne Bilodeau. I am the founder and Executive director of Greater New Britain Teen Pregnancy Prevention, Inc., more commonly known as the Pathways/Senderos Center.

We originated eight and one half years ago, as a neighborhood-based, coed, teen pregnancy prevention youth and family center. We are an independent, private, nonprofit organization dedicated strictly to providing successfully evaluated, long-term, comprehensive, holistic prevention services.

Our Board of Directors is comprised mostly of successful business people, lawyers, bankers and a few other key community stakeholders such as the Superintendent of Schools, Director of Family Planning, the clergy and leadership from both the Democratic and Republican parties.

Our annual evaluation conducted by Philliber Research Associates of Accord, New York, documents that only two of our participants have ever created a pregnancy, while 100 percent remain in school; with only 25 percent have ever been involved in a physical fight; 4 percent have ever carried a weapon; and only 8 percent have tried cigarette smoking.

Our program population is 50 10–18 year olds from one of New Britain's poverty-stricken neighborhoods. All of our children are Latino, most Puerto Rican, while the others come from Peru, Columbia, Mexico and Panama. For most, English is a second language.

At least 80 percent of our (pre)teens come from families started by teen parents. Some of the children are being raised by their biological parents, while others are raised by their single grandmothers or mothers who may be single, married to a stepfather or living with a boyfriend. Our TANF-dependent families were affected by the first wave of Connecticut's welfare reform. All are currently employed in low-paying, entry-level jobs with many working as certified nursing assistants. Our families are members of the working poor, people who run out of food frequently while trying to make ends meet. At Pathways/Senderos we also provide food and clothing pantries. We distribute at least one bag of groceries a day.

Our program model and philosophy are based upon the work of Dr. Michael Carrera and the New York's Children's Aid Society, which was recently identified

as being successful by the National Campaign's "Emerging Answers" report. We believe that by participating in a safe environment with a parallel family structure every day after school and during the summer that young vulnerable people can develop the skills and inner fortitude necessary to avoid negative, risk-taking behaviors and instead engage in activities that encourage academic success, and where they can make the right choices to eventually attain self-sufficient adulthoods.

Ours is a child-focused, family systems intervention, which involves us with families for years. Our primary service components emphasize education, career/vocational exploration, community service projects, family life and sex education, arts and life-long sporting activities. We have also started a business, Barcodes aRe Us, a bulk-mailing service, which trains and employs our age-eligible youth who maintain at least a "C" average in school. Our business also provides a source of revenue for us.

Our Board of Directors is finalizing a year-long strategic planning process which will identify an expansion of our scope of services to include additional children from the elementary grades. Currently we recruit sixth grade students. Since welfare reform, our data indicates that the children now spend less time with their parent(s), and have greater exposure to and involvement with risk-taking behaviors than did their peers prior to welfare reform. We would like to reach out to these younger children who may not be properly supervised when out of school. We would like to involve children at an earlier age with our philosophy of hard work, cooperation, making the right choices and team effort.

Although we currently "save" the youth who are most likely to fall between the cracks, we believe that we could be so much more successful in moving poverty-stricken children and their families forward if we had the resources to serve more children at an earlier age. Pathways/Senderos assists vulnerable families by providing intensive, long term, multi-faceted services. Over time, we have seen so many families slowly overcome the barriers created by undeveloped education, limited skill training and lack of English language skills. With our daily involvement, the children flourish and prosper. As they grow in this positive manner, the rest of the family follows, including parents and extended family.

Pathways/Senderos is also credited by the local clergy with contributing to the stabilization of our highly-transient, inner-city neighborhood. When we first arrived, local gangs controlled the area and neighborhood teens either joined a gang for protection or stayed in their apartments. The police cleaned out the gangs and Pathways/Senderos replaced them as the option of choice.

We have created a positive peer group, which carries on when we are not there on some weekends and during school hours. Our youngsters bond as a family and strive together to become responsible, civic-minded, self-sufficient citizens.

Chairman HERGER. Thank you very much, Ms. Bilodeau. What an impressive program, and we thank you for coming and sharing that with us.

And now Dr. Joe S. McIlhaney, Jr., M.D., president, Medical Institute for Sexual Health, Austin, Texas. Dr. McIlhaney.

STATEMENT OF JOE S. McILHANEY, JR., M.D., PRESIDENT, MEDICAL INSTITUTE FOR SEXUAL HEALTH, AUSTIN, TEXAS

Dr. MCILHANEY. Thank you, Chairman Herger and other distinguished members of the panel. I am a gynecologist and actually am comfortable being on a panel with five wonderful women.

I left a rewarding medical practice in 1995 to spend the rest of my medical career helping women and men avoid the problems I saw every day in my medical practice, sexually transmitted disease (STD), non-marital pregnancy and emotional damage of inappropriate sexual behavior.

You probably know that one-third of pregnancies in America are born out-of-wedlock and that those drive much of the problems that we see in this country, poverty, child health, education, crime,

much more that has been mentioned already. I have some of those statistics in my written testimony.

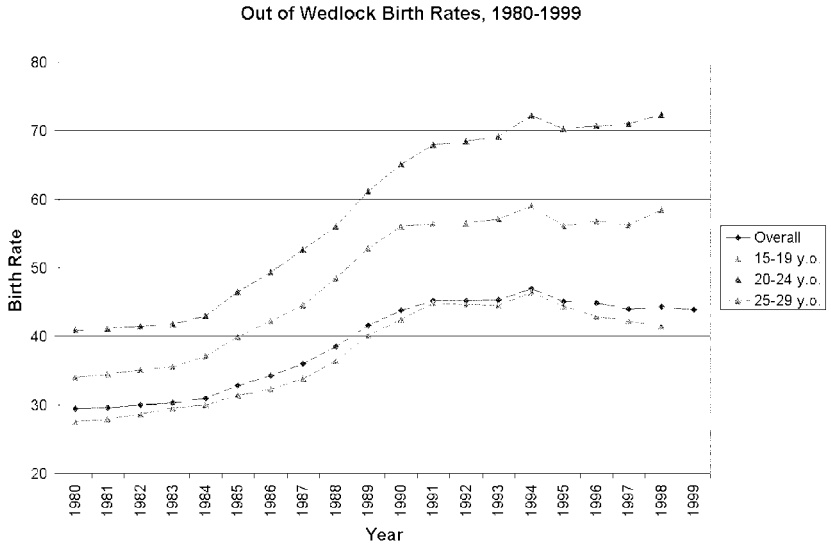
We could go on and on with how dramatically these non-marital pregnancies and the problems from them impact all of America, every element of our society. We must dramatically reduce its occurrence.

In the seventies and eighties the primary efforts were to emphasize contraceptive use, but the pregnancy rates continued to climb. The first governmental legislation to fund abstinence promotion was the Title XX program initiated in the mid eighties. There is some suggestion of success of these efforts as they matured, in that teen sexual activity began declining in 1990. A non-governmental abstinence program was proven to work by the ADD Health, National Longitudinal Study on Adolescent Health, Study, the biggest study ever done on American adolescence. It showed that kids who took pledges of abstinence, that those pledges were the biggest influence in the lives of those children who were delaying the onset of sexual activity. That ADD Health Study also showed that 10 percent of American boys and 15 percent of American girls in their adolescent girls were taking those pledges. The pledges were at first ridiculed by the scientific community. No more.

In addition to these efforts, there are studies accumulating of specific abstinence programs which are showing surprising success. You have already heard from Members of this panel about some of them, and others of them are mentioned in our written testimony. As a result of these efforts, teen sexual activity has been decreasing since 1990. Today, as you know, over 50 percent of students in high schools across the country are still virgins, and during this same period of time teen birth rates have been declining, as we have heard.

The chart I put here on out-of-wedlock birth rates from 1980 to 1999 clearly suggest that abstinence efforts have played a major role in this healthy trend. Almost all efforts to encourage sexual abstinence, particularly Title XX and Title V, have been directed toward teens. And as the chart shows, that red chart at the bottom, that it is the group, the teens in which out-of-wedlock birth rates have fallen. If these decreased birth rates were primarily due to increased contraceptive rates, birth rates among unmarried women in their twenties should also have fallen because they obviously had at least equal access to contraceptives as the teens did. It was only the age group in which abstinence efforts had been focused that has experienced not only reduced pregnancy rates, but also reduced rates of sexual activity.

[The chart follows:]



It is of great importance to note, however, there is a major problem which is often disastrously overlooked in discussing the problem of out-of-wedlock pregnancy, and that is the epidemic of sexually transmitted disease. When I gave testimony before this same Committee in 1996, I highlighted those problems. They are still with us. Fifteen point five Americans get a new sexually transmitted disease every year. The result is that today 70 million Americans are living with a sexually transmitted disease. Sixty-five million of those are infected with incurable STDs because they are viral. One specific example literally tears at our hearts, and that is that 50 percent of women having sex, who are between the ages of 18 and 22, right now half of them are infected with human papillomavirus (HPV), the virus that causes 99 percent of cervical cancer, a cancer which is killing between 4,000 and 5,000 American women a year, more than die of AIDS.

When I started practicing in 1968 there were only two STDs you worried about. Today there are over 25 STDs we worry about, and more people are infected today. In those days 1 in 47 teens was infected with an STD. Today one in four teens is infected with an STD.

The reason we must include the problem of sexually transmitted disease when we talk about out-of-wedlock pregnancy is that the contraceptive techniques more reliable for preventing pregnancy, DepoProvera and oral contraceptives, provide no protection from STD transmission, and this is the reason it is so convenient to ignore the STD problem when discussing out-of-wedlock pregnancy. To be honest about physical problems that can result from out-of-wedlock sexual activity, we must always discuss both of these problems.

The only technique that provides any protection from the STDs are condoms. However, a major National Institute of Health panel reviewed the world's data on this subject, and this scientific panel this year reported that if condoms are used 100 percent of the time, they will reduce the risk of HIV and gonorrhea, gonorrhea in men; they do not reduce the risk of HPV, which is the most common STD and causes cancer, and we don't know whether they reduce the risk of other STDs or not. So this is information that we just must understand.

And unfortunately, sex is sexist. When people become infected with diseases, it is the women that suffer. I am just about through. And we all know that it is the women who suffer from out-of-wedlock pregnancies. They are the ones, not the men, that submit their bodies to the surgical procedure called abortion. They are the ones that deliver the babies and then often are left with those babies to raise as enormous personal, educational and economic sacrifice. Many students of American culture are of the opinion that these problems are the most damaging on the American culture of all the problems we have, and I agree.

Finally, for the health of individuals in all society, we need to emphasize marriage as a core element of society and emphasize its importance as the ultimate answer for these health problems plaguing our country and other countries, by the way, around the world. A major step in accomplishing this is TANF reauthorization, and additional TANF funds being earmarked for abstinence and marriage efforts, not just limited to adolescence either.

And finally, Title V funds for abstinence education should not only be continued but increased. If these steps are not taken, there is significant danger that the promising trends that we see over here, decreasing sexual activity and decreasing teen pregnancy, will reverse. We need a cultural transformation regarding sexual activity for the protection of all society, and you as leaders can play a huge role in this happening.

Thank you, sir.

[The prepared statement of Dr. McIlhaney follows:]

Statement of Joe S. McIlhaney, Jr., M.D., President, Medical Institute for Sexual Health, Austin, Texas

Thank you, Chairman Herger and other distinguished members of this committee. I am a gynecologist who practiced clinical medicine for twenty-eight years. I had a rewarding practice of in-vitro fertilization, surgery, and healthcare for women. However, I left that practice in 1995 to spend the rest of my medical career helping women and men avoid the problems I saw every day—problems that physicians today are seeing even more often. Those problems are non-marital pregnancy, sexually transmitted disease, and the emotional damage of inappropriate sexual behavior.

First, births to unmarried women. There were approximately 4 million births in the United States in 1999.[1] Approximately 1/3 of those (1,300,000) were out-of-wedlock. Seventy percent of these were to women twenty years of age and older, but 50 percent were to mothers who were under age 20 when they bore their first child.[2] These out-of-wedlock births are often disastrous for the mothers, for the children,

[1] Ventura SJ, Martin JA, Curtin SC, Menacker F, Hamilton BE. Births: Final data for 1999. National vital statistics reports; vol. 49, no. 1. Hyattsville, Maryland: National Center for Health Statistics. 2001.

[2] Ventura SJ, Bachrach CA. Non-marital childbearing in the United States, 1940–99. National vital statistics reports; vol. 48, no. 16. Hyattsville, Maryland: National Center for Health Statistics. 2000.

and often for the fathers—but they are also disastrous for society. They affect poverty, child health, education, and crime.

The specific facts I will now cite come from an insightful new book, *The Case for Marriage—Why Married People Are Happier, Healthier, and Better Off Financially*.[3]

Poverty: In 1996, for example, 11.5 percent of children younger than 6 who lived in a married couple family were poor, compared to almost 59 percent of those living with a single mother.

Child health: For college-educated white mothers, being unmarried increases the risk that a baby will die by 50 percent.

Education: Living in a single-parent family approximately doubles the risk that a child will become a high school dropout—29 percent vs. 13 percent.

Crime: Boys raised in single-parent homes are twice as likely to have committed a crime that leads to incarceration by the time they reach their early thirties than boys raised in the home of two biologic parents.

I could go on and on to show how dramatically the non-marital pregnancy problem has impacted almost every facet of society. We must dramatically reduce its occurrence. And we have made some progress with teen pregnancy. Prior to the government's first legislation funding abstinence education, the Title XX program, teen pregnancy rates were skyrocketing. As a result of Title XX funding, by 1990 approximately 200 abstinence programs had been founded and implemented. Subsequently, in the early 1990s not just teen pregnancy rates, but also teen sexual activity rates began falling—together. These trends continue for teens and are most likely due in large part to abstinence promotion, which received a big boost from Title V funds made available through the welfare reform legislation of 1996.

The abstinence pledge movement is alive and well among teens and has had a powerful influence in helping them maintain a healthier lifestyle. Pledges by teens to remain abstinent have been proved by the ADD Health Study to be one of the biggest influences in a young person's decision to delay the onset of sexual activity. ADD Health also shows that a surprisingly large number of adolescents have taken such a pledge—10 percent of boys and 15 percent of girls. This movement was begun as the Southern Baptist True Love Waits Campaign in 1993. It has now spread to both religious and secular environments nationwide. Pledges were at first ridiculed by the scientific community—no more!

In addition to these national statistics there are studies accumulating of specific abstinence programs which are showing surprising success. These are both published and unpublished. The best known is Rowberry's study of *Best Friends*. The most recent has been a report from the Monroe County, NY, Department of Health regarding the success of its *Not Me, Not Now* program.[4] A Title XX program performed in rural South Carolina showed dramatic reduction in teen pregnancy in the 1980s.[5] A Cleveland study recently showed a 2/3 drop in the onset of sexual activity of virgins and a return to abstinence by some sexually experienced students (unpublished). There are others.

Those who are attempting to discredit abstinence promotion efforts emphasize the fact that there are only a small number of studies of these programs. It is vital to remember two things about these efforts. Implementation of abstinence education is still relatively new. Additionally, it takes a lot of time, money, and expertise to evaluate abstinence promotion programs—money not made available until recently.

Let's compare this to smoking. A brave Surgeon General in 1964 said smoking was harmful and that Americans should not smoke. No study of abstinence from smoking would have shown success in those early years. Now, thirty-seven years later, we know that adult smoking has dropped from 43 percent to 23 percent. We all praise this success. What we need to also remember about this is that smoking hardly ever hurts a teen while they are a teen—the cancer and emphysema do not usually happen for years. Sexual activity, however, often hurts teens while they are still teens with disease and/or pregnancy. We need to be as comfortable and intentional in urging them to be abstinent from sex as we are in urging their abstinence from cigarettes. And we need to be patient and unrelenting so efforts can mature.

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[3] Waite LJ, Gallagher M. The Case for Marriage: Why Married People Are Happier, Healthier, and Better Off Financially. New York: Doubleday, 2000.

[4] Doniger A, Adams E, Utter C, et al. Impact evaluation of the Not Me, Not Now abstinence-oriented, adolescent pregnancy prevention communications program, Monroe County, New York. J of Health Comm. 2001; 6:45–60.

[5] Vincent ML, Clearie AF, Schluchter MD. Reducing adolescent pregnancy through school and community-based education. JAMA. 1987;257:3382–3386.

[6] Centers for Disease Control and Prevention. CDC Surveillance Summaries, June 9, 2000. MMWR 2000;49 (No. SS–5).

[7] Mann J, McIlhaney JS, Stine CS. Building Healthy Futures, The Medical Institute for Sexual Health, 2000.

There has been some success. Teen sexual activity has been decreasing since 1990. Today over 50 percent of students in high schools across the country are still virgins. During this same period of time teen birth rates have also declined to their lowest level in recent memory.

The chart "Out of Wedlock Birth Rates, 1980–1999" clearly suggests that abstinence efforts have played a major role in this healthy trend. Almost all efforts to encourage sexual abstinence, particularly Title XX and Title V, have been directed toward teens and, as the chart shows, that is the group in which out-of-wedlock birth rates have fallen. If these decreased birth rates were primarily due to increased contraceptive use, birth rates among unmarried women in their 20s should also have fallen because undoubtedly these groups go to the same healthcare providers and have equal access to contraceptives. It was the only age group on which abstinence efforts have been focused that has experienced not only reduced pregnancy rates, but also reduced rates of sexual activity.

This information makes it clear that Congress was wise in including Title V funding for abstinence promotion in its 1996 welfare reform legislation. The success being shown by studies of abstinence efforts, regardless of criticism of the strength of those studies, is the first beam of light showing us the way out of the dark tunnel of not only teen pregnancy, but also out-of-wedlock pregnancy for all age groups.

The goals of Title V legislation encourage adolescents to remain abstinent until marriage and TANF legislation emphasizes marriage by stating in three of its four goals, and I quote:

> "2. To end the dependence of needy parents on government benefits by promoting job preparation, work, and marriage.
>
> 3. To prevent and reduce the incidence of out-of-wedlock pregnancies and establish numerical goals for preventing and reducing the incidence of these pregnancies.
>
> 4. To encourage the formation and maintenance of two-parent families."

These messages from America's political leadership are powerful and influential. I believe it is vital that Congress continue to help America by reauthorizing TANF and Title V abstinence efforts and also funding ongoing evaluation. Efforts to support, strengthen, and promote marriage are evolving and efforts to encourage sexual activity in only that environment are maturing. Evidence suggests these will result in greater health for all. Studies are necessary to encourage continued improvement of such efforts and to learn which are most effective for different communities.

It is of great importance to note that there is a major problem which is often conveniently and disastrously overlooked in discussions about out-of-wedlock pregnancy. That is the epidemic of sexually transmitted disease. When I gave testimony before this same committee in 1996, I highlighted those problems, and they are still with us.

- 15.5 million Americans are infected with a new STD every year[8]
- It is estimated that over 70 million people are currently infected with STD; 65 million of those are infected with an incurable viral disease.[8]

Specific examples tear at our hearts.

1. In a recent study of women receiving routine gynecologic care in New Mexico, 50 percent of sexually active women between the ages of 18 and 22 were infected with human papillomavirus (HPV), the virus that causes 99 percent of all cervical cancer.[9] Only a tiny fraction will get cancer, but will one of these be your daughter? And, between 4,000 and 5,000 American women a year are dying from this disease—more than die of AIDS.

2. One in five Americans 12 years old and older is infected with genital herpes,[10] a disease from which many suffer painful recurrences and emotional distress.

3. Approximately 6 percent of teenaged females attending family planning clinics are infected with chlamydia. Most have no symptoms and yet this infection can cause them to become sterile if untreated.[11]

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[8] American Social Health Association. Sexually Transmitted Diseases in America: How Many Cases and at What Cost? Menlo Park, CA: Kaiser Family Foundation; 1998.

[9] Peyton CL, Gravitt PE, Hunt WC, Hundley RS, Zhao M, Apple RJ, Wheeler CM. Determinants of genital human papillomavirus detection in a US population. J Infect Dis. 2001;183:1554–64.

[10] Fleming DT, McQuillan GM, Johnson RE, et al. Herpes simplex virus type 2 in the United States, 1976 to 1994. N Engl J Med. 1997;337:1105–1111.

[11] Centers for Disease Control and Prevention. Sexually Transmitted Disease Surveillance, 2000. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, September 2001.

When I started practice in 1968, there were two major sexually transmitted diseases that worried us. Now there are over twenty-five such diseases and many more people infected. In the 1960s 1-in-47 sexually active teens was infected with an STD. Now it is 1-in-4.[12]

The reason we must include the problem of sexually transmitted disease when we talk about out-of-wedlock pregnancy is that the same risky behaviors are responsible for both. But the contraceptive techniques most reliable for preventing pregnancy, DepoProvera and oral contraceptives, provide no protection from STD transmission. So we therefore must not focus our efforts on reducing pregnancy alone. We must include reducing STD also.

The obvious question then is "Don't condoms make sex safe enough?" A major NIH panel considered the world's data about this subject. The report was published this year. This scientific panel found the following: If used 100 percent of the time, condoms reduce the risk of HIV by 85 percent and of gonorrhea for men by 47 percent to 75 percent. However, for the most common STD (HPV) they provide no protection from infection. For the other diseases there is just not enough data to say whether protection is provided by condoms or not.

Unfortunately, sex is sexist. It hurts women far more than it does men. I invite you to look at the diseases a moment.

- The very common disease, HPV, causes persistent warts, abnormal Pap smears, and cancer in women. Men rarely have more than a tiny, almost undetectable bump.
- Herpes is extremely common and can make a woman burn so much she cannot have intercourse. It can also infect her baby during birth resulting in severe damage or even death. It hardly bothers a man.
- Chlamydia causes huge numbers of women to become sterile. Most men don't even know they are infected.
- Then we all know that it is the women who suffer from non-marital pregnancies. They are the ones—not the men—that submit their bodies to the surgical procedure—abortion. It is they who are usually left to give birth to and then raise the children—often at terrible personal educational and economic sacrifice.

In summary, all this information, in my opinion, provides credible scientific evidence showing the wisdom of Congress in passing TANF legislation and including its emphasis on two-parent families and marriage. This information also provides data showing the wisdom of including in Title V legislation funding for teaching adolescents that they should reserve sex for marriage. This is not just a moral or religious issue. Many aspects of marriage, including its very formation and dissolution, are regulated as civil matters by secular government.

For the health of individuals and of all society we need to emphasize marriage as the core issue for society and as the ultimate answer for these health problems plaguing our country and other countries around the world. A major step in accomplishing this is TANF reauthorization with additional TANF funds being earmarked for abstinence and marriage efforts which are not limited solely to the adolescent age group. In addition, TANF bonus money for decreasing out-of-wedlock pregnancies should be restricted to use for abstinence and marriage promotion, the efforts by which those states obtained the money in the first place.

Finally, Title V funds for abstinence education should not only be continued but increased. If these steps are not taken, there is significant danger that the promising trends of decreasing sexual activity and decreasing teenage pregnancies will reverse. In addition, if funds are not made available for promoting marriage and sexual abstinence until marriage for single people in their 20s, that group will continue to suffer. We need a cultural transformation regarding sexual activity for the protection of all of society. You as leaders can play a huge role in this happening.

Chairman HERGER. And now to inquire, the gentlelady from Connecticut, Mrs. Johnson.

Mrs. JOHNSON. Thank you very much, Mr. Chairman. And I thank the panel for all of their information. It certainly is helpful

[12] Institute of Medicine. The Hidden Epidemic, Confronting Sexually Transmitted Diseases. Washington, D.C.: National Academy Press, 1997.

to be able to have the breadth of view that so many of you have provided along with the concrete experiences from the rest of you.

Elayne Bennett, I was interested that your program has so many more female participants than male participants, and in the long run, I hope that won't be true.

Mrs. BENNETT. But that is because it was designed for girls. We only target girls. Girls are our only Members.

Mrs. JOHNSON. I think that that is a cultural bias that was unfortunate. Males are responsible for sexual behavior; it is just as important as——

Mrs. BENNETT. We now have a Best Men program.

Mrs. JOHNSON. Well, I do understand that, and I am glad you are doing that, but I think this whole idea that women are responsible and men don't have to be is terribly destructive in our lives, and so I am glad you have a Best Friends. I personally think it is better to have the boys and girls together, because in the end, relational strength in America in the long term of your life depends on being able to talk intimately.

Mrs. BENNETT. We did research on this, and we asked them. The girls said they preferred to have their own session back in 1987 when we began at Langley High. And we did some sample sessions, and the boys took over, and the girls said nothing, and the boys ran the session.

Mrs. JOHNSON. Yes. I do appreciate that that is a problem and remember that from those kinds of programs when I was that age. But I think it is something we have to be challenged by rather than comply with.

But I was wondering, what do you see as the barriers to your program participating in an evaluation such as the one Dr. Maynard is doing?

Mrs. BENNETT. Well, we have an extensive evaluation, 15 years worth, and we just actually are publishing our comparison study that compares our girls' behavior with the Youth Risk Behavior Surveillance study——

Mrs. JOHNSON. I appreciate that. I just wonder why you can't participate in Dr. Maynard's evaluation because it does help us.

Mrs. BENNETT. Okay, I will tell you.

Mrs. JOHNSON. It has been of concern to us.

Mrs. BENNETT. Because the study that Mathematica proposed wanted to do comparison of girls within the school, their sexual activity behavior of girls in the same school. We wanted a comparison school study because the Best Friends' philosophy, we train all the teachers, all who are mentors in the school. We have the principals attend two 2-day training conferences. All the materials are in the schools. The whole philosophy is reach out to your friend; help make your friend a better person. The best kind of friend to have is that person who does that.

The evaluation proposed by Rebecca Maynard—and we worked for 2 years on this, and I am very sorry we could not participate, actually. My academic board voted against it. I was excited about it because I want a definitive study showing how effective abstinence is, and how effective, frankly, we have been. But we could not allow a comparison of girls within the school who have been, you know, the ripple effect, who see their friends who want to be

in our program. We have a waiting list in schools. So what you would be doing is asking girls in a Best Friends' school where we have been 5 and 6 and 7 years, where all the teachers have been trained, where the sexual activity has declined because girls see what is happening with the core group of Best Friends' girls. We wanted a matched sample.

Mrs. JOHNSON. So you didn't want a comparison between the girls who were participating in the program and those who were on the waiting list basically.

Mrs. BENNETT. Exactly. We wanted a comparison with girls who had not had a Best Friends Program in their school so we could get the clear dramatic benefit.

Mrs. JOHNSON. But they are different bodies of information that could have been sought through those different comparisons.

Mrs. BENNETT. We were told there was no money to have a comparison school survey, and that is what—actually, I wanted to do both, the girls within the school and the matched sample, the matched school comparison, and we were told there was no money to do that and we could not do that. And that was why the academic board voted it down.

Mrs. JOHNSON. I only have very little time, and I want to get to Dr. Maynard, because I think this is an important issue. Dr. Maynard.

Dr. MAYNARD. Well, I think reasonable people can differ. I am very sad that we don't have Best Friends in the evaluation, but will say that we have some wonderful programs in the evaluation, and we will learn a lot from the evaluation that we are doing, and there may be opportunities down the road to do other similarly controlled evaluations of other programs.

Mrs. JOHNSON. What percentage of all the abstinence programs have been evaluated either by you or other sort of objective outsiders?

Dr. MAYNARD. I would say there are no really strong evaluations of abstinence programs that have been done to date, I mean where there are large samples, long-term follow-up, external data collectors, et cetera. We have only five programs in the evaluation that we are doing. They were carefully selected because of the strengths of the programs, the diversity of the programs, and the diversity of settings. So we did as much as we could to build a broad information base from the evaluation, given the resource constraints we had. We were also constrained by going to those sites where we could do the controlled comparison design. We felt strongly that in an area as controversial as this, there is absolutely no point in spending public dollars on an evaluation that will be discredited by those who do not favor the results. That is not a good use of public money. So we want to do this at the highest standard.

Mrs. JOHNSON. Thank you.

Chairman HERGER. Thank you very much for your testimony. The gentleman from Maryland, Mr. Cardin, to inquire.

Mr. CARDIN. Thank you, Mr. Chairman. Let me again thank all the witnesses. This has certainly been extremely helpful to us.

Dr. Maynard, we really do look forward to the results of your evaluation. The difficulty, as I see it, and it is not your fault, is that we are not going to have good information before Congress has

to act on TANF reauthorization. We need to act next year, and your work will not be completed until after we have had to make decisions on reauthorization. So I guess I would just ask for you to share as much information as you can during this process, so that we can have the benefit of your work as we move through this process.

I guess my concern, looking at the different statistics, Dr. McIlhaney, I will just make one point about the chart that you raise, and that is that the trend line on teenage pregnancy started to drop before the Federal funds were available for the target programs for abstinence programs. I mention that because I am not sure we know why we have been successful. We know there is multiple factors, as I indicated in my opening statement. I just really want to raise the concern of abstinence-only programs I and of itself, because I think it does raise certain problems. I said in my opening statement that I support abstinence, and I think it is a bipartisan strong support in this Congress to support abstinence as the first line of attack against teenage pregnancy and for values that we believe are important. So I think there is no question about it.

I am concerned that when you isolate, whether through funding or through trying to determine how an abstinence program in and of itself works, it is not reality. And I think the public understands it.

And, Ms. Brown, I appreciate the work that your organization has done, and one of the surveys that recently came out—and let me just give this number. When it was asked, given three choices, the choice that the overwhelming majority of Americans think is the right choice, whether they be teenagers or whether they be adults, is that teens should not be sexually active. The teens who are should have access to birth control or protection. That is where America is. That is what most Americans believe, 73 percent of the adult population, 56 percent of the teenage population, and the teenage population is skewed more to believing sex is OK than the adult population.

I mention that because I think we are denying reality when we try to pigeonhole teenagers into a limited program and not giving all the information. Abstinence should be combined with sex education. Ms. Brown, you point out what we all know now to be the case, that sex education doesn't increase sex. It should be combined. Abstinence should be combined with constructive activities for teenagers, so they don't get in trouble, whether it is through sexual activities or through drugs or through alcohol or violence, it should be combined with constructive activities. Abstinence should be combined with other services that are available to teenagers, and that is basically the commitment we made to our States in 1996 through TANF, which was flexibility. Don't pigeonhole how States have to respond. Don't tell them they have to set up a program for a limited purpose so that we can express our views. Let the States do what they believe is correct in order to accomplish the overall objectives. And I guess that is one of my major concerns.

And the last point, Ms. Brown, that you point out, the realities of the situation. Two-thirds of our high school seniors have engaged

in sexual activities. That is the facts. We would all like to see that number lower. We all would like to see that number lower. We should work to get that number lower. We know there is going to be a large number of teenagers who are going to be involved in sexual activities, and to just put our head in the sand and say that is not going to happen, I think is naive.

So I guess my concern is that the Congress has expressed a goal of reducing teenage pregnancies. That is our goal. We want to be successful in doing that. And the best way to do it, is to allow the States to be able to move forward with abstinence education and contraceptive information and any other tool that they can in order to try to reduce teenage births. And I think sometimes it is counterproductive that we try to pigeonhole how programs have to be developed at the local level to satisfy our parochial favorite programs to reduce teenage pregnancy.

Thank you, Mr. Chairman.

Chairman HERGER. Thank you, Mr. Cardin. Now the gentleman from Louisiana, Mr. McCrery to inquire.

Mr. MCCRERY. Thank you, Mr. Chairman.

I don't disagree with what Mr. Cardin has said, and I agree with him that reality today is that too many teenagers engage in sexual activities, but I think what we would like to do is create a different reality, and that is what these programs, these abstinence programs are trying to do. In the meantime, I don't disagree with you that we have to address what is before us, but I think the purpose of these programs is to create a different reality.

And Ms. Grant and Mrs. Bennett, why do you all believe that teens should be taught abstinence as the primary way to avoid the negative consequences of teen pregnancy. Ms. Grant.

Ms. GRANT. Primarily, when I look at young people in sexual activity, a lot of times we quote statistics and we merge a lot of things together. But those young people who have not yet engaged in sexual activity, we need to bring a message to them and support skill building, education, that helps them postpone sexual activity for as long as possible, which for me is primary prevention. That is primary. Then there is early intervention, and it goes on down the line toward treatment.

And I think earlier in the comments there was a statement about how do we determine which kid needs what? I think as a nation you bring the primary message first and foremost. There are those young people—and they clearly surface—who will need more intensive intervention on down that progression and that continuum from prevention to intervention. And that then you tailor messages to meet those sub-populations. But I think what has happened historically, as I looked at this and worked in this, is that for those kids who were not yet thinking about engaging in sexual activity, who weren't there yet, we didn't have anything for those young people. And I think abstinence-until-marriage education gave a context for young people to deal with sexuality education and issues around relationships, negotiating relationships, that they didn't have before. So I think that is primarily why we need it.

In the Virginia Health Department we have a continuum. We work from abstinence-until-marriage education all the way up to our family planning services, and so we have a continuum that we

look at, and we all work together. We are trying to have a comprehensive model that this doesn't become a either/or. These dollars for abstinence education did not displace the family planning dollars. It did not displace other dollars. It was an addition to, and I think it met a void and is meeting a void to help us provide a continuum in terms of service delivery.

Mr. MCCRERY. Before Mrs. Bennett responds, I just want to ask you about, I think you say in your testimony that you don't have sufficient data really to give results on abstinence education today, but can you give us some impressions that you have from watching the program and other data that would lead you to some conclusions as to the effectiveness of the program?

Ms. GRANT. Right now what we see in our data, and what I have prepared in my written package, is just looking at our first-year data, and then moving on to our second-year follow up. We started with seventh and eighth graders, so naturally, knowing that the number of young people in our data set, in our target population, report lower rates of sexual activity, we are waiting to see, and hoping to be able to continue our longitudinal study as these kids age into solo dating, pairing off, what happens in those rates. We are hoping that we can keep our transition rates low, but that is yet to be determined as we look at this, so I really can't share.

What we see in short term right now looks good, but that is very short term and we are talking about kids who don't engage in the sexual activity that much, so that is why I am very reserved about that, because we need time. We need time and resources to be able to really critically look at this.

Mr. MCCRERY. Thank you. Mrs. Bennett, do you want to respond to the first question?

Mrs. BENNETT. Well, and I agree with Ms. Grant.

We have had time and we have had resources at Best Friends. We have completed our comparison study that is going to be published, as comparing the CDC data, the Youth Risk Behavior Survey, which is given here in the D.C. Public Schools. We have been in the D.C. Public Schools since 1987. CDC found that 17.8, nearly 18 percent of seventh grade girls in D.C. are sexually active. That doubles to 32.8 percent of eighth grade girls, so that is nearly a third of the girls here right down the street, who are sexually active in eighth grade. We compared those schools, in many cases same schools, but with the girls from Best Friends. Four point 2 percent of our seventh grade schools—and we began early in fourth or fifth like you were talking about—4.2 are sexually active in the seventh grade, 5.6 in the eighth grade. So we don't even have that doubling. I mean we could expect, if we followed the trend, that we would have 8 or 9 percent of our girls sexually active by eighth grade. We have 5.6 percent. So we know we are on to something that works. We know that with every fiber of our being. Our teachers will tell you that. Our parents will tell you that.

We have 1,000 girls here in D.C. Public Schools. We have 5,000 girls nationwide. And the reason is, it is not just about abstinence from sex, you know, that is not the issue. The issue is the larger picture. It is about self control. It is about saying early on, what kind of life do you want?

And then we have a tremendous impact on drug and alcohol use as well. These two issues can't be separated out from sexual activity. If you are drinking at 12 and 13 and 14, you are sexually active. We see that. I was just in a huge conference in suburban Montgomery County. Girls are drinking. They are binge drinking. They are sexually active at seventh and eighth and ninth grade, and these are in our most prestigious private schools. So this is not, first of all, it's very clear to me, this is not an issue only that is pertinent to the urban areas, it is not a socioeconomic issue. This is an issue that transcends all families, no matter what their socioeconomic status. It is about character. It is about what we want for our children. It is about how we stand as a Nation, what our standards are, and are we going to expect our children to strive for some high aspirations. Low aspirations, you get low performance. We know that as teachers. And if as adults, if we give them our best, if we say, "This is what we expect," children respond in kind. And we need to begin at 7 and 8 years of age.

We also know, a thing that I discovered that I did not anticipate when I began, is we have reduced sexual abuse by 66 percent among our girls. Many of our girls, and I am not just talking inner city, Montgomery County, out of 25 fifth grade girls, 5 had been sexually abused in the fifth grade, and we were not even allowed in Montgomery County to discuss sex. We came in and talked about friendship. We talked about self respect, were not even allowed to use the three-letter word of sex. By accident, a survey was given, have you ever been forced to have—5 of the 20 girls in a middle class community in Montgomery County. So we know there is something else going on there, if we can get to our children early.

Also our little girls, look at the data, watch Brittney Spears, look at what is happening, look at the message. I chaperon for a seventh grade dance. I have a 12-year-old son. The girls are dressing like street walkers. It is cool. That is the way they think they should look. When they dress like street walkers, what are the boys supposed to think?

Oral sex is going on at Catholic school dances. We have been able—that has dropped, that activity seems to be curtailing somewhat, but we have some real issues here. We have to decide what we want our children to hear from us.

Mr. MCCRERY. Thank you, Mr. Chairman.

I applaud all of you who are working on this problem, and I am glad that you are starting a program for boys because I think boys need to be part of the solution as well.

Chairman HERGER. I want to thank each of you. I have been very liberal with the time, on both sides, and that is because this issue is so, as a parent, as virtually all of us are parents here, this is an issue and an area that is of great concern to all of us, regardless of which way or combination that we address this in our work of reauthorizing this legislation next year. We want to come up with the programs that are going to be the most effective, however that is.

With that, there are several who would like to go for a second round of questions. So, Mr. Cardin, would you like to inquire?

Mr. CARDIN. Thank you, Mr. Chairman.

Ms. Brown, I just want to get focused on what this Committee can do. We have TANF reauthorization next year. It provides significant resources to our States. The philosophy 1996 was to provide most of that in basically a block grant type of format with broad national goals, with maximum flexibility to States to try to configure how they could arrange use of these funds in order to get people off of cash assistance, to get people self sufficient, and to reduce teenage births, pregnancies.

I guess your focus is on reducing or preventing teen pregnancy. How can we be constructive in TANF reauthorization to assist in your efforts?

Ms. BROWN. I am so glad you asked. There is some material in my written statement on this, but let me just hit the high points. We made several suggestions. First of all, obviously, we need to maintain funding for TANF and not allow the net resources to decline for any number of reasons, which you all understand very well. We need to maintain the flexibility of TANF as well. There are, unfortunately in my view, not enough TANF dollars going to teen pregnancy prevention. The current estimate is only about 1 percent. Those are still precious monies in this field so we need to retain the flexibility that allows stats to tap into that funding source in ways that suit their culture and their citizens.

We need to get increased information to States and communities about community-level programs that work. Interestingly, the question we are most often asked at the National Campaign is, "What do I do?" From the Pittsburgh Health Department, from Cloverdale, California, from all over: "What do I do?" As you know, we try mightily to answer that question and other credible groups do, too, but we need a much larger more organized source to get this information out.

Of course the second question people always ask is, "How do I pay for what works?" And I think that is back to the TANF question in part.

We might even want to consider a block grant for teen pregnancy prevention within the overall effort. There is some justification for that. We can talk more with you about that in the future if you would like to.

We also think that there is merit in asking the Federal government to pay more attention to State level efforts to prevent teen pregnancy. They are all required to have it in their TANF plans, but I have yet to see a real hearing, or a high-profile publication saying, "What are States doing in this area? What is working? What are they trying?" Actually, you asked these questions a lot this morning. "What is going on? How do you decide what to do?" There is a way of getting that information under the existing statute, and I think we need to do more.

And then generally in the total body of the law, I think we do need to retain a focus on a strong abstinence message, as everybody has agreed this morning, but never at the expense of family planning and good information about reproduction to adolescents and to others, and all within a context of flexibility and accountability.

Mr. CARDIN. There are two approaches that we could take aimed directly at reducing teen pregnancy, and that is we could offer com-

petitive funds to encourage States to come forward with innovative programs and try to fund them in that way, or we could use a bonus arrangement, which we have used, based upon performance of States in accomplishing the goal.

Do you have preference as to, we have a limited amount of dollars, which approach would be a better approach?

Ms. BROWN. Well, there are merits in both approaches. On balance, I would probably go for competitive proposals from States, not just for innovative programs, although we certainly need those, but to build on what we already know. There is, as I said earlier, a lot of good news, and we need to take this good news and say, "Fine, we actually have some successful programs we can point to." This program profiled in Connecticut is an example of great success with very hard to reach kids. It is quite expensive, of course, but there are others for lower-risk kids that are less expensive and could be applied to large numbers of youth. So I think, yes, we need more innovation, but I really think we need to build on successes.

We also need to find a way to work more with the media. You know, I love programs and I love school programs, but if you talk to the average teenager and say, "What is shaping your attitudes and views and the social script in your head?" They will often talk an enormous amount about the television shows, Internet sites and magazines that they consume in huge quantities. So part of this money also has to go, in my view, to finding ways to influence popular culture through these hugely influential institutions, which are the media, in order to complement the efforts of individual community programs.

We need both. Doing just one without the other, I think, is insufficient.

Mr. CARDIN. That is very helpful, particularly on sharing of information, and that is one of the things that I think all of us would agree we have programs that work. We need to get that information out, and we need to evaluate programs a lot faster than the current system has been operating. I know it started a new direction in 1996, but it is useful if we could get information shared in a more expeditious way than we have in the past.

Thank you, Mr. Chairman.

Chairman HERGER. Thank you, Mr. Cardin.

I have a couple closing questions. Dr. McIlhaney, in your testimony, you had some chilling, I believe, comments that people simply don't talk about these very serious health consequences, whether it be the venereal diseases or others, of early sexual activities. Why do you suppose that we don't hear more about these issues, and is there some way that we can better spread this very important information?

Dr. MCILHANEY. I think it is vital, as I said to include the warnings and information and education about the sexually transmitted diseases, along with the messages about out-of-wedlock pregnancy.

I was just sitting here, I was just listening, and there was not a word, as we talked about efforts to reduce teen pregnancy, in talking about what at the same time we have the problems of STD in those same people who have the pregnancies, and the contracep-

tives just flat don't work, the ones commonly used. And I think it is a disaster.

It is difficult to talk about sexual issue, I think, in our society. As a matter of fact, the numbers I gave you, and so many more I could give you, have been in the newspapers. They just get dropped. And I think it is just absolutely vital that we include that information as we talk about teen pregnancy every time. And as a matter of fact, I strongly advocate that any program that is having success in reducing pregnancy be sure they are also testing for STD among their young people, and older single people too, because they also are suffering these problems.

I would like to just say one thing about the success of programs. If our programs, who emphasize contraceptives, were working or had been working, we wouldn't be here talking because, because those rates that we see over there would not have kept climbing during the 1980s, because it was during the 1980s that by far the dominant programs were those programs that were strongly advocating contraceptive use. And we see those pregnancy rates kept climbing. The STD rates did keep climbing too. And so obviously, is that mandates that we make some changes in what we are doing.

The one light in this tunnel of darkness of not just teen pregnancy, but pregnancy among older people, younger adults, the one light is the issue about sexual abstinence, because it is beginning to show that there maybe is a way.

The problem with saying that there are programs that work, and I am on the Research Task Force for the National Campaign with Doug Kirby, that wrote "Emerging Answers", and he and I, I keep arguing with him. I say, Doug, the other statistical evidence of success, and that is a technical calculation, but the actual dramatic drop in pregnancy rates, we are just not seeing with the programs that are mixing the messages. Where we are really seeing startling results sometimes, and there is not enough of it yet, I totally agree with that, are the programs that are good abstinence programs that are gradually beginning to emerge, that is a new area, but those programs are gradually beginning to emerge, and we are seeing some surprising statistics with some of them, but I think that all of them must start including education about STDs and testing.

As a matter of fact, Johns Hopkins, a couple of years ago, said that every single sexually active adolescent must be tested for chlamydia every 6 months. I mean, they are that concerned about this problem. Are we doing that in all our programs, you know? If we are not, then we are really not giving the kind of care we should.

Chairman HERGER. Thank you very much, doctor. And I think the point is here, even with the protection, the diseases are still being transmitted and I believe that is something that is not being talked about enough.

Dr. MCILHANEY. That is right. May I say one more thing, sir?

Chairman HERGER. Yes.

Dr. MCILHANEY. Very briefly. I mentioned marriage in my testimony, and that is three of the four goals of TANF funding mentions marriage strongly. The reason is that the biggest risk for a person becoming infected with a sexually transmitted disease is

how many sexual partners they have had in their lifetime. We have good evidence that when people are single and sexually active, they almost always continue to have more and more sexual partners, which therefore dramatically increases a risk of STD.

The biggest study on sexual practice in America came out of the University of Chicago a few years ago, and it showed that married rarely, few married people have sex outside of their marriage. They usually have sex only with that one partner, their marriage partner, which is a huge public and personal health message, and that is why marriage I think is so wisely including in TANF funding, and also why so many abstinence programs, for example, do talk about marriage to you.

Chairman HERGER. Thank you, doctor. Now, I will go to the gentlelady from Connecticut, Mrs. Johnson.

Mrs. JOHNSON. Thank you, Mr. Chairman.

I just wanted to get your opinions, as you are sitting here as a group, about the importance of the connectivity factor of not just talking to kids about abstinence and sexuality and sexually transmitted diseases, as important as all those things are, but connecting them into doing well in school and why that matters and career choices, connecting them into their families, and their families into support services and into their mothers' aspirations and so on.

I mean, I appreciate, of course, that the latter is nicer, but I mean in terms of affecting the lives of these kids, what should we be looking at, because after all, welfare reform is a systems issue, and we have an opportunity to have a systems focus. And I am asking your advice on how broadly we should try to focus our effort to prevent teen pregnancy? We will just take in order anyone who wants to comment. Ms. Grant. Keep it brief so we can just run down the whole panel, anyone who wants to.

Ms. GRANT. I think your earlier statements about connectivity really spoke to, really in answers to the question I think, we cannot isolate young people or just parents and say, "We will have a program specifically for you," that even the latest research around kids and risk behaviors and some of the PSAs that we are seeing now, talk about that shift that we have in society where young people want to hear from their parents. They are not asking to hear from their peers on critical issues. They want their parents to talk to them, and they clearly state they are listening. So I think our efforts, you know, we are always behind the ball trying to catch up with it, and I think we really need to look at that and bring that into the forefront, that then how do we structure strategies that encourage that?

In Virginia, what we are doing through our initiative is we are not just targeting young people, we are training medical professionals to talk about these issues as kids come into clinical settings. We are spending time educating parents through radio while they are listening to the traffic report and that kind of thing, to try to say, "Hey, kids want to hear from you", and to tell kids, "Go talk to your parents about this", and make those connections from a State-wide perspective. That is what we are trying to do.

Mrs. JOHNSON. Let's keep it brief since we have so many to hear from.

Mrs. BENNETT. Goal setting, telling our young people that they should have dreams, and how to kind of reach their dreams with a plan. Our girls set goals starting in the fifth or sixth grade, what they are going to have, what they want to achieve academically, what they want in their lives. It is amazing how many girls say they want to be married someday, and they want a house, and they want a family.

What we, and you are exactly right, it is not just about talking about STDs, it is not just about limiting at-risk behavior. It is about the big picture, and we have discovered that kids, children, no matter what their background, their own home background, they have dreams and goals, and if we can, which I think we do a very good job of in Best Friends, we have the goal setting activities. We have the individual mentoring. We have the community service. And then we have fun, the singing and the dancing, fun dancing, fun singing, the jazz choir, the jazz dance troupe, all of those kinds of things that are fun. Kids want to have fun. Show them how to have fun without negative behavior.

Ms. BROWN. I think you are absolutely right, it is this larger context that really makes the difference. We often say it is not just about body parts, it is about values and relationships and feelings and families.

We have four bodies of information now that shed light on this youth development approach. The Adolescent Health Survey—a Federally funded adolescent health survey—showed that strong connections between teenagers and their schools and strong connections between teenagers and their families were some of the most highly protective factors against adolescent pregnancy. That has gotten a lot of press.

We also now have all the information I summarized for you today from "Emerging Answers" on youth development programs. They get the biggest results in reducing teen pregnancy. Some of them don't actually even address sex, but they give these kids a lot to say yes to.

And finally, the National Academy of Sciences released a report just last week on community-level programs for youth that goes into a large number of databases about all these different programs, what risk factors they address and what their outcomes are, and it is very consistent, Mrs. Johnson, with just the kind of thing you are saying.

Finally, the most popular publication that the Campaign has released to this day—and we are moving 600,000 pieces this year—is "Ten Tips for Parents to Help Their Children Avoid Teen Pregnancy." It offers very simple advice like: talk to your kids; know what they are watching, reading and listening to; be clear about your own values; and so on. This pamphlet remains to this day the piece of information everybody most wants from the National Campaign.

Dr. MAYNARD. I would just add to this that while I think the evidence on connectivity is really out there, we have had 40 years of erosion of the American family and communities, I think that, for some time to come, we need to be on a dual track where we are working to promote connectivity and have those more intensive youth development focused programs where we can. But, we don't

want to leave behind the kids who are still living in communities and in families where we may not be able to achieve all that we would like on the connectivity front.

Ms. BILODEAU. Ours is a family systems program, and that is where our greatest emphasis is, is on building strong families and on encouraging children to gain educational skills. As I indicated, at least 80 percent of our kids come from families that were started by teen parents, and therefore you have families that do not necessarily value education, do not have a work ethic that combines education as a way of moving forward, but rather people who tend to stay in low-paying jobs.

We believe that the key to teen pregnancy prevention is education, and that the better a kid does in school, the more likely it is that they are going to stay in school, and the greater their reasons are going to be to avert early sexual activity and teen pregnancy.

When we first started our program for the first couple of years, at least 10 to 20 percent of incoming sixth graders did not know the alphabet. That is where we put our emphasis. Now we have an alphabet test as part of the intake process. We receive our primary funding from the Connecticut Department of Social Services, and so I tell the kids that the State makes us do it, that is the only way we can get the money is if they do the alphabet for us.

Recently, in the past couple of years, well, really in the past year, we have not seen that happen. We have the superintendent of schools on our board, and so that information obviously did get passed back to the superintendent of schools. But with poverty-stricken children, the children who are most apt to become teen parents, they have to have the concrete, tangible, every-day support that moves them from the bottom of the class—you know schools do tracking, everybody tracks; our kids are always tracked with the groups that is least likely to succeed. You have to break that mentality for them and for the schools and for the whole community, who expects our kids to be the gang bangers, the pregnant teens, the drug addicts and the drug runners. That is what our neighborhood has always been about. We have to break people's perceptions, and not just the kids and not just the parents, but the whole community has to value those children who are most likely to fall through the cracks. And then that is how you create a continuity and a bonding, so that those children don't belong just to a family, they belong to a larger community, and that they, our kids are growing up believing that they too will be the Mayor.

When we go to visit Nancy's office, I always tell them, "Look around because I expect in a few years to see one of you here," and they look at it that way. Hope for the future, that is the key.

Dr. MCILHANEY. It is almost not necessary to add anything, but I will. The health, hope and happiness of our society and of so many people in this country are really being hurt. I totally agree with you, Congresswoman Johnson, that the connectivity, the environment that our kids live in, that we all live in, really is the vital thing that must be transformed, and the central element of that is the family and marriage, because that is the core of our culture.

Unfortunately today, what I think all of us have found is that parents often feel disempowered. They don't believe their kids will

listen to them. They really don't believe they have that kind of influence, and we have some statistical information that is really helpful, and we use it a lot, I think all of us do. The ADD Health Study, the biggest study ever done on adolescence showed that of all the risky behaviors, drugs, sex, alcohol, running away from home, all of them, that the kids that were doing the best were those kids who had connectedness with their parents. We need to empower parents.

And my belief, I think probably the belief of all of us, is it is going to take leadership, and that is one thing at the end of my testimony I said, you as leaders in this country can make such an enormous difference. As Rebecca said, the whole discussion in this area about sex changed when Congress allocated money, and it really started in some sense back in the eighties with the Title XX Program.

So how we all are in this together. We need to consider all the risky behaviors because there is good evidence that impact one of them. We have to impact all of them, and the one that usually gets left out is sex. We need to include that in our encouragement and guidance to young people.

And finally, Elayne mentioned the AAUW, American University Women's report that those kids basically all said that no one in their whole environment, not their parents, medical people, their boyfriends or girlfriends—and these were girls—encouraged them not to be involved in sexual activity. So we have got to start at the top, and come and surround young people with a world that supports them in avoiding these problems so that they have hope for the future.

Chairman HERGER. Thank you very much. I want to thank each of our witnesses for their outstanding testimony. I trust that the witnesses would respond to additional questions on these issues for the record.

Again, it has been a very interesting hearing, one that is very important not only to the Members of this Committee, but certainly to the Nation, to the parents, and the young people of this Nation.

With that, this Subcommittee stands adjourned. Thank you.

[Whereupon, at 12:07 p.m., the hearing was adjourned.]

[Questions submitted from Chairman Herger to the panel, and their responses follow:]

Virginia Abstinence Education Initiative
Richmond, Virginia 23219

1. I understand from your testimony about the evaluations your program is undergoing, but I'd like to know more abut the programs themselves. Please describe the abstinence education programs in Virginia. For example, how do teens come into your programs? Do you involve parents of the teens in these programs? How about teens who have already had kids—is part of your program preventing subsequent births to teens who have already had one or more babies? Is your program only about girls, or are boys involved, too? What is the source of your funding?

VIRGINIA ABSTINENCE EDUCATION INITIATIVE

Program Descriptions

- **Reasons of the Heart**
  Organization: Alliance for Children & Families (Lynchburg, VA)
  Director: Maureen Duran

Localities: Fairfax County, Fauquier County, and Loudoun County
Target Population: 7th graders **
Description: Utilizes original materials and classic film clips to help youth (in school, after school, detention and probation homes) examine the impact of character on sexual decisionmaking and choosing abstinence until marriage. The Reasonable Reasons to Wait curriculum will be implemented in health classes teaching youth the value of abstaining until marriage.

- **Individuals Abstaining 'til Marriage**
  Organization: Alliance for Children & Families of Central Virginia
  Location: Lynchburg, VA
  Director: Joan Foster
  Localities: Pittsylvania County and City of Lynchburg
  Target Population: 7th graders **
  Description: Utilizes the Wait Training! curriculum and peer mentors to promote the abstinence until marriage message in both the school and after school settings. Community based programming will be provided for participants during the summer.
- **Very, Important, Person (VIP)**
  Organization: Horizons Unlimited Ministries, Inc. of Hampton, VA
  Location: Newport News, VA
  Director: June Sullivan
  Localities: Newport News (East End and Denbigh areas)
  Target Population: 7th graders **
  Description: Utilizes the Reasonable Reasons to Wait curriculum to help youth appreciate their ability to abstain from sexual activity until marriage because they have value and can relate to others with integrity and purity.
- **I Can Abstain Now**
  Organization: Sussex Rural Abstinence Project with Social Services Department County of Sussex, VA as lead agency and fiscal agent.
  Location: Sussex, VA
  Director: Melody Walker
  Locality: Sussex County
  Target Population: 7th graders **
  Description: Utilizes the Families United to Prevent Teen Pregnancy and Managing Pressures Before Marriage curricula to teach skills to resist the pressures to become sexually active and remain abstinent until marriage. Peer mentors and adult leaders will be trained and supported in modeling appropriate behaviors for participants. Parent education and a community-based resource center are additional components of the program.
- **My Choice, My Future!**
  Organization: Powhatan Partners In Prevention Coalition with Powhatan County Health Department, of Powhatan, VA as the lead agency and fiscal agent.
  Location: Powhatan, VA
  Director: Ginell Ampey-Thornhill
  Locality: Powhatan County
  Target Population: 7th graders **
  Description: Utilizes the Reasonable Reasons to Wait and Wait Training! curricula to motivating youth to choose and maintain an abstinent lifestyle. The program will be implemented through the health and physical education classes. This program is part of a Federally funded evaluation.

Participants in the school-based programs are given consent to participate by their parents. The abstinence educational sessions are taught during the health education classes. All of the abstinence education curricula have been reviewed for compliance with the Standards of Learning guidelines established by the Virginia Dept. of Education.

Parental involvement is limited in these programs, but Parent Information Nights are offered at the beginning of the school year and most of the programs have activities and events that are structured for teen and parent attendance.

Because these programs are primarily school based there are students who may be pregnant or parenting in the classes. These students continue to participate in the classes and if necessary are referred to school staff for additional services. The participants in these programs are both male and female.

** This is the initial point of contact with students. Students receive abstinence educational sessions ranging from 12 to 18 weeks in duration. All program participants are given a program booster in subsequent grades. To date we have students receiving abstinence education instruction in 7th through 11th grades.

The Virginia Abstinence Education Initiative is funding through Title V—Abstinence Only dollars. Virginia receives $828,619 in Federal funds that is matched with $375,098 General Funds and in-kind dollars from abstinence education program providers and added value generated by our media campaign. Additional funds are provided through the Department of Social Services TANF dollars in the amount of $211,000.

Gale Grant
Director

Best Friends Foundation
Washington, DC 20008
December 6, 2001

Hon. Wally Herger
Chairman
House Committee on Ways and Means
Subcommittee on Human Resources
Washington, D.C. 20515

Dear Chairman Herger:

Thank you for the opportunity to provide the subcommittee with additional information about the programs of the Best Friends Foundation and our efforts to prevent teenage pregnancies.

As you know, the Best Friends Foundation, a 501(c)(3) organization incorporated in the District of Columbia, was founded in 1987 and now reaches more than 5,500 girls through its Best Friends program and about 500 boys through the recently created Best Men program. The programs operate in 23 cities and 14 states, including the Virgin Islands. Our message is very simple: Enjoy adolescence by abstaining from sexual activity until high school, and illegal drugs, and alcohol.

While that message may not be new, the method in which it is delivered is profoundly different. And we have had great successes.

Now, let me address the questions you raised in your letter of Nov. 19:

1. How do youths come into your program? Are other Members of their family involved, such as the young person's parent(s) or siblings?

Students may enter the Best Friends (girls) or Best Men (boys) program beginning in the fifth or sixth grade. Every effort is made to take an entire class of students. If that is not possible, a random sampling is done. We work to make certain that the Best Friends program is representative of the entire student body and there is no stereotyping of the group (we have a carefully balanced mix of high achievers, middle achievers and at risk students. Once they join the program, each girl and boy is invited back to the program at the start of the next school year. Indeed, experience has shown that a blend of students consisting of high and average achievers, along with those who fall below the mark, provides a productive learning environment.

The support of family is very important to the success of the programs. Best Friends/Best Men parents give permission for their child to participate. We are happy to report that we have received 100 percent parent permission. Each school holds a parent information meeting at the beginning of the school year, which includes a video about the Best Friends/Best Men program. Best Friends/Best Men staff are on hand to answer any questions. At the end of each school year, families celebrate the commitment of their children at the Family and School Recognition Ceremony-about 80–90 percent of the parents attend the event. Each Best Friends/Best Men participant acknowledges his/her parents with a symbol of gratitude. In 15 years of operation, only two parents did not allow their children to participate in the program, and no parents ever have removed their children from the program.

2. What are the primary sources of funding for the Best Friends program?

The Best Friends Foundation operates the Best Friends/Best Men program in seven schools in D.C. and two in Maryland, paying for all of their instruction and materials, field trips, and the annual Family and School recognition ceremony with funds raised from the private sector. Our funders include the Bradley Foundation. the Robert Wood Johnson Foundation, the Case Foundation, the Kellogg Foundation, the Marriott Foundation and American Standard. We also raise funds from our Annual Donor Dinner. The cost of providing the Best Friends/Best Men program is approximately $250—$600 per student. Additionally, a number of schools and school systems around the country have replicated the Best Friends/Best Men program,

using their own funding. We have established a National Training and Technical Assistance Center, which develops the curriculum, monitors and evaluates the effectiveness of each program and trains educators. We require that our model be followed and that all educators providing instruction be trained by the Best Friends Foundation. The replication sites' funding sources include local education dollars; local and state grants, including money from state "Drug Free Schools" grants; Title V grants and grants from private foundations and companies.

Because the programs take place during the school day, the Best Friends/Best Men curriculum is taught by teachers who are, in most cases, employed by the school system. Teachers and other school staff Members volunteer to serve as mentors to participants.

3. How does your program address peer pressure so that young people reinforce one another to abstain from sex? What do the young people say about this?

The Best Friends/Best Men program's primary goal is to help adolescents gain self-respect, make positive decisions, and support one another in postponing sex and in rejecting illegal drug and alcohol use. Our program works because participants become part of an intensive peer support group based on friendship. We emphasize that friends must help each other make good decisions and that friends sometimes must intervene in each other's lives. We create a group within a school-usually 30–40 students-that puts peer pressure on its Members not to have sex. In an anonymous survey of Best Friends girls following the 1999–2000 school year, we found that 30 percent of our fourth- and fifth-graders, 36 percent of our sixth-graders, 48 percent of our seventh-graders, and 60 percent of our eighth-graders helped a friend make a decision about sex. When we first started the Best Friends program in 1987, testing the concept with 10th-graders at a Virginia high school, more than 73 percent of the students surveyed said they would like to belong to a group that supported one another in waiting to have sex at least until after high school graduation. More recently, one student commented: "It was hard to say 'no' until I became a Best Friends girl. I have all these friends in Best Friends that check on me and say, 'How you doin'?' One time I was going to go with this guy who had this great 'line,' but they wouldn't let me. I'm glad. He got another friend of mine pregnant and left her alone. She's sad. We watch out for each other at Best Friends. I can say 'no' in seven different ways."

The program also "deglamorizes" the barrage of sexual images that come from popular culture. We present the students with an upbeat message, one that emphasizes the joys of pre-teen and teenage years free from the complications of sexual activity, and we give them something to "yes" to: good grades, self-respect, and, for those who stay in the program through high school, college scholarships. The program is designed to reach children in early adolescence, when their attitudes toward life are forming and when they need to discuss their personal concerns with and receive support from friends and respected adults.

The messages which are taught in the Friendship module include the best kind of friend is the one that makes you a better person and friends help each other make the right decisions

4. I think we have seen from Dr. McIlhaney's testimony, and most of us know intuitively, that abstinence is the only way to prevent the risk of pregnancy and the spreading of sexually transmitted diseases. Yet, some people claim that the abstinence message puts young people at risk. Is there any evidence of that? What does your experience suggest?

There is no evidence that teaching-as the Best Friends/Best Men program does-that abstinence from sex is the only 100 percent guarantee against pregnancy and sexually transmitted diseases is putting young people at risk. That claim cannot be made regarding teaching students about various contraceptive devices and practices. Recent research published by Child Trends data is showing there is a decrease in the use of contraception and subsequent sexual activity. There is no definitive research on sex-ed programs that focus on contraceptive education. There has been a flurry of attempts by the contraception advocates attempting to say that abstinence education results in participants not using contraception once they have decided to become sexually active. This is a flawed study and has been seized upon by those who wish to see all abstinence funding eliminated. The contraception lobby would do far better to focus their efforts on why, after years of participation in their education programs, sexually active students are not using contraceptives and why STDs are at epidemic proportions. It is important to remember that since the advent of sex education classes in schools in the sixties, the number of out-of-wedlock births in the U.S. rose 450 percent by the early nineties. Only since 1995, when

there was a concerted push for abstinence education, have teenage and out-of-wedlock births started to fall.

Our curriculum includes a section on AIDS and STDs, giving candid information about the most common STDs, the symptoms, treatments, and consequences. Young people are not put at risk through an abstinence-only message but rather through confusing messages that say sex is OK as long as you use a condom or birth control.

The experience of the Best Friends/Best Men program has been that young people want to hear the abstinence message. When Emory University's Marian Howard asked 1,000 teenage mothers what they wanted to learn in sex education classes, 82 percent of them said "how to say 'no' without hurting my boyfriend's feelings." A recent survey conducted by the American Association of University Women Foundation of 2,000 11- to 17-year-old girls found that the vast majority said that sex and how to say "no" in emotionally charged relationships was their number one concern. And the National Campaign to Prevent Teen Pregnancy found that 98 percent of teens said "it is important for teens to be given a strong message from society that they should abstain from sex until they are at least out of high school."

And we have proof of the success of our program. An independent evaluation of data from a Centers for Disease Control survey of D.C. public school students and data collected from Best Friends girls attending D.C. public schools found that 18.5 percent of the seventh-graders and nearly 35 percent of the eighth-graders in the CDC survey were sexually active compared with 4.2 percent of seventh-graders and 5.6 percent of eighth-graders in the Best Friends program. Additionally, in a spring 2000 survey of Best Friends participants, 92 percent of the girls said they want to wait until at least high school graduation to have sex; 69 percent want to wait until marriage.

The Best Friends/Best Men program works because its message is simple-abstain from sex, drugs, alcohol, and violence-and supported by caring adults and fellow students. As Aristotle said: "The best friend to have is the one around whom you are a better person." We are striving to mold young people into friends who make others better people.

I refer to you once again; to look at the YRBS study which compares the Best Friends sexual activity rates to children not in the program. I implore that you please call us for accurate information on abstinence education. Please understand this is a message that both our teenage girls (boys and girls) need to hear. It is very difficult for kids who do not want to be sexually active when all the efforts are directed to contraception sex ed methodology. Please read Robert Blum ADD health survey. It clearly demonstrated that parental disapproval for teenagers is a protective factor in the onset of sexual activity. This was a valid study and the contraceptive lobby has successfully buried this information.

Thank you again, Mr. Chairman, for giving the Best Friends Foundation this opportunity to contribute to the discussion on this extremely important topic.

I am available for meetings or phone conferences at your convenience.

Sincerely,

Elayne Bennett
Founder, President and CEO

National Campaign to Prevent Teen Pregnancy
Washington, DC 20036
November 29, 2001

Rep. Wally Herger
Chairman, Committee on Ways and Means
Subcommittee on Human Resources
Washington, DC

Dear Chairman Herger,

Thank you for the opportunity to testify about teen pregnancy prevention before your Subcommittee. We commend the Subcommittee for focusing on teen pregnancy which affects so many young people. As I mentioned at the hearing, the National Campaign to Prevent Teen Pregnancy strongly believes that reducing teen pregnancy is a highly effective way to make progress on a number of related social issues: child poverty, welfare dependency, out-of-wedlock childbearing, and responsible fatherhood.

In a letter dated November 19, 2001, you asked me to respond to several additional questions. Below, please find your questions and my responses.

1. In your testimony, you mentioned that culture and family environments of teens can be very powerful in determining their behavior. What do you think we can do to affect these influences, particularly with respect to the media and popular culture?

Teen pregnancy is rooted in broad social phenomena, including the images portrayed in the entertainment media, the values articulated by parents and other adults, and popular teen culture most of all. The task of preventing teen pregnancy is often complicated by a culture that too often sends young people messages that having sex at an early age is just fine, that getting pregnant at a young age is no big deal, that contraception is not all that important, that "everybody is doing it," and that parents have lost their children to peers and popular culture.

With respect to parents, the primary challenge is to convince them that they matter. Over two decades of research confirms that families—and particularly parents—are an important influence on whether teenagers become pregnant or cause a pregnancy. In a variety of ways, parental behavior and the nature of parent/child relationships influence teens' sexual activity and use of contraception. While parents cannot necessarily determine whether their children have sex, use contraception, or become pregnant, the quality of their relationships with their children can make a real difference.

A recent National Campaign survey illustrates this challenge. Teens cited parents more than any other source as having the most influence over their sexual decisionmaking. But, adults believe that peers influence teens' sexual decisionmaking more than parents. The inescapable conclusion is that many parents do not recognize how influential they are in this area or how many opportunities they have to shape their children's behavior. Kids report to us time and time again that they want to hear from their parents about sex, love, and relationships but often do not. Adults need to be clear about their own values and communicate them to young people.

Teen pregnancy prevention is as much about moral and religious values as it is about public health. Teens, like adults, make decisions about their sexual behavior based in part on their values about what is right and wrong, what is proper and what is not. New research from the National Campaign makes clear that religious faith is associated with delayed sexual activity among some groups of teens. Survey data also recently released by the National Campaign indicate that morals, values, and/or religious beliefs affects teens decisions about whether to have sex more than concern about STDs, fear of pregnancy, or other reasons. And research from the nonprofit organization Child Trends shows that the primary reason that virgin teen girls say they abstain from sex is that having sex would be against their religious or moral values.

Clearly, peers also shape teens' environment. Research and common sense show that peer influence can play an important role in the sexual behavior of teens. Accordingly, teens need accurate information about what their peers are doing (or not doing) because what they think other teens are doing has an impact on their behavior. Teens need to understand that not everyone is "doing it," and that many teens who are sexually active wish they had waited longer.

Teens who are abstinent should speak about their choice, to the extent they are comfortable, so that their peers will not so often overestimate the level of sexual activity around them. Teens who are careful users of contraception should also speak out so that the use of contraception is not so mysterious or surrounded by so much misinformation. Teen girls need to tell each other that sex doesn't guarantee a loving relationship. Teen boys need to tell each other that having sex is no

way to prove manhood. Being a father too soon leads to major financial burdens, legal risks, and a lifetime of personal complexities. Teen parents need to speak to their peers about the difficulties that early pregnancy and parenthood have posed for them.

As noted above, reducing teen pregnancy requires a change in social values and popular culture. The entertainment media has a major influence on popular culture and, therefore, working with this sector is essential. According to a recent study by the Kaiser Family Foundation, 99 percent of households in the United States have televisions, and two-thirds of kids aged 8 and older have a television in their own rooms. This study also reported that young people aged 8–18 spend an average of 28 hours per week watching television—which is twice as much time, over the course of a year, as they spend in school. Given the extraordinary amount of time that young people spend consuming media, it is clear that we cannot solve the problem of teen pregnancy without the help of the media. Conveying responsible messages through the entertainment media is both powerful and efficient. By reaching millions every minute and shaping popular culture, the media must be—and often is—a force for good.

We should encourage the media to show that sex has consequences. Many teens say that although the media shows them a lot about sex, it rarely portrays real consequences. For our part, the National Campaign suggests that the media show teens doing the right thing—saying "no" to sex or saying "no" even if they've said "yes" before. Show teens making the case to each other that postponing sexual involvement is their best choice for many reasons, including emotional ones. Show sexually active teens doing the right thing—using contraception and dealing directly with the fears and myths surrounding it. Show parents being parental, not passive—talking with their kids about sex, love, and values from an early age; setting limits on early dating and on the toxic older guy/younger girl combination; providing supervision and setting curfews; and addressing the power of peer influence. And we suggest the media show adults setting honorable examples in their own sexual behavior if for no other reason than because it affects the behavior of their children and teenagers.

How does the National Campaign get its messages before the entertainment media? Since our inception, we have been working closely with the writers and producers of TV shows, magazines, and websites, focusing primarily on influencing the content of entertainment media. To encourage media leaders to weave prevention messages into the content of their work, we offer specially tailored face-to-face briefings to key editors, scriptwriters, and producers about the problem of teen pregnancy and its solutions. We discuss with them various messages well suited to their shows or magazines, and talk about different ways that these messages can be presented in their media.

One final point about the current culture and teen pregnancy. We have noted a distinct unwillingness among adults—and in the culture generally—to take a clear stand on whether teen pregnancy is or is not OK. In recent National Campaign polling fully one-third of adults said they do not think that the kids in their communities are getting a clear message from the adults in their lives that teen pregnancy is wrong. This may be due to a reluctance of adults to take a stand that has a values component, it may reflect a popular culture that is increasingly tolerant of unwed pregnancy and childbearing, it may be that some adults are fearful of offending those teens who are already pregnant or parenting or that they might inadvertently stigmatize the children of teen mothers, or it may simply be that many parents are uncomfortable talking to their children about sex and values.

But if we can't even simply say that teen pregnancy and parenthood is in no one's best interest, how can we be surprised at the high rates of teen pregnancy in this country? Fundamentally, teen pregnancy is a question of values, standards, social norms, and what a society prescribes as the best pathway from childhood to adult life. If we are to make continued and lasting progress in reducing teen pregnancy we need to offer more straight talk to young people—and conversations with them—about the critical need to postpone pregnancy and parenthood until adulthood.

2. A report released by the National Institutes of Health shows condoms are not necessarily effective in preventing most sexually transmitted diseases. Is your organization sharing this important information with teens? Do you believe that should become a key part of any family planning curriculum?

Teens need to know that abstinence is their best choice for preventing pregnancy and avoiding sexually transmitted diseases (STDs). They also need to be given accurate information about the relative effectiveness of various methods of contraception and the National Campaign has been at the forefront of communicating both messages. The recent report from the National Institutes of Health makes clear what many of those concerned about the well being of youth have been saying for some

time—condoms are not 100 percent effective at preventing pregnancy and that the jury is still out about their efficacy in preventing many STDs. The clear national consensus—among adults and teens alike—is that middle and high school kids, in particular, should be given a clear message that abstinence from sexual intercourse is the right thing to do because of the numerous important consequences.

Nonetheless, contraception is still a very important part of reducing teen pregnancy. A sexually active teen who does not use contraception at all has a 90 percent chance of getting pregnant within one year. However, we must be careful to put this remedy into perspective. Some teens, like many young adults, overestimate the effectiveness of condoms and many have difficulty consistently using the array of contraceptive methods currently available. For example, among young women aged 15–19 relying on oral contraception as their only form of birth control, only about 70 percent took a pill every day during a 3-month period. Moreover, nearly one-third of teen girls were completely unprotected the last time they had sex, and between 30 and 38 percent of teens who use contraception are not consistent users.

Despite the availability of the pill for more than three decades, despite the fact that many teens now have access to copious amounts of information about contraception from schools, magazine articles, and websites, despite the availability of non-prescription methods in virtually every drugstore, the vast majority (78 percent) of pregnancies among teens are unintended. Improving the degree of access that teens have to contraception might improve this statistic, but there is no reason to think that this approach alone will be sufficient. Increasing access that teens have to contraception is important—to be sure, without sustained attention to contraception over the past years, teen pregnancy rates today might be even higher—but, again, this is still only one of many remedies required.

3. I appreciate your point about "what works." However, the prevailing wisdom used to be that 5 million families had to be on welfare because they couldn't work. That logic proved to be flawed. As Dr. McIlhaney mentioned, the prevailing wisdom also used to be that smoking rates would never decline significantly because it was too ingrained in our culture. That has certainly changed too. Given the limited availability of abstinence education should we try to overturn the prevailing wisdom once again by expanding the availability of abstinence education?

As a general matter, the National Campaign strongly agrees with the sentiment of this question. That is, abstinence is the first and best choice for teens. Our polling data clearly indicate that the majority of adults and teens support providing teens with a strong abstinence message and research makes clear that abstinence has made a significant contribution to declining teen pregnancy and birth rates during the 1990s. We offer our support for a strong abstinence message for teens, however, with three important caveats:

- While American adults and teens clearly feel that young people should be given a strong abstinence message, the research on the effectiveness of abstinence *programs,* is not as clear. As *Emerging Answers: Research Findings on Programs to Reduce Teen Pregnancy,* a comprehensive research review recently published by the National Campaign makes clear, the jury is still out on the effectiveness of specific programs or curricula for conveying abstinence-only messages to young people. All of this leads us to be cautious about massive public funding of programs that do not *yet* have clear, scientific evidence of their effectiveness.
- It is also true that even when given strong advice to remain abstinent, some young people will not do so: for example, currently 65 percent of high school seniors have had sex. More of these young people can—and should—be encouraged to abstain from sex, but experience suggests that some (perhaps most) will continue to be sexually active. For these young people, the national consensus is that easily available contraception can reduce the chances of pregnancy and STDs. Put another way, American adults and teens clearly feel that abstinence is better than contraception, but using contraception is better than getting pregnant too soon. And, importantly, whatever the level of support for abstinence, it can never come at the expense of support and contraceptive services for sexually active teens.
- In the absence of good program evaluation data, and given both the great sensitivity of teen sexuality issues and the great diversity of American culture, the Federal government should not dictate precisely what states and communities should do to promote abstinence. While there is considerable consensus about the importance of preventing teen pregnancy, there is somewhat less consensus about how to go about it and the answers may vary in different communities and for different teens. Setting performance goals and expectations is a good idea. Rigidly prescribing how to achieve these goals is not. Consistent with the devolution philosophy underlying the 1996 welfare reform legislation, states

and communities require flexibility in designing strategies to reduce teen pregnancy in order to accommodate differing local circumstances. In a country as big and diverse as America, and on an issue as complex and sensitive as teen pregnancy, it is important to allow multiple approaches.

Sincerely,

Sarah S. Brown
Director

University of Pennsylvania
Philadelphia, Pennsylvania 19104
November 30, 2001

Mr. Wally Herger,
Chairman
Subcommittee on Human Resources
Committee on Ways and Means
House of Representatives
Washington, DC 20515
Via e-mail

Dear Mr. Herger:

I appreciate your offering me the opportunity to testify before your Committee on November 15, 2001. The following are my responses to your requests for clarification and additional information in support of my testimony.

Request 1: Please elaborate on your statement that there need to be more evaluations and funding for research on a variety of approaches to deal with the problems of teen pregnancy and STD transmission.

The national evaluation of Title V abstinence education program is the first major effort to gather scientifically rigorous evidence about the efficacy of this particular approach to reducing teenage sexual activity, exposure to STDs, and pregnancy. While there have been studies of a wide range of particular programs directed in whole or part at these same goals, the earlier research is of variable quality, inconsistent in its coverage of program approaches, and therefore of limited usefulness as a guide to designing effective national policies.

These shortcomings of past research were well documented in the recent review of teen pregnancy program evaluation findings by Dr. Douglas Kirby for the National Campaign to Prevent Teen Pregnancy. To be sure, Kirby's review of the research identifies statistically reliable evidence that several intervention strategies, tested in particular settings, have reduced teen sexual activity and pregnancy rates. However, this review identifies even more instances where studies have been unable to find clear evidence that the interventions favorably affected the key outcomes and some instances where the programs had adverse impacts. The only way to generate the scientific knowledge base needed to support smart policy development is to systematically assess a range of policy relevant approaches to the problems under varied implementation settings and using scientifically rigorous study designs.

Request 2: Please elaborate on your statement: "We have no definitive evidence linking any of the TANF teen pregnancy and nonmarital birth prevention provisions with favorable trends in teen pregnancy."

The decline in teen birth rates and the leveling off of nonmarital birth rates during the nineties could be related to those particular policy changes directed specifically at addressing teen pregnancy and nonmarital births. However, at the same time that these particular policy changes were being made and the favorable trends emerging, other potentially important factors were also shifting. Concurrent with the decline in the teen birth rate, increasing numbers of states were experimenting with other welfare reform elements now central to TANF and its broader focus on responsible behavior—the institution of time limits, the strengthening of child support enforcement, the stepping up of work requirements and support, and the institution of family caps. The 1990s also was a period of strong economic growth and changing demographics among the teenage population. These myriad other changes could also have had important effects on teen pregnancy trends. At this point, there have been too many simultaneously changing factors to establish definitive causal links between the teen pregnancy aspects of welfare policy change and the trends in teen and nonmarital birth rates, or to predict the relative contribution of particular policy changes.

Request 3: Are the abstinence programs you have observed mandatory or voluntary programs? Are family planning curricula typically offered on a voluntary or mandatory basis? What are the implications of the manner in which these programs are offered for your study findings?

Based on the observations my colleagues at Mathematica Policy Research, Inc., and I have been making, I would say that both abstinence programs and programs offering family planning curricula to youth operate in one of two ways. Where services are provided through community groups or as an extra-curricula activity within the school setting, participation is usually entirely voluntary and generally the parent must provide active consent. In contrast, in cases where the programs are offered as a part of the core curricula within the school setting, they generally use a passive consent process. For example, parents will be notified about the program/class and informed about its content and they will be given the opportunity to request that their child not participate. However, in some cases, schools do require active parental consent for students to participate in any type of health or sex education curriculum.

The implication of this pattern of service delivery for our study is simply that we need to be careful to document the nature of both the abstinence programs we are studying and the counterfactual services youths would be receiving if the Federally supported programs were not available to them. This information provides the context for interpreting the study findings and judging the extent to and circumstances under which they can be generalized.

Request 4: Please provide more specifics regarding your statement that "demand for abstinence programs frequently exceeds current capacity, as evidenced by program waiting lists and requests for programs to expand to new sites." Is there a demand by young people to become involved in these programs? Are the programs voluntary?

Our experience suggests that abstinence education programs embedded within well-run broader youth development and/or service programs, such as mentoring programs, activity clubs, or after school programs, tend to be very popular among youth and their parents. Such programs often have limited capacity and as a result have waiting lists.

Some of the more dynamic, school-based programs also are in high demand by school administrators. For example, principals in Miami, Florida, have expressed a wish that *ReCapturing the Vision* could serve more than the 20 to 30 girls per school it presently serves and the program director has been asked to bring the program into more schools, both within the district and throughout the state. This program is among those where we have clear evidence that, not only are school administrators eager to expand services, but that there are many more youths who would participate in the program voluntarily if they were offered the option.

Many schools where curriculum is offered in only one or two grade levels have expressed interest in extending the curriculum to lower and/or to older grade levels. School-based curricula programs tend to be voluntary on the part of parents, not students. However, our observation is that middle school youths generally are quite receptive to the programs. The response of older youths to purely curriculum-based programs is more mixed.

Request 5: Do you agree with Dr. McIlhaney's argument that it is too early to have concrete evidence about the success of abstinence education programs, but that "as was the case with the effects of smoking cessation initiatives, the data will come in time?"

It would be great if we had definitive evidence about the effectiveness of the Title V abstinence education programs now. However, Title V is delivering services largely to middle school youths, and these services are geared to preventing behaviors throughout the teenage years and even into young adulthood. For this reason, it simply is not possible to know at this time how effective these programs ultimately will prove to be. We need to wait and see how successful they are in getting youths to abstain from sexual activity as they move well into their teen years. The national Title V evaluation being conducted by Mathematica Policy Research, Inc., under contract to the U.S. Department of Health and Human Services will provide strong evidence on this issue by 2005, when its final report is due.

I hope these responses are helpful to you. Please let me know if I can be of further assistance.

Sincerely,

Rebecca A. Maynard
University trustee Chair Professor

Medical Institute for Sexual Health
Austin, Texas 78716–2306
November 28, 2001

Hon. Wally Herger,
Chairman
House of Representatives
Committee on Ways and Means
Subcommittee on Human Resources
Washington, DC 20515
Attn: Ryan Work
Sent by e-mail

DEAR REP. HERGER:

Thank you very much for your letter of November 19, 2001, and for your kind words.

We are pleased to provide for the record the following answers to the questions posed in your letter.

1. Do you have any recommendations about areas in the welfare reform law we might improve to further our efforts to prevent teen pregnancy and delay sexual activity among young people? What more can or should we do?

A. While three of the four declared purposes of TANF relate to promoting marriage, preventing and reducing the incidence of out-of-wedlock pregnancies, and encouraging the formation and maintenance of two-parent families, only a very small percentage of TANF funds have been spent to date for these purposes. We recommend that a specified percentage of TANF funding be designated for these issues, not just for teens, but also for other affected groups which fall within the purview of the enumerated goals of TANF. Furthermore, since the data, as discussed in greater detail in my testimony dated November 15, 2001 submitted to this Committee, clearly shows that abstinence outside of marriage is the healthiest behavior, and the only approach which adequately confronts both the pregnancy and disease issues, we recommend that at least half of the funding allocated for these three purposes be reserved for furtherance of abstinence outside marriage as the desired normative behavior. We are not advocating that sums presently being funded for other worthy causes, if needed, be diminished, but only that some significant TANF funding be designated for these three purposes.

B. As to Title V funding, strong evidence supports the conclusion that at least some of the programs being funded by the $50,000,000.00 per year allocation are beginning to realize very positive results. To discontinue this program now, prior to the extensive evaluation presently underway being completed, would not only severely hamper, if not destroy, these programs, but might also negate the meaning and usefulness of the pending evaluation. Clearly, these programs need to be renewed, and, if available, additional spending made available for abstinence programs through Title V, SPRANS, or other sources, so that parity with other type programs is achieved. There were a number of programs which were approved under both Title V and SPRANS, but which did not receive requested funding due to the shortage of available funds.

C. Since, as noted, abstinence is the only totally effective manner to deal with both out-of-wedlock and disease issues, and constitutes the only truly healthy behavior in this area, efforts should be made to emphasize abstinence outside of marriage as the desired choice and normative behavior for all legislation dealing with sexual behavior and its effects, including health legislation.

2. We often hear about the link between teen sexual activity and pregnancy and therefore welfare receipt. But clearly, there are serious health consequences even if teens don't become pregnant. Can you comment on some of the costs to individuals and society of that—both in terms of the obvious personal costs to teens and the tangible costs like increased Medicaid and other health care spending? Only abstinence can effectively and completely address these sorts of issues, correct?

We agree that only abstinence can effectively and completely address these sorts of issues.

The total costs to individuals and society, other than those directly related to out-of-wedlock pregnancies, of teen and other out-of-wedlock sexual activity, although difficult to accurately determine or even estimate, are of enormous proportion. These expenditures fall into several categories which include the following:

A. Direct medical and related costs

A 1997 report of the Institute of Medicine's Committee on Prevention and Control of Sexually Transmitted Diseases, entitled *The Hidden Epidemic, Confronting Sexually Transmitted Diseases,* states, in the Introduction to its Summary;

"Of the top ten most frequently reported diseases in 1995 in the United States, five are sexually transmitted diseases (STDs) (CC 1996c). With approximately 12 million new cases of STDs occurring annually (CDC, DSTD/HIVP, 1993), rates of curable STDs in the United States are the highest in the developed world. In 1995, STDs accounting for 87 percent of all cases reported among the top ten most frequently reported diseases in the United States (CDC, 1996c). Despite the tremendous health and economic burden of STDs, the scope and impact of the STD epidemic are under-appreciated and the STD epidemic largely hidden from public discourse. Public awareness and knowledge regarding STDs are dangerously low but there has not been a comprehensive national public education campaign to address this deficiency. The disproportionate impact of STDs on women has not been widely recognized. Adolescents and young adults are at greatest risk of acquiring an STD, but STD prevention efforts for adolescents remain unfocused and controversial in the United States."

As to the economic consequences of STDs, the report states, at page 7,

"The costs of a few STDs have been estimated . . . but no comprehensive, current analysis of the direct and indirect costs of STDs is available. . . . the Committee estimates that the total costs for a selected group of major STDs and related syndromes, excluding HIV infection, were approximately $10 billion in 1994. This rough, conservative estimate does not capture the economic consequences of several other common and costly STDs and associated syndromes such as vaginal bacteriosis and trichomoniasis. The estimated annual cost of sexually transmitted HIV infection in 1994 was approximately $6.7 billion. Including these costs raises the overall cost of STDs in the United States to nearly **$17 billion in 1994.** These cost estimates underscore the enormous burden of STDs on the U.S. economy. (emphasis added).

In a report dated December, 1998 prepared for the Kaiser Family Foundation by the American Social Health Association, entitled, *"Sexually Transmitted Diseases in America: How Many Cases and at What Cost?,* the panel calculated that the "actual number of new cases of STDs is approximately 15 million annually," and that this could be as high as 20 million new cases per year. This report confirmed the very high cost of STDs. An unpublished study by our office reaches the same conclusion.

B. Other costs

As noted, there are many costs, monetary or other, in addition to those related to pregnancies, which can be traced to or at least associated with sexual activity outside marriage. These include:

1. Loss of work time and productivity due to having an STD.

2. Psychological and emotional damage and stress, including suicide and other self-inflicted damage. For example, in a study entitled *Premature Sexual Activity as an Indicator of Psychological Risk* published in the February 1991 issue of the journal *Pediatrics,* non-virgin girls in the teen group evaluated were 6.3 times more likely to have attempted suicide (31.9 percent compared to 6.9 percent).

3. Involvement in other risky behavior—For example, non-virgin boys and girls were more than six times as likely to have used alcohol, were 3.8 (boys) to 7.2 (girls) times more likely to have smoked cigarettes, and 4.8 (boys) and 10.4 (girls) times more likely to have used marijuana. *Premature Sexual Activity as an Indicator of Psychological Risk,* supra, p. 144.

4. Damaged relationships caused by one partner (married or otherwise) having an STD. *"Sexually Transmitted Diseases in America: How Many Cases and at What Cost?,* supra, p. 23.

5. Pre-term labor.

6. Infertility. Between 30 and 40 percent of couples who require in vitro fertilization because of the woman's infertility are required to do so because of a prior STD infection. The cost of this procedure, both monetarily and emotionally, is very high.

7. Miscellaneous others. As noted in *"Sexually Transmitted Diseases in America: How Many Cases and at What Cost?, supra,* p. 23.

"In addition to the economic impact of STDs, the panel noted that STDs have a high human cost in terms of **pain, suffering and grief.** Complications of chlamydia and gonorrhea can lead to **chronic pain, infertility and tubal pregnancies, which can affect a woman's health and well-being throughout her lifetime.** The **harmful impact of STDs on infants** leads to **long-term emotional suffering and stress** for families which cannot be captured in dollar terms. Unlike other diseases, STDs often cause **stigma and feelings of shame** for patients diagnosed with these infections." (emphasis added)

Thank you for including us among those testifying on this important issue, and the opportunity to respond to the inquiries in your letter. Please do not hesitate to let us know if we can be of further service.

Sincerely,

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

[Submissions for the record follow:]

Statement of Melanie Howell, President, Abstinence Educators' Network, Inc., Mason, Ohio

Thank you Honorable Chairman Herger and other distinguished members of this committee to allow me to express my request for continued funding of premarital abstinence education. I am president of Abstinence Educators' Network, the only state-wide premarital abstinence education network in Ohio. Our non-profit agency has received Title V funding for 4½ years and this July received a SPRANS implementation grant to expand efforts into more of the underserved areas of Ohio.

I am a nurse, and since 1989, have worked in the trenches teaching premarital abstinence education to parents, teens, teachers and other professionals. I know first hand the value, importance, and results of premarital abstinence education for the teens and communities in our state. And, I know first hand the importance of state and federal funding. Without government funding our organization would not be reaching 10,000 people per year with the health and societal benefits of abstinence and the necessary character development and refusal skills to be successful with a premarital abstinent lifestyle.

More and more communities now desire the highest standard of sexual health for their children. The approach is well received and makes good sense to parents, teachers, and students. Every day, we hear comments that they are tired of the old message and the mixed message approach. Clear guidance is sought after in these difficult times.

Ohio's 29 Title V agencies have worked hard in the trenches over the last four years to educate many more Ohioans about the importance of such topics as: character development, healthy relationships, love vs. infatuation, successful refusal skills, the importance of marriage and family, the limitations and failure rates of contraceptives/condoms for teens, and the short and long term devastation of over 25 Sexually Transmitted Diseases.

We are thankful that three new SPRANS Ohio grantees can now reach more who desire this approach for their children and students. Many of these communities we have had to turn away in the past.

The need for abstinence dollars is obvious to anyone who works in the field. It is what the common people are asking for. In some ways, it reminds me of the war in Afghanistan. The common people are looking for truth and liberation. Title V dollars are the army's foot soldiers, who go in the caves and trenches to clean things up. The SPRANS dollars are the heavy artillery, the big guns, to work the broad approach from the top. Both work together to form the best strategy for increasing the numbers of students to abstain from sexual activity. Both methods of funding are needed desperately.

Please continue to move forward, not backward, for our children. Continue to provide more funding for premarital abstinence education. Its saves the lives of children and families.

Thank you.

THE AGENCY'S FOURTH YEAR "TITLE V FOURTH YEAR EVALUATION SUMMARY"

BY DR. RAJA TANAS, WHITWORTH COLLEGE, SPOKANE, WA

This report is based on the fourth-year data generated from the multi-faceted programs that Abstinence Educators' Network of Ohio offered to students, peers, adult mentors, parents, social workers and other professionals. The underlying objective of these programs was to present information and give support to the development of skills directed toward helping junior high and senior high school students abstain from teen sex and develop healthy lifestyles.

Results reported in this study came from six sets of data. The primary data set was obtained from 1505 students enrolled in grades seven through twelve at nine schools in the State of Ohio during the 2000–2001 school year. The one-group pretest-posttest experimental design was used to evaluate the impact of Lakita Garth's presentations on promoting abstinence among teens. The other five sets of data were obtained from other students, student peers, social workers, other professionals, and parents who participated in mentoring, training workshops and seminars designed to support teens in their decisions to abstain from sex until marriage.

Similar to results reported in previous reports, Lakita Garth's rallies continued to produce statistically significant impact on students' attitudes and behavioral intentions supporting abstinence. The pretest-posttest analysis using the t-test statistical technique for independent samples yielded results showing that the rallies moved the students toward a greater degree of agreement on each of the eight variables targeted by the program. While this year's study replicated the results of last year's study, one notices a greater impact on the latter four items than was found in previous years. Specifically, after attending Lakita Garth's presentations, students were more likely to agree that:

- they understood the advantages of abstinence (92 percent)
- sexual urges are always controllable (64 percent)
- it was possible for them to say no to sex (80 percent)
- it was important for teens to stop having sex (70 percent)
- having sex before marriage was against their personal standards and values (56 percent)
- they were currently practicing sexual abstinence (66 percent)
- they intended to save sex from now on and until marriage (56 percent)
- they would like to have more support to say no to sex (57 percent)

Participants in the other workshops and seminars equally found their programs useful and effective in terms of providing information and material; hands on training; effectiveness of presenters and effectiveness of teaching methods; and relevancy of the material to the stated objectives. The large majority of participants in each program expressed their greatest degree of satisfaction with the organization and administration of a respective program.

Many open-ended comments also reflected strong support to the various facets of the programs and expressed their appreciation to AEN for helping them develop new understanding of issues relative to teen sex. It is no exaggeration to conclude that this year's results were exceptional given the larger size of the student samples; the variety of programs, activities, objectives, and locations; and the diversity of audiences that AEN served during the academic year 2000–2001.

Alan Guttmacher Institute
New York, New York 10005
November 29, 2001

The Honorable Wally Herger
Chairman, Human Resources Subcommittee
House Ways and Means Committee
Room B–317, Rayburn House Office Building
Washington, DC 20515

Dear Chairman Herger:

The Alan Guttmacher Institute (AGI) applauds you for convening a hearing on November 15 before the Human Resources Subcommittee designed to shed light on the problem of teenage pregnancy. As you noted at the hearing, accurately diagnosing why teen pregnancy rates are declining in this country is extremely important to our ability to make further progress in this area, particularly as legislators begin work on welfare reauthorization.

AGI researchers in 1999 first set out to determine the extent to which increased abstinence from sexual activity among teenagers and/or other factors, such as changes in contraceptive behavior among sexually experienced teenagers, contributed to recent declines in teenage pregnancy. Due to the controversy inherent in the subject matter and the various ways in which different people have examined and interpreted the trends, AGI researchers went to extraordinary lengths to make sure that their approach and methodology were the most appropriate ones given existing data, and that their conclusions were ones that they—and the Institute—could fully stand behind. This included participation at a consensus meeting convened by the National Institute of Child Health and Human Development to examine measurement issues regarding sexual activity and contraceptive use of teenagers, which involved researchers from AGI, the National Center for Health Statistics, Urban Institute, Child Trends and the National Campaign to Prevent Teenage Pregnancy. AGI's methodology for measuring factors potentially contributing to pregnancy rate declines—sexual experience and contraceptive use levels—follows the consensus of this group.

AGI's findings appeared in our publication *"Why Is Teenage Pregnancy Declining? The Roles of Abstinence, Sexual Activity and Contraceptive Use,"*[1] which I have attached as an exhibit for your review. Our analysis was based on calculations using the following data sets:

- Pregnancy rates—released by AGI in April 1999 in *"Teenage Pregnancy: Overall Trends and State-by-State Information"*—are based on birth rates from the National Center for Health Statistics and abortion data from periodic AGI Abortion Provider Surveys. Information on the proportions of young women who have had sexual intercourse are from the National Center for Health Statistics' 1988 and 1995 National Surveys of Family Growth (NSFG).
- Information on sexual activity and contraceptive use is from 1988 and 1995 NSFG.
- Overall contraceptive failure rates are based on NSFG information on contraceptive use and from first-year failure rates calculated from the 1995 NSFG and the 1994–1995 AGI Abortion Patient Survey.[2]

AGI's analyses showed that the teen pregnancy rate dropped significantly—from 111.4 to 101.1 per 1,000 women aged 15–19—between 1988 and 1995, a decline of 9 percent.[3] National survey data indicate that during that time period there was a decline—or at least a leveling off—in the proportion of teenagers who have ever had sexual intercourse. The proportion of women aged 15–19 who report that they have ever had sexual intercourse decreased 2 percent between 1988 and 1995.[4] Analysis showed that about 25 percent of the decline in the overall U.S. teen pregnancy rate was attributable to this increased abstinence.

Of greater magnitude, AGI's analysis of the available data found that approximately 75 percent of the decline in teen pregnancy between 1988 and 1995 was attributed to declines in pregnancy rates among *sexually experienced* teenagers. In-

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[1] Darroch JE and Sing S, *Why Is Teenage Pregnancy Declining? The Roles of Abstenence, Sexual Activity and Contraceptive Use,* Occasional Report, New York: The Alan Guttmacher Institute, 1999, No. 1.

[2] http://www.agi-usa.org/pubs/journals/3104669.html.

[3] Darroch JE and Singh S, op. cit. (see reference 1), pages 8-9 and Table 1.

[4] The percentage of 15–19 year old women who say they have ever had sexual intercourse was 51.3 percent in 1995 and 52.6 percent in 1988. Ibid.

deed, the drop in pregnancy rates among sexually experienced teens has been marked—7 percent between 1988 and 1995.[5]

Declining pregnancy rates among sexually experienced teens must be attributable to one or more of the following three factors:

1) less frequent sexual activity;
2) an overall increase in contraceptive use (that is, an increase in the proportion of sexually experienced teens using a contraceptive); and/or
3) improved (in other words, more effective) contraceptive use.

Government data do *not* bear out a decrease in levels of sexual activity among sexually experienced teens.[6] And, there *is* evidence that only a slightly larger proportion of sexually active teens were using contraceptives.[7] More significantly, however, by 1995 teens using contraceptives were choosing more effective methods. Most notably, there has been a substantial shift among sexually active teens toward the use of highly effective, long-acting contraceptive methods—the contraceptive injectable (Depo Provera) and the contraceptive implant (Norplant). These methods only hit the U.S. market in the early 1990s, but by 1995, over one in ten (13 percent) sexually active teen women at risk of unintended pregnancy was using one of them.[8] Because these long-acting methods are so effective and so easy to use, they made a big dent in the teenage pregnancy rate.

Use of Depo Provera and Norplant may have played a particularly large role in reducing second pregnancies among teen mothers. Data released by NCHS showed a dramatic 21 percent decline between 1991 and 1996 in the proportion of teen mothers giving birth a second time.[9] During a corresponding time period, the proportion of teen mothers using long-acting methods rose to one-quarter.[10]

A recent analysis conducted by the National Campaign to Prevent Teen Pregnancy found that 40–60 percent of the decline in teenage pregnancy rates between 1990 and 1995 was probably due to fewer teens having sex and 60–40 percent to lower pregnancy rates among sexually experienced teens. (Looking at the years 1988–1995, the Campaign found that 20–50 percent of the drop resulted from lower rates of sexual experience and 50–80 percent from decreased pregnancy rates among sexually experienced teens.)[11] This analysis, however, contains certain methodological flaws that hamper the reliability of its findings. First, it places on equal footing data gathered in 1990 through telephone surveys with data collected in 1988 and 1995 through in-person interviews, making it impossible to determine whether differences between 1990 and 1988 or 1995 are due to an actual change in behavior or the changes in survey methodology. Second, it uses arbitrary and inconsistent measures of respondents' age in 1988 and 1995 (rather than the consistent point in time of when respondents were interviewed), which produces biases in different directions in 1988 and 1995, and thus overstates changes in sexual activity. And third, it measures sexual experience to include those young women who have had sex before menarche, which is inappropriate for measuring teen pregnancy since these women, by definition, are not at risk for pregnancy. When this analysis is adjusted such that it is based on comparable survey methodology and quality over time (1988 and 1995 NSFGs), unbiased measures of age (at the time respondents were interviewed), and appropriate measures of sexual experience (ever had sexual intercourse after menarche)—the most scientifically consistent and rigorous approach—it yields a conclusion similar to AGI's findings in Why is Teenage Pregnancy Declining?

In summary, AGI's analysis found that approximately one-quarter of the decline in teen pregnancy rates is due to increased abstinence; about three-quarters is due

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[5] In 1988, the pregnancy rate among sexually experienced 15–19 year olds was 211.8 per 1,000; in 1995, it was 197.1 per 1,000. Ibid, page 8.

[6] A somewhat lower proportion of sexually experienced young women reported having had intercourse in the three months prior to the National Survey of Family Growth in 1995 than in 1988 (79 percent vs. 81 percent); however, over the entire prior year, sexually experienced young women reported having had intercourse during the same average number of months in both the 1988 and the 1995 NSFG (8.6 months). Ibid, page 10.

[7] The proportion of sexually experienced teens reported currently using a contraceptive—using one within the last month—was 80 percent in 1995, compared with 78 percent in 1998. Ibid, page 10.

[8] Ibid, page 11.

[9] Ventura SJ, Mathews TJ and Curtin SC, Declines in teenage birth rates, 1991–1997: National and state patterns, National Vital Statistics Reports,1998, Vol. 47, No. 12.

[10] Using data from the 1995 National Survey of Family Growth, NCHS researchers estimate that about one-fourth of teens who are mothers are using Depo Provera or Norplant. NCHS, Unpublished tabulations.

[11] Flanigan, C, What's behind the good news: The decline in teen pregnancy rate during the 1990s, Washington, DC: The National Campaign to Prevent Teen Pregnancy, 2001.

to more successful pregnancy prevention efforts among teens who are sexually active. Many questions still remain around why teen contraceptive use has improved, why more teens are remaining abstinent, and whether these trends have continued since the mid-1990s. But the bottom line is that both phenomena are making a difference in combating teen pregnancy. This strongly suggests that even as abstinence is being promoted to our nation's young people, accurate and reliable information about contraceptives, as well as access to contraceptives for those teens who are sexually active—half of all U.S. teens—is also vitally important to reducing teen pregnancies, fully eight in 10 of which are unintended. Again, we applaud your effort to devote attention to the critical issue of teenage pregnancy, and strongly urge you to take this information into account as you and members of your subcommittee move toward welfare reauthorization next year.

Sincerely,

Jacqueline E. Darroch, Ph.D.
Senior Vice President
Vice President for Research

Center for Law and Social Policy
Washington, DC 20005
November 29, 2001

The Honorable Wally Herger
Chairman, Human Resources Subcommittee
House Ways and Means Committee
Room B–317, Rayburn House Office Building
Washington, DC 20515

Dear Chairman Herger:

The Center for Law and Social Policy (CLASP) appreciates the opportunity to submit this statement for the record of the public hearing on Teen Pregnancy Prevention that was held on Thursday, November 15, 2001.

CLASP is grateful that you held a hearing on the topic of teen pregnancy prevention in preparation for reauthorization of the Temporary Assistance for Needy Families program in 2002. The importance of the relationship of teen childbearing to poverty cannot be overstated, yet, too often it is not given the attention it deserves. Also up for reauthorization in 2002 is the separate abstinence education program enacted in 1996, which received the most attention by the witnesses who testified on November 15.

In this brief submission, CLASP will focus on the abstinence education program. We have written and will continue to publish updated materials on the full range of issues related to reauthorization and teen pregnancy/reproductive health including such topics as: TANF spending on teen pregnancy prevention, TANF spending on teen parent services, the TANF teen parent living arrangement and education requirements, the out-of-wedlock bonus, teen marriage, TANF teen parents with disabilities, and "family cap" policies. Our materials are all available free of charge on our web site: http://www.clasp.org/.

The 1996 federal abstinence education program is often misunderstood. In part this is because abstinence education can mean different things to different people. For some, abstinence education means information that asserts one should abstain from sex at every age unless one is married; for others, abstinence education means programs that promote abstinence as the only sure way to avoid pregnancy and sexually transmitted illnesses and that when one stops abstaining it is important to know how to contracept. Many are unaware that the statute defines a program with the former approach, the most restrictive approach—sometimes called abstinence-unless-married education.

The law's definition of a fundable program has eight points, including that the program teach that "sexual activity outside the context of marriage is likely to have harmful psychological and physical effects" [Attachment A provides the full text of the law]. The program operates through the Maternal and Child Health (MCH) block grant and provides $50 million in federal funds each year to support abstinence programs that preclude education about contraception; a state match of $3 for every $4 federal dollars is required.

The law was enacted without any research base suggesting that a restrictive abstinence approach works at reducing teen pregnancy and births. There still is none. As noted in a recent review of evaluations of abstinence programs published by the National Campaign to Prevent Teen Pregnancy, "there do not currently exist any

abstinence-only programs with reasonably strong evidence that they actually delay the initiation of sex or reduce its frequency." The author used strict criteria in determining what studies of sexuality education programs to include in his review of evaluations; only three such abstinence-only studies met the criteria.[1]

Unfortunately, the federally funded evaluation of abstinence-unless-married programs funded through the 1996 law will not be finalized until 2003; thus, the 2002 reauthorization process will not be able to benefit from any insights offered by the evaluation. While the evaluation should help us learn more about some of the impacts of the programs it will, nevertheless, not answer the question that needs to be asked. That central question is "How does a program of abstinence-unless-married education compare to an abstinence program that also provides contraceptive education?"

There is good reason to compare different types of approaches to abstinence: available research raises concerns about an abstinence education approach that does not provide contraceptive education. At the same time, there is a bit of encouraging news that some abstinence strategies may help delay the onset of sexual activity, particularly among the youngest adolescents. But the abstinence-unless-married approach can backfire when aimed at older teens.

- A comparison of in-school youths who took a "virginity pledge" and those who did not found that some virginity pledgers were at greater risk when they first engaged in sexual intercourse. The pledge—to abstain from sex until marriage—did delay first intercourse on average by nearly 18 months. However, pledging had no effect among teens who were 18 or older and also contributed to health risks for those who became sexually active.[2]

  According to researchers Peter Bearman and Hannah Brueckner, who tracked those pledgers who had intercourse during the study period, "the estimated odds for contraceptive use for pledgers are about one-third lower than for others." The researchers noted that "pledgers are less likely to be prepared for an experience that they have promised to forego." They also found that "pledging does not work for adolescents at all ages" and that the efficacy of the pledge in some schools depended on its being uncommon: "Once the pledge becomes normative, it ceases to have an effect." Thus "policy makers should recognize that the pledge works because not everyone is pledging."[3]

- Another study compared an "abstinence" program with a "safer sex" program that involved 659 African-American middle-school adolescents and found that, among those who already were sexually active when the courses began, participants in the "safer sex" program reported less-frequent sexual intercourse and less-frequent unprotected sex one year after the program. Further, when the abstinence group was compared with a control group, it reported less sexual activity at three months following the intervention, but this distinction evaporated over time.[4]

- A study conducted by Edward J. Saunders and colleagues at the University of Iowa School of Social Work compared survey responses from participants in a comprehensive sex-education program that promoted abstinence but allowed

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[1] "The review examined the evidence available regarding studies that met the following criteria: met the scientific standards requisite for inclusion in professional journals or publications; published in 1980 or later; analyzed data collected from U.S. adolescents, most of whom were 19 or younger; used a sample size of at least 100; measured the relationship between the antecedents and one or more of the following sexual behaviors: initiation of sex, frequency of sexual intercourse, number of sexual partners, use of condoms, use of any type of contraception, pregnancy, or childbearing. (Studies that measured only out-of-wedlock pregnancy or childbearing were not included.)" Douglas Kirby, Emerging Answers: Research Findings on Programs to Reduce Teen Pregnancy, (Washington, DC: National Campaign to Prevent Teen Pregnancy, 2001), p. 35.

[2] The highlighted Kirby report above did not include these community-based Virginity Pledge efforts.

[3] Peter Bearman and Hannah Brueckner, "Virginity Pledges and the Transition to First Intercourse", Pregnancy Prevention for Youth: An Interdisciplinary Newsletter, Vol. 3, No. 2, (June 2000); also, "Virginity Pledges as they Affect the Transition to First Intercourse", American Journal of Sociology, Vol. 106, No. 4, (2001).

[4] "The abstinence intervention acknowledged that condoms can reduce risks but emphasized abstinence to eliminate the risk of pregnancy and STDs, including HIV. It was designed to . . . strengthen behavioral beliefs supporting abstinence. . . . The safer-sex intervention indicated that abstinence is the best choice but emphasized the importance of using condoms to reduce the risk of pregnancy and STDS, including HIV, if participants were to have sex. It was designed to . . . increase skills and self-efficacy regarding [the] ability to use condoms." John B. Jemmott III, Loretta Sweet Jemmott, and Geoffrey T. Fong, "Abstinence and Safer Sex HIV Risk-Reduction Interventions for African American Adolescents, A Randomized Controlled Trial", Journal of the American Medical Association, Vol. 279, (May 20, 1998).

contraceptive information with survey responses from participants in an abstinence-unless-married program. The authors found that the former program was more successful in imparting knowledge about aids and other stds. In addition, while the authors suggested that program comparisons should be viewed cautiously because of differences in the age of the participants, the length of the programs, and a range of other variables, they noted that the program that offered contraceptive information also appeared to be more successful than the abstinence-unless-married program in "promoting communication between parents and youth about sex."[5]

Further, evaluations of programs that combine abstinence education with contraceptive information find that they can help delay the onset of intercourse without a concomitant concern about health risks, and that they also reduce the frequency of intercourse and the number of partners.[6] If there are stronger approaches that further delay the onset of intercourse by the too-young, those lessons should be adapted by programs that combine abstinence education with contraceptive information—in that way such programs will cause no health harm.

Even in the absence of evidence that abstinence-unless-married education reduces the risk of teen pregnancy and birth, and in spite of the new research that the reduction in sexual activity is accompanied by an increase in the health risk for some, funding for this approach has expanded beyond the $50 million per year authorized in the 1996 welfare law. As of fiscal year 2002, at least $533 million will have been earmarked in federal and state funds since 1996. Two other federal sources, the Adolescent Family Life Act (AFLA) and Special Projects of Regional and National Significance-Community-Based Abstinence Education (SPRANS–CBAE) program, have made more money available. Under the SPRANS grants, MCH can by-pass states and award grants directly to local projects; grantees, however, may not provide contraceptive education, even with separate funds. The House has increased its funds for SPRANS–CBAE from $20 to $40 million (efforts to increase it to $73 million failed); the Senate Appropriations committee would provide $30 million. Any differences will be resolved shortly in Conference.

Proponents of increased funding for SPRANS–CBAE argue that funding "parity" is needed between abstinence-unless-married education and family planning. This comparison, however, contrasts expenditures for education against costs for medical services. Thus, this is a comparison of "apples" and "oranges" and creates even greater misunderstanding in the public debate.

The public supports abstinence education but wants contraceptive education along with it. Virtually all of the parents of 7–12th graders (97 percent) want their child's sexuality education program to cover abstinence, according to a national study in 2000 by the Kaiser Family Foundation.[7] Notably, these parents also want lessons on how to use condoms (85 percent) and on general birth control topics (90 percent).[8] State and local surveys also have found strong support for information about both abstinence and birth control.

The Subcommittee on Human Resources hearing on teen pregnancy revealed bipartisan support for a more flexible approach to the available federal abstinence education funds. Not only were a number of attending Democratic members of the Subcommittee concerned that the law's approach to abstinence education is too restrictive, so too was Congresswoman Nancy Johnson (R–CN). This bi-partisan call for increased flexibility as an issue for reauthorization is encouraging and appropriate.

The Center for Law and Social Policy recommends further attention to abstinence-only education funding during reauthorization and a closer examination of how the research points to the importance of greater flexibility in spending available funds.

Sincerely,

Jodie Levin-Epstein
Senior Policy Analyst

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[5] Edward J Saunders, et al., "Evaluation of Abstinence-Only Education: Year One Report", University of Iowa School of Social Work, (October 1999).

[6] Douglas Kirby, Emerging Answers: Research Findings on Programs to Reduce Teen Pregnancy, (Washington, DC: National Campaign to Prevent Teen Pregnancy, 2001); Douglas Kirby, No Easy Answers: Research Findings on Programs to Reduce Pregnancy, (Washington, DC: National Campaign to Prevent Teen Pregnancy, March 1997).

[7] "Sex Education in America: A View from Inside the Nation's Classrooms", A Series of National Surveys of Students, Parents, Teachers, and Principals, Kaiser Family Foundation Website, (September 26, 2000), (Accessed November 6, 2001), Available online: http://www.kff.org/content/2000/3048/ Chartpack.pdf.

[8] Ibid.

Attachment A

SEPARATE PROGRAM FOR ABSTINENCE EDUCATION

"SEC. 510. (a) For the purpose described in subsection (b), the Secretary shall, for fiscal year 1998 and each subsequent fiscal year, allot to each State which has transmitted an application for the fiscal year under section 505(a) an amount equal to the product of—

"(1) the amount appropriated in subsection (d) for the fiscal year; and

"(2) the percentage determined for the State under section 502(c)(1)(B)(ii).

"(b)(1) The purpose of an allotment under subsection (a) to a State is to enable the State to provide abstinence education, and at the option of the State, where appropriate, mentoring, counseling, and adult supervision to promote abstinence from sexual activity, with a focus on those groups which are most likely to bear children out-of-wedlock.

"(2) For purposes of this section, the term 'abstinence education' means an educational or motivational program which—

"(A) has as its exclusive purpose, teaching the social, psychological, and health gains to be realized by abstaining from sexual activity;

"(B) teaches abstinence from sexual activity outside marriage as the expected standard for all school age children;

"(C) teaches that abstinence from sexual activity is the only certain way to avoid out-of-wedlock pregnancy, sexually transmitted diseases, and other associated health problems;

"(D) teaches that a mutually faithful monogamous relationship in context of marriage is the expected standard of human sexual activity;

"(E) teaches that sexual activity outside of the context of marriage is likely to have harmful psychological and physical effects;

"(F) teaches that bearing children out-of-wedlock is likely to have harmful consequences for the child, the child's parents, and society;

"(G) teaches young people how to reject sexual advances and how alcohol and drug use increases vulnerability to sexual advances; and

"(H) teaches the importance of attaining self-sufficiency before engaging in sexual activity.

"(c)(1) Sections 503, 507, and 508 apply to allotments under subsection (a) to the same extent and in the same manner as such sections apply to allotments under section 502(c).

"(2) Sections 505 and 506 apply to allotments under subsection (a) to the extent determined by the Secretary to be appropriate.

"(d) For the purpose of allotments under subsection (a), there is appropriated, out of any money in the Treasury not otherwise appropriated, an additional $50,000,000 for each of the fiscal years 1998 through 2002. The appropriation under the preceding sentence for a fiscal year is made on October 1 of the fiscal year.".

Statement of Onalee McGraw, Director, Educational Guidance Institute, Front Royal, Virginia

Evaluation of the effectiveness of Title V Programs must be consistent with all of the A–H elements of Title V (Personal Responsibility and Work Opportunity Reconciliation Act of 1996 P.L. 104–193)

Title V mandated a model for teaching about sexuality that represented a major departure from the long established safer sex/risk reduction approaches. Evaluation of Title V programs should be fully consistent with the norm building, values formation core of the A–H elements of Title V–not only in the programs themselves, but in the methods of evaluation that are used.

The methodological assumption relied on by both the National Title V Evaluation and state Title V evaluation efforts in various states, e.g. Virginia, was grafted on to the abstinence-until-marriage model from evaluation theories utilized for evaluating risk reduction and HIV/AIDS prevention interventions. The theory of evaluation is that (1) adolescents' sexual activity can be adequately and accurately measured by their self-reported answers to survey questions and (2) statistical analysis of these survey responses from subjects in intervention and control ("no treatment") groups can be utilized to answer the question of whether or not the intervention programs thus measured are effective in reducing the onset of sexual activity.

This methodology is not appropriate, however, for the norm-based, values teaching, character education oriented goals and objectives of the abstinence-until-mar-

riage programs supported by Title V. This positivist methodology will fail to establish a *credible baseline* of sexual behavior change in the intervention and control/no treatment groups. The question of whether such survey questions are ethically and developmentally appropriate is a perennial issue in school settings. School districts and parents are rightly opposed to their students being asked intrusive questions about their sexual behavior.

Many of us in the abstinence education community desire a new direction in evaluation, one that has an evaluation theory base and methodology that is philosophically compatible with the mandated A–H elements. Under the principle of "do no harm" no participant in either an intervention or a so called "control" group should be exposed to invasive questions about their own personal sexual histories.

Existing methods of evaluating Title V programs through group survey methods of measuring sexual behavior change involve serious empirical and developmental problems.

(1) *Empirically* the establishment of the baseline is problematic because our culture currently has subcultures of pre-teens and teens engaging in oral sex play that they do not consider to be sexual. The methodology of measuring sexual behavior change with group surveys will fail to adequately establish a participant sexual behavior baseline for determining whether programs reduce the onset of sexual activity.

Survey questions asking students if, when and how many times they have had sexual intercourse will be answered "no" by students who have not had sexual intercourse and who are not engaging in oral sex play, and "no" by students who have not had sexual intercourse but who have been engaging in oral sex play. In 1999, the national media reported that subcultures of teens were engaging in behaviors they did not consider to be sexual.[1] For example, girls who reported engaging in oral sex 50 or 60 times related in clinical settings that they were "virgins and were going to wait to have intercourse until they meet the man they will marry."[2] The meanings of the words "having sex" or "sexual activity" have changed so that many respondents would rightly answer "no" to the question, "have you had sexual intercourse?" Leaders in the abstinence education community cautioned supporters of the group survey methodology that survey questions concerning "sexual activity" and "sexual intercourse" would not produce empirically valid measurement, but these concerns were not heeded when there was still an opportunity to address them.

Another empirical problem is the contamination of the comparison groups when the program evaluated is norm-based and value-laden. Many of the same educational elements implemented in the intervention groups are likely to be present in the comparison groups because more teachers in the present cultural climate affirm the abstinence message; teachers have a strong influence over learners in the values they impart.

(2) *Developmentally,* this positivist methodology fails to adequately account for the emotional, social and moral domains of human development that together fully integrate human sexuality.

Because human beings are whole persons, self-report responses to survey questions about sexual behavior provide a flawed and incomplete picture of each subject's genuine and holistic state of mind and heart. Jerome Kagan, one of the nation's leading social scientists in the field of human development, has said that the methods of social science observation in studying human behavior will always be greatly limited by the *mode of observation* chosen by the particular social scientist. Contrary to the position taken by supporters of the group survey methodology, operational principles of social science observation vary greatly; they are not universally applied to all types of subject matter. As Kagan, in the *Nature of the Child* observes, any given mode of observation of human subjects can reveal only a *portion* of events observed.[3] That is, the responses given by adolescents to survey questions about their sexual behavior provide only a "snapshot in time" of what the respondent is truly experiencing and how he or she has actually behaved.

Principles of Whole Person Development Require Respect for Every Human Subject in K–12 Settings

The same developmental and age-appropriate assumptions that guide abstinence-until-marriage model programming must apply to the survey instruments that evaluate the effectiveness of these programs. The five prin-

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[1] *The Washington Post*, July 8, 1999, *Talk Magazine*, February, 2000.
[2] *Mona Charen, "Sexual play as a preteen pastime," Washington Times, April 13, 2000.*
[3] *Jerome Kagan, The Nature of the Child, Basic Books, 1994, p. 18.*

ciples of age appropriate practice outlined below affirm the whole person reality and integrity of human subjects in K–12 group evaluation settings.

Principle #1: Human sexuality is strongly intertwined with social and moral values

The authors of *Sex in America: A Definitive Survey,* describe the erroneous concept of human sexuality that has dominated our culture for so long as "the belief that the individual is the sole actor on the sexual stage" The authors found instead that "sexual behavior is shaped by our social surroundings. We behave the way we do, we even desire what we do, under the strong influence of the particular social groups we belong to."[4] The theory of behavior change that guides the research base of the HIV/AIDS prevention establishment (and inappropriately grafted onto Title V evaluation) is the very same notion discredited by the Sex in America research. A review of HIV/AIDS prevention research literature consistently reveals that the underlying theoretical presupposition is to assist the individual conceived as "the sole actor on the sexual stage" to make autonomous and rational decisions about sexual behavior.

In light of the differences over proper methodology that shape the Title V Evaluation debate, it is useful to review the methodology that was followed by the researchers that produced *Sex in America.* Adult subjects were interviewed by highly trained interviewers in their homes. The *Sex in America* methodology recognized the whole person nature of the subjects in these one-on-one interviews. By contrast, the method used in state and national Title V evaluation efforts has been to place in front of the adolescent respondent a hard copy survey or computer program and to assume that the students will be able to "report" objectively and accurately on the subjective state of their minds and hearts with regard to their sexuality.

Principle #2: Ethics in evaluation require treating respondents as whole persons

The group survey method using self-report for explicit sexual behavior questions places great reliance on confidentiality and parental consent to frame its ethical requirements. The problem with self-report in the survey method is that the emotional dispositions of the person from whom the information is sought *cannot be known.* Because of this unpredictable element of emotional response, *especially when the topic is sex*, the aggregate results of respondents' self report are likely to be "inconclusive." By and large, adolescent respondents are incapable of addressing their sexuality in the cognitive domain by separating out through an act of the will (upon assurances of confidentiality), the emotional, social and moral aspects that make them whole persons.

The abstinence-until-marriage model's theoretical foundations, learning theory, and principles for evaluation rely on a view of the human person seen as a whole, not just in the part of the "self" that involves sexual behavior. The complex interconnections of the moral, emotional social and cognitive domains are at any moment in time an ***unknowable*** result of the survey's psychological impact on not only the mind, but the heart of the learner. As opposed to being a "sole actor on the sexual stage," each person has an inner core—a personal dignity that must not be invaded except in a setting preceded by personal or parental consent, as in one-on-one counseling or in a therapeutic setting with licensed helping professionals.

Principle #3: Surveys containing personal questions about respondents' sexuality are by that very fact psychologically invasive

The fact that the survey carries a "guarantee" by its administrators of confidentiality is certainly an ethical imperative, but it is not the only ethical imperative that must be followed. Ethical considerations related to respecting research subjects as whole persons are paramount because the survey instrument is not only a tool for gathering data about sexual behavior, but it is also an intervention that is educational and therapeutic in its potential impact on the respondent. The survey that asks about sexual behavior is therapeutic in that it reaches into the respondents' personal inner core *and alters it.* It is educational in that it sends a message about sexuality under the authority of the survey administrators. Such interventions, whether educational or therapeutic in their impact, may be harmful in some cases to the healthy emotional, moral and social development of the adolescent.

Principle #4: The survey not only questions, it also teaches

A prominent educator in the abstinence movement has pointed out that any survey that purports to measure sexual behavior change *teaches adolescents at the same time that it questions them.* When the subject is sex, school officials and parents have an instinctive sense of boundaries being crossed. The survey teaches and

[4] *Robert T. Michael, John H. Gagnon, Edward O. Laumann, and Gina Kolata, Sex in America: A Definitive Survey, Little Brown and Co., 1994, p. 16.*

asks questions about personal sexual behavior to the adolescent in a *value free context*, and in so doing sends a message that contradicts the norm building essence of A–H in Title V. This is especially true for the respondents in the "no treatment" comparison groups.

Principle #5: The same "whole person" principles of age-appropriateness apply to surveys as well as programs

A common assumption made by many persons committed to the methodology of survey measurement of sexual behavior change is that the content of the intervention and the instrument by which the intervention is being evaluated exist on two totally separate tracks. In fact, principles of sexual development apply to human subjects when they are survey-takers just as they apply to these same whole persons when they are in the classroom. The survey is a teaching instrument as well as a research vehicle, and as such, must be subject to the same principles of adolescent development and age-appropriateness that guide the intervention being evaluated.

The intellectual error plaguing the National Title V Evaluation and state evaluations is the concept that the programs that teach A–H and the survey research conducted to determine Title V program effectiveness exist in *two separate realms.* The assumption is that the program has educational purposes and potential impact that is social, psychological and cognitive, but the survey that is utilized as an evaluation tool has merely cognitive impact as an instrument for gathering data. The assumption that the subjects of the evaluation can, in a dualistic fashion, separate their cognitive selves from the rest of their whole personhood, is rooted in the empiricist/positivist school of behavioral research that is inappropriate for norm-driven programs that teach "abstinence until marriage as the expected standard for all school age children"

A Case Study Showing Emotional Harm to a Vulnerable 12-Year-Old Participant in a State Title V Survey

By an unexpected set of circumstances, there is a documented case of serious emotional harm that was done to a twelve year-old boy who experienced a negative reaction as a result of participating in a state level Title V survey that asked him questions about his personal sexual behavior. This case is known to the officials in the state where the incident occurred. Given the cloak of confidentiality in the evaluation process, few events like the case described below are likely to be reported outside the small circle of any state or national evaluation effort. If such adverse emotional impacts are encountered, most school officials, parents and teachers would have no knowledge of the event (unless it was reported to them by students).

In 2000, a state sponsored Title V evaluation survey was being administered in a cafeteria school setting to a number of students. The incident grew out of the emotional response of a 12 year-old boy who wrote the "F" word in letters so large on his survey booklet that it caught the eye of the survey administrator who was passing near his desk. The survey administrator was familiar with the school's policy against writing obscenities, and took the boy to the principal's office. The boy apologized to the survey administrator for his actions, but stated that many of the other students felt the same way. The principal made a decision to suspend the boy for 5 days from school. The boy was in a home without a father and apparently grew upset when he had to put down in the survey that his father was not in the home in which he lived. Already in an agitated state, the boy reacted strongly to the questions about his personal sexual life, and wrote the offending word in big letters across the page of the survey.

Human beings develop sexually as whole persons

If we review again the findings of *Sex in America*, the response of this 12-year-old boy is not that surprising. This young person, who is now 13 or 14 years old, is a whole person who longs, as any young person would, for his father. If he were, as the HIV/AIDS prevention theorists and their predecessor, Alfred Kinsey, believe, a "sole actor on the sexual stage," the question of whether his father was in the home or not should not have upset him so much. But whole persons have a sense of who they are and who they are is deeply shaped by the family structures in which they grow to maturity. This survey violated a young boy's personal core where he was exceedingly vulnerable.

As whole persons, human beings think, feel and act simultaneously as both agent and object. The methodology of measuring sexual behavior change by self-reported student responses assumes that adolescents can, with reasonable ease and assurances of confidentiality, transform themselves into objective, self-therapists who through their cognitive domain examine their sexuality in an objective manner. The

Sex in America findings confirmed that *moral norms were key to how the adults in their study formed their views of sexuality and their concepts of who they were (Sex in America, p. 240).* If we live as whole persons with our sexual attitudes and behavior, how can we assume that adolescents in their nature and sexual development are able to compartmentalize their sexuality and turn themselves into a subject for their own self study?

Albert Bandura, Stanford Professor and Former President of the American Psychological Association, in his major book, *Self-Efficacy: The Exercise of Control,* has this to say about the integrated nature of our subjective and objective consciousness as human beings. Bandura says that, "The duality of self as agent and self as object pervades much of the theorizing in the field of personality." We might also say that viewing the self in the dualistic framework of agent and object underlies the theoretical structure that pervades safer-sex/ HIV/AIDS research and the same intellectual error supports evaluating Title V through the use of surveys asking questions about sexual behavior. Bandura comments as follows:

"Social cognitive theory rejects the dualistic view of self.... It is one and the same person who does the strategic thinking about how to manage the environment and later evaluates the adequacy of his or her knowledge, thinking skills, capabilities, and action strategies. The shift in perspective does not transform the person from an agent to an object, as the dualist view of the self would lead one to believe." (*Self-Efficacy: The Exercise of Control,* p. 5.)

CONCLUSION

Under The Ethical Principle of "*Do No Harm*" No Group Surveys in K–12 Settings Should Include Personal Questions About Sexual Behavior

The concept that most survey-takers will go along with the survey is not sufficient justification for this method The typical survey asking questions about sexual behavior relies on the fact that most students will probably conform to the expectations of the survey administrators. Their emotions will prompt them to go along because the survey administrators have authority over them. But under the ethical principle of *"do no harm"* the concept that most survey-takers will go along with the survey is not sufficient justification for this method. The intrusive questions can do emotional harm to young people from any walk of life but, as shown in the case study above, the emotional harm can be serious when it affects young people who are already vulnerable and who may not have involved parents to opt them out of intrusive surveys. The vulnerable minority of students who are at risk in our society are the most prone to risk taking in terms of drugs, sex and alcohol, are clearly also the most vulnerable to questions that invade their personal core.

The evaluation of Title V should be rooted in the abstinence-until-marriage model's own distinctive theory base that supports programs that teach the norm that abstaining from sex until marriage is the accepted standard for all school age children." The fact that both risk reduction and abstinence-until-marriage programs have similar goals of pregnancy prevention and STD reduction does not mean that they are rooted in the same theory of sexual behavior change. Using Albert Bandura's social cognitive theory as the foundation, a credible alternative approach can be utilized to evaluate Title V programs. This new direction should not depend on measuring sexual behavior change by asking pre-teens or teens invasive questions about their personal sexual behavior. These questions invade respondents' personal inner core and can therefore cause harm to some adolescents' emotional development. Under the principle of **"do no harm" no adolescent should be placed at risk.**

Friends First
Longmont, Colorado 80502–0356
November 28, 2001

Ways and Means Committee

To Whom It May Concern:

I am writing you in support of the Title V abstinence education funding. As a former "Safe Sex" educator in Boulder Valley School District, I have observed first hand the damage that occurs by misleading adolescents to believe that sex outside of marriage is free from consequences. I will always regret teaching that philosophy to teens, but at the time I had no other choices or options.

Thanks to Title V, teachers and school districts now have choices to consider in sexuality education. Since starting FRIENDS FIRST in 1993, I have seen incredible improvements with the type of sexuality education offered to schools, families, and communities. I strongly encourage you to reauthorize the good work that Title V has begun. We need to offer communities this choice too. I am attaching some letters of support for abstinence until marriage education that we have done over the last five years.

Sincerely,

Lisa A. Rue
Certified Health Educator
President/CEO

[Attachments are being retained in the Committee files.]

Statement of Bob and Peggy Green, Cape Canaveral, Florida

We support this measure one hundred per cent as a way to teach our children that the God given gift of sex should be preserved for the marriage bed and that it is a healthy thing to remain chaste until marriage. Giving condoms which cannot prevent all STDs is not the answer. Thank you.

Statement of Leslee J. Unruh, President and Founder, National Abstinence Clearinghouse, Sioux Falls, South Dakota

BACKGROUND

As President and Founder of the National Abstinence Clearinghouse, I have an innate understanding of the problem of unwedded pregnancy—especially teen pregnancy—and the best, safest way to prevent premarital pregnancies. I have been working with both sexually active and virginal teens for over 17 years, convincing them that sex is best when saved for marriage. They can decide not to have sex, no matter what decisions they have made in the past.

I became interested in abstinence-until-marriage education after my husband and I founded the Alpha Center, a crisis pregnancy center, and The Omega Maternity Home, a home for pregnant girls and new moms, located in Sioux Falls, South Dakota. Through counseling clients and helping the mothers rebuild their lives, I came to realize that I was only treating the symptoms not the problem.

The real problem is not premarital pregnancy. The problem is premarital sex. Premarital pregnancy is a symptom of premarital sex. Admittedly, there are problems solely associated with premarital pregnancy and birth; for example mothers who have children outside of marriage are much more likely to live in poverty. However, there are also problems associated with promiscuity. The current worldwide HIV/AIDS pandemic and sexually transmitted disease (STD) pandemics have been caused by rampant sex outside of marriage. Premarital sex has also been linked to higher divorce rates,[1] teen depression and teen suicide.[2]

My call to work in abstinence-until-marriage education was further strengthened while my son, Chase, was in 3rd grade. When he brought home a textbook from his science class, I took the opportunity to review the material he was being taught. The information in the text and the pictures were far beyond what I as a parent and abstinence educator deemed appropriate for his age and development level. The graphics would have been considered pornography had they been in a magazine. These pornographic pictures were being used to teach my son about sex! In addition, the lessons supported the idea that everyone was having sex and there were no consequences if the female was on birth control. When children are given this lesson, it is no wonder that they become sexually active before they are married.

I lobbied state legislators in South Dakota and surrounding states to teach abstinence until marriage instead of comprehensive (condom) sex education. I began to speak to teens at churches and schools on taking charge of their lives. In my talks, I gave them a positive message that they do not *have* to become sexually active. For those who are already sexually active, I encourage them to make a change and to

[1] Joan R. Kahn and Kathryn A. London, "Premarital Sex and the Risk of Divorce," *Journal of Marriage and the Family* 53 (1991): 845–855.

[2] "The Troubled Journey: A Profile of American Youth" Search Institute, 1993. p. 8.

become secondary virgins. Studies have shown that most sexually active teens wish they had waited to have sex.[3] I give the non-virgins a message of hope for the future. For those who were raped or sexually abused, I tell them that even if they had experienced these terrible abuses, there is hope and they do not have to turn to sex to experience love. Simple evaluation forms passed out after each of my presentations showed that many who had been sexually active are choosing secondary virginity, and those who are still virgins choose to remain so until marriage. These evaluations are not longitudinal studies, but a review of the 1997 teen pregnancy rates revealed that the four states where our abstinence program had been presented had four of the five lowest teen pregnancy rates in the nation.[4]

In 1993, I began to network with abstinence speakers around the country through the Alliance of Chastity Educators (ACE). The goal of ACE was to exchange and coordinate abstinence-related ideas, projects and resources. As abstinence speakers, the other ACE members and I were bombarded by requests for trusted abstinence resources. It was obvious to all of us that a central location was needed where abstinence-until-marriage materials could be easily evaluated, accessed and requests processed. The ACE members all felt that we must be united in this effort because the need for abstinence-until-marriage education was too great for anyone to meet alone. I accepted leadership of the project, and the Abstinence Clearinghouse became officially operational in 1997.

The Abstinence Clearinghouse is the central location where materials and trainings are offered to effectively convey the abstinence-until-marriage message. The mission of the Abstinence Clearinghouse is to promote the appreciation for and practice of sexual abstinence (purity) until marriage through distribution of age appropriate, factual and medically-accurate materials. The Clearinghouse has a National Advisory Council, consisting of more than forty nationally known abstinence educators and supporters. In addition, the Clearinghouse and the Medical Abstinence Council is comprised of approximately 75 health professionals from across the country who are dedicated to not promoting or prescribing contraceptives to unmarried teens. We also have the Teen Abstinence Advocates who are committed to remaining sexually pure until marriage and an International Advisory Council consisting of individuals and organizations from across the globe working to promote abstinence in their own countries and communities.

ABSTINENCE DEFINED

There has been much debate as to what the definition of abstinence is. The members of the abstinence-until-marriage movement are not confused about the definition of abstinence. In fact, to end any confusion there may have been, the Abstinence Clearinghouse collected hundreds of definitions of abstinence. A panel of leaders in the abstinence-until-marriage field then decided on a definition. The abstinence-until-marriage definition of "abstinence" is as follows:

> "The commitment to not engage in any sexual activity prior to marriage. This includes intercourse, oral sex, anal sex, mutual masturbation and any genital contact or other contact that is sexually arousing."[5]

The true abstinence-until-marriage educators are not confused about what abstinence means. Those who claim there is confusion probably support so-called "abstinence-based," "abstinence-plus," "abstinence-focused" or other non-abstinence-until-marriage programs. Programs using these terms often include information about non-coital sexual behavior, contraception, safe sex and risk reduction while also mentioning not having sex as another option to avoid pregnancy and STD. These programs give a mixed message and confuse adolescents about what the best and expected behavior is.

MIXED MESSAGES

As a leader in the national abstinence-until-marriage movement, I always warn people to look out for "wolves in sheep's clothing." These are programs which use the word "abstinence" in the title but are really comprehensive sex education. They may also be programs that support abstinence, but do not teach the children when it is socially acceptable to be sexually active. True abstinence-until-marriage programs follow the Title V A–H definition and teach adolescents that sex is only healthy and socially acceptable in a committed marriage.

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[3] "Not Just Another Thing To Do: Teens Talk About Sex, Regret, and the Influence of Their Parents" National Campaign to Prevent Teen Pregnancy. June 30, 2000.

[4] "National and State-Specific Pregnancy Rates Among Adolescents—United States, 1995–1997" *CDC MMWR Weekly,* July 14, 2000/49 (27);605–611.

[5] *Abstinence Survival Kit*. Abstinence Clearinghouse, 2000. p. 13.

Programs that teach anything else give a fuzzy, mixed message. Programs that give the "abstinence until an adolescent is ready" message do not work. Every 16-year-old girl who thinks she is in love is "ready." When programs explain that it is best to wait until an adolescent is out of high school, students become pregnant outside of marriage during their early twenties. The greatest number of premarital pregnancies is currently in the 20- to 24-year-old age group, not the 15- to 19-year-old group.

Other programs say abstinence is best, but if you are going to do it anyway, here is how to "protect" yourself. What this mixed message actually does is lower the standard of expected behavior. This message gives permission for adolescents to have sex.

ARE CONDOMS PROTECTION?

A National Institute of Health study released July 2001, reviewed condom studies to determine the effectiveness of condoms against eight STDs—HIV, genital herpes, syphillis, gonorrhea, human papilloma virus (HPV), chlamydia, trichomonas and chancroid. The scientific panel found that condoms are 87 percent effective in preventing HIV transmission, and 40–76 percent effective against gonorrhea transmission from women to men, but only when they are used perfectly, during every sexual encounter. For every other STD there is no evidence that condoms slow transmission rates.[6]

HPV can cause genital warts. Some strains cause no external symptoms; with these strains, the carriers may never know they have it and spread the disease. The strains that have no symptoms cause 90 percent or more cervical cancer cases. Approximately 15,000 women are diagnosed with cervical cancer each year and 5,000 die. (Only 3,500 women in the United States die from HIV/AIDS each year.) HPV has also been linked to cancer of the penis. It is estimated that 20 million people have HPV, and 5.5 million more will contract the disease this year. There is no cure for HPV. The disease is spread by skin-to-skin contact anywhere from mid thigh to mid stomach. Condoms can not cover all that area, but a wet suit will stop the spread of HPV.

Condoms also can not stop the body from releasing oxytocin during sexual arousal. Oxytocin is a powerful hormone that creates permanent chemical bonds linking the person to their sex partner. Oxytocin allows men to vividly recall and mentally picture minute details of the sexual experience. In women, it creates an unbreakable linkage and emotional bond to their partner. Oxytocin explains why women will fight each other on national talk shows to keep a boyfriend who is currently sleeping with other women. It also explains why he is able to sit back, grin and enjoy his memories while they fight. Condoms do not stop oxytocin bonding.

Teens who are given condoms have a 20 percent pregnancy rate in their first year of sexual activity. There is no evidence that they will slow the spread of most STDs. Condoms cannot protect the heart against heartache or stop teen depression and suicide linked to teenaged sexual activity.[7] If premarital sex causes all of these problems and condoms do not stop many teens from becoming pregnant or contracting diseases, why are we giving condoms away with "safer" sex lessons? Why not tell the medically-accurate, factual truth that abstinence until marriage is the best and premarital sex, even with condoms is unhealthy?

THE EIGHTY PERCENT CONTRACEPTION, TWENTY PERCENT ABSTINENCE LIE

The good news is that abstinence-until-marriage education does work and it is being taught in more schools each year. According to the Alan Guttmacher Institute, 35 percent of schools teach abstinence-until-marriage programs.[8] The children and adolescents in these programs are not given destructive mixed messages or comprehensive sex education, but are taught the skills necessary to remain pure until marriage. Abstinence-until-marriage education was first given federal money in the early 1990s. The introduction of abstinence funds and abstinence education in schools coincided with the dramatic decreases in the teen pregnancy and abortion rates. Some groups claim that the decline of adolescent pregnancy and abortion was due 80 percent to better contraceptive use and only 20 percent to abstinence. These groups can not cite a source for these findings, as no factual, scientific study was ever published. Instead, it appears as though the numbers were made up and cir-

[6] "Workshop Summary: Scientific Evidence on Condom Effectiveness for Sexually Transmitted Disease (STD) Prevention" National Institute of Allergy and Infectious Diseases, National Institutes of Health and Human Services. July 20, 2001.

[7] "The Troubled Journey: A Profile of American Youth" Search Institute, 1993. p. 8.

[8] "Can More Be Done? Teenage Sexual and Reproductive Behavior in Developed Countries, Executive Summary" The Alan Guttmacher Institute. November 2001.

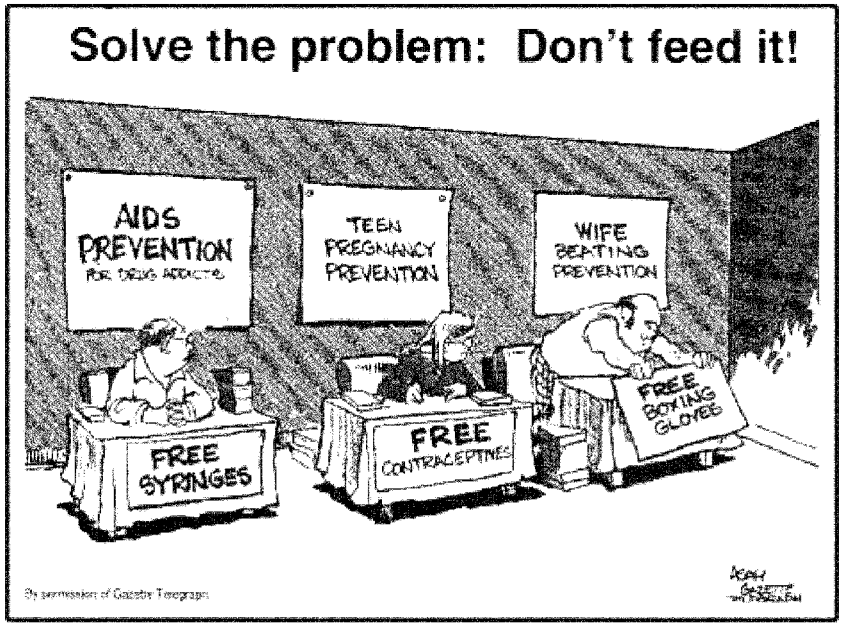
culated on a "talking points" memo. A study was done that supported abstinence as the sole cause of the decline.

The Consortium of State Physicians Resource Council commissioned the study, "Declines in Adolescent Pregnancy, Birth and Abortion Rates in the 1990s: What factors Are Responsible?". The group of 11 practicing physicians reviewed studies on types and frequency of contraceptive use by adolescents, sexual behaviors of adolescents and adolescent pregnancy, abortion and birth rates. The papers they reviewed came from a multitude of sources; a total of 45 articles were cited from organizations and journals such as the CDC, *JAMA* and *Family Planning Perspectives*.

The physicians concluded that "the evidence points to sexual abstinence, not increased contraceptive use, as the primary reason for the decline in teenage pregnancy and birth rates throughout the 1990s."[9] Furthermore the authors found that there is a correlation between increased condom use and higher out-of-wedlock pregnancy. According to the studies they reviewed, abstinence-until-marriage programs have a greater success at producing abstinence behavior than do comprehensive sex education and mixed message programs.[9]

CONCLUSION: SOLVE THE PROBLEM: DON'T FEED IT

Abstinence-until-marriage is the only 100 percent effective protection we can give our children and adolescents against premarital pregnancy and STDs. Let us not give them condoms and other contraceptives, which lead to unplanned pregnancy, HIV, HPV, heartbreak, depression and even future divorce. Let us give them a strong, clear message that abstinence and sexual purity is what is not only expected of them, but will also keep them healthy and happy. Let us give them abstinence-until-marriage education.



[9] "Declines in Adolescent Pregnancy, Birth and Abortion Rates in the 1990s: What factors Are Responsible?" The Consortium of State Physicians Resource Council, January 1999.

National Organization on Adolescent Pregnancy,
Parenting and Prevention
Washington, DC 20037
November 28, 2001

House Ways and Means Subcommittee on Human Resources:

The National Organization on Adolescent Pregnancy, Parenting and Prevention (NOAPPP) is a national membership nonprofit organization, with over 20,000 constituents and members from all fifty states who work in the field of adolescent pregnancy, parenting and prevention. Our members are educators, health professionals, administrators, and youth workers offering services to youth, parents and communities. Services are offered in schools, churches, neighborhood centers, hospitals, health facilities, and public institutions.

Our agency and our membership are dedicated to preventing teen pregnancy, and to providing the best possible services for those teenagers who become pregnant and who are parenting. Our goals are to increase positive health and education outcomes for all youth so they can reach their full potential, including those who are pregnant and parenting, and their children.

NOAPPP's Board of Directors has recently adopted two national policy statements that relate to Welfare Reform and Reauthorization and specifically address the following:

1) the high correlation between childhood abuse, interpersonal violence and teenage pregnancy, and
2) comprehensive sexuality education and abstinence education.

Based on our experience with our constituents representing over twenty years of work in the field of adolescent pregnancy, parenting and prevention, NOAPPP strongly recommends that both policy statements be considered as TANF reauthorization is being reviewed.

Thank you for the opportunity to respond.

Sincerely,

Mary Martha Wilson
Acting Executive Director

Policy Statement on Interpersonal Violence and Adolescent Pregnancy

Below is the policy statement of the National Organization on Adolescent Pregnancy, Parenting and Prevention, Inc. (NOAPPP) on interpersonal violence and adolescent pregnancy. The first section provides broad recommendations applying to a number of different fields. The third page has recommendations dealing solely with welfare legislation. These recommendations emanate from NOAPPP's value statements which, along with definitions, are described on page four.

The Policy

Interpersonal violence and adolescent pregnancy are intricately intertwined. While no national data are available on all aspects of the relationships between these two factors, evidence available from state and other data suggest that:

- Many adolescents are currently in violent or coercive intimate relationships. This is particularly the case for adolescents who become pregnant.[1]
- Many women who become pregnant as adolescents were violated or abused as children.[2]

Due to the link between interpersonal violence and adolescent pregnancy, NOAPPP makes the following recommendations.

1. NOAPPP recommends widespread efforts to inform, educate, and train practitioners and policymakers about the nature, extent and consequences of interpersonal violence and its links to adolescent pregnancy.

2. NOAPPP recommends that community-wide supports and resources be made available that incorporate links among the full range of relevant fields (e.g., health, education, violence and violence prevention, law enforcement and criminal justice,

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[1] Evidence from a variety of samples suggests that no fewer than a quarter of adolescent mothers experience some form of interpersonal violence in the year surrounding their pregnancy, with some studies reporting rates of 50 to 80 percent (Leiderman S., Almo C., Interpersonal Violence and Adolescent Pregnancy. CAPD/NOAPPP, 2001).

[2] For example, a study in the state of Washington suggests that up to 66 percent of pregnant teens report histories of abuse (Boyer D., Fine D., "Sexual Abuse as a Factor in Adolescent Pregnancy and Child Maltreatment," Family Planning Perspectives, Vol. 24: 4–11, 19, 1992).

mental health, and child and youth development). All supports need to be trauma-sensitive and provide non-stigmatizing opportunities for adolescents who have experienced or are experiencing interpersonal violence to identify themselves and seek support.

3. NOAPPP recommends trauma-sensitive comprehensive sexuality education that:

- Includes information on the prevalence of interpersonal violence in this country, and the different forms that violence can take in relationships;
- Includes a component on how to deal with coercive behavior; and
- Refrains from shame—and fear-based approaches as well as abstinence-only-until-marriage for they run the risk of re-traumatizing victims of violence.

4. NOAPPP recommends that abstinence-only-until-marriage as the sole strategy for adolescent pregnancy prevention is inappropriate for a number of reasons including the high levels of coercion and violence in the lives of adolescents. Since teens' ability to choose abstinence is often compromised, it is imperative that we give adolescents all of the information and skills they may need to prevent pregnancy and sexually transmitted infections.

5. NOAPPP recommends caution about promoting marriage among adolescents because of the prevalence of interpersonal violence in the lives of pregnant and parenting adolescents.

6. NOAPPP recommends that supports for adolescents who have experienced interpersonal violence should balance strategies that build on and reinforce their strengths and resiliency with strategies focused on acknowledging and recovering from trauma and victimization.

7. NOAPPP recommends resources to reduce or eliminate interpersonal violence in the lives of children and adolescents should be targeted to both men and women. Further, we believe it is important to acknowledge differences between the ways men and women experience violence in targeted programming and practice.

8. NOAPPP recommends that changes be made in subsidized housing programs and domestic and homeless shelters to ensure that adolescents and their children can be placed in safe, stable and supportive housing. Pregnant and parenting adolescents who experience interpersonal violence need safe places to live, both in the short term when they are in crisis and for the longer term as they parent their children.

9. NOAPPP recommends that practitioners have access to relevant best practices and receive training to identify typical consequences, behaviors, and attitudes stemming from violence and abuse and link adolescents with appropriate supports, programs, or treatment. They will also need to have access to secondary trauma support to prevent compassion fatigue.

Policy Recommendations Related to Welfare Reauthorization

1. NOAPPP recommends that the bonuses awarded to states that show the greatest reductions in the rates of out-of-wedlock births should be eliminated. This is consistent with our recommendation for caution when promoting marriage among adolescents. Rather, we recommend these resources be redirected to reducing rates of adolescent pregnancy through researched-based pregnancy prevention programs, including comprehensive sexuality education.

2. NOAPPP recommends that youth workers, eligibility workers, and others who influence or inform teens about TANF regulations should understand fully, publicize, and implement existing exemptions to the minor parent living arrangement provisions in TANF. Further, NOAPPP recommends transitional determinations of eligibility to give teens time and opportunities to disclose information about interpersonal violence in their lives. Safe housing must be provided that allows parents and children to stay together (unless the minor parent is the perpetrator of the violence).

3. NOAPPP recommends that each state and program review its regulations and practices with respect to paternity establishment, to make sure they are not putting adolescents at increased risk for interpersonal violence.

4. NOAPPP recommends that states affirmatively identify pregnant and parenting adolescents who have been victims of interpersonal violence and may have difficulty meeting the applicable work, school, or living arrangement requirements. For these adolescents, states need to provide a qualified program that:

- Re-establishes housing, income, transportation and other supports;
- Reinforces skills needed for school success that may have been disrupted by interpersonal violence; and
- Begins a process of healing and recovery.

NOAPPP's Related Value Statements and Definitions

NOAPPP's Board of Directors has adopted a set of seven value statements, which articulate the core philosophical beliefs of the organization. These value statements serve to inform the policies and practices of the organization. Four of these seven statements have particular relevance to the issues of interpersonal violence and adolescent pregnancy. These four statements are as follows:

- We believe that effective adolescent pregnancy, prevention and parenting programs are comprehensive, utilize research-based strategies, demonstrate an understanding and respect for the rights and capabilities of adolescents, and include a range of stakeholders in the decision-making, implementation and evaluation processes. We further believe that identification and evaluation of innovative strategies and promising approaches will serve the field.
- We believe that all children deserve to grow up in safe, nurturing environments that promote their healthy development. We further recognize the responsibility to address the multiple needs of children of young parents. We believe that individuals and organizations in the field must have access to the most current information on research, best practices, and fiscal resources, as well as professional growth opportunities.
- We believe that the involvement of families, communities, practitioners, schools, religious institutions and local, state, regional and national coalitions and networks is essential in addressing the issues of adolescent pregnancy, prevention and parenting.

Interpersonal violence (also called relationship or intimate partner violence): while there is no standard definition, interpersonal violence is usually defined as violent acts between individuals including throwing an object at someone, pushing, slapping, kicking, hitting, beating up, threatening with a weapon and using a weapon. Interpersonal violence may also include sexual assault, sexual abuse, stalking, psychological abuse, enforced social isolation, intimidation and the deprivation of key resources such as food, clothing, money, transportation or health care.[3]

Compassion fatigue: for a practitioner, cumulative feelings of being overwhelmed, exhausted and/or unable or unwilling to continue one's efforts to assist victims of maltreatment. Compassion fatigue is particularly likely to occur when a practitioner cannot access the resources to help everyone with whom he or she works, and/or when the root causes of the maltreatment persist.

Secondary trauma: trauma experienced by a practitioner (or other person) trying to support or treat an abuse victim. Secondary trauma can be the result of repeated exposure to overwhelmingly painful or graphic information (especially in high volumes) and/or from resurfacing of one's own past abuse or trauma as a consequence of working with others.

Trauma-sensitive: a condition of heightened awareness about the nature, extent and consequences of violence or abuse reflected in, for example, practitioner choices about how to work with young people, curricula offered, incentives and sanctions built into eligibility requirements and guidelines for programming, practitioner training, and legislative and other policies affecting young people.

Policy Statement on Comprehensive Sexuality Education

Below is the policy statement of the National Organization on Adolescent Pregnancy, Parenting and Prevention, Inc. (NOAPPP) on comprehensive sexuality education. The first section provides broad recommendations. The second section provides NOAPPP's value statements that are related to the issues of comprehensive sexuality education, and hence this policy statement. Definitions are provided at the end.

The Policy

With reference to NOAPPP's values, and based on currently available evidence of the effectiveness of various strategies:

1. NOAPPP recommends and encourages the teaching of developmentally and age-appropriate comprehensive sexuality education, as it holds the greatest hope for reducing the risk of sexually transmitted infections (STIs) and unintended pregnancy among adolescents.

[3] Technical Bulletin: Domestic Violence, No. 209, American College of Obstetricians and Gynecologists.

- NOAPPP believes the teaching of abstinence is an integral part of comprehensive sexuality education.
- NOAPPP supports comprehensive sexuality education because it is research and evidenced-based, religiously neutral, and free of fear-based and shame-based strategies.

2. NOAPPP recommends ongoing training and professional development opportunities for those involved in teaching sexuality education because we believe comprehensive sexuality education should be taught by trained, qualified instructors.
3. NOAPPP encourages open communication between parents and teens on the issues addressed by comprehensive sexuality education.
4. NOAPPP recommends that all children and youth have access to information and clinical services that meet their age, developmental and reproductive health needs. This is especially important for sexually active adolescents and teen parents, for whom secondary prevention is critical.
5. NOAPPP recommends that all adolescent pregnancy prevention programs require high quality quantitative and qualitative evaluation that is mandatory, not voluntary, and adequately funded at not less than 10 percent of the project's total budget.
6. NOAPPP is concerned that many adolescents believe they are abstinent even though they are participating in sexual behaviors which could lead to STIs, HIV and pregnancy. For this reason, we encourage the adoption of a common definition of abstinence which includes refraining from the full range of sexual activity that can lead to pregnancy, STIs or HIV transmission.

We encourage members and affiliates to use this policy to inform the development of state, local and/or institutional policies and standards.

NOAPPP's Related Value Statements and Definitions

The NOAPPP Board of Directors has adopted a set of seven value statements which articulate the core philosophical beliefs of the organization. These value statements serve to inform the policies and practices of the organization. Five of these seven statements have particular relevance to the issues of Comprehensive Sexuality Education.

These five statements are as follows:

- We believe youth can make responsible decisions about sexuality, pregnancy and parenting, as well as be effective parents when they have complete, accurate, culturally relevant, age-, gender-, and-developmentally-appropriate information, skills, resources and support.
- We believe that effective adolescent pregnancy prevention, pregnancy programs and parenting programs are comprehensive, utilize research-based strategies, demonstrate an understanding and respect for the rights and capabilities of adolescents, and include a range of stakeholders in the decision-making, implementation and evaluation processes. We further believe that identification and evaluation of innovative strategies and promising approaches will serve the field.
- We believe that both male and female partners are equally responsible for preventing early pregnancy, as well as supporting, nurturing and parenting their children.
- We believe that individuals and organizations in the field must have access to the most current information on research, best practices, and fiscal resources, as well as, professional growth opportunities.
- We believe that the involvement of families, communities, practitioners, schools, religious institutions and local, state, regional and national coalitions and networks is essential in addressing the issues of adolescent pregnancy, prevention and parenting.

Comprehensive Sexuality Education: developmentally appropriate sexuality education which provides complete, positive, accurate information on human sexuality throughout a person's lifespan, including, but not limited to: anatomy, human reproduction, intimate sexual behaviors, healthy relationships, sexual risk reduction and pregnancy prevention strategies (including abstinence and contraception), gender roles and stereotypes.

Evidence-based: information that is supported by research, recognized as accurate and objective by leading medical, psychological, psychiatric, and public health organizations and agencies, and, where relevant, published in peer-reviewed journals.

Abstinence: not engaging in any activity that puts one at risk for sexually transmitted infections or pregnancy.

Religiously neutral: respecting all religious traditions while not preferring or promoting any one over another.

Fear-based strategies: educational/motivational strategies that use misinformation and exaggeration or present 'worst case scenarios' as the norm, for the purpose of scaring people from engaging in any activity that might put one at risk for sexually transmitted infections or pregnancy.

Shame-based strategies: educational/motivational strategies that have the effect of shaming people for personal choices made relative to sexual conduct and behaviors or the consequences of one's choices.

Approved by the NOAPPP Board of Directors, June 2, 2001.

New Mexico GRADS
Roswell, New Mexico 88203
November 29, 2002

To whom it may concern:

I realize there are many aspects to the re-authorization of TANF, but I would like to address two issues that I am familiar with. I am the pregnancy prevention coordinator for a teen parent program in New Mexico that utilizes TANF funds to recruit teen parents who have dropped out of school. We provide child care and services to ensure that these teen parents graduate from High school. Our teen parents have a much lower repeat pregnancy rate and a much higher graduation rate than the national average for teen parents. We feel that the TANF funds have been well utilized for these important goals, and encourage re-authorization for these funds. I have reviewed TANF changes proposed by Rep. Patsy Mink, and feel many changes will be beneficial EXCEPT for the cut in incentives for pregnancy prevention.

Although non-federally funded abstinence programs began in some New Mexico schools in 1989, The Title V program of 1996 has proven to be an astonishing success in helping to reduce teen birth rates. After nearly 3 decades, (all through which the safe sex message prevailed) new statistics from the National Center for Health Statistics show a 22 percent decrease in teen birth rates from 1991 to 2000! We are on the right track and making significant progress in reducing the economic, physical and emotional burdens of teen pregnancy. Please ensure that these Title V funds continue this success.

Thank You,

Kathy Van Pelt
Pregnancy Prevention Coordinator

Statement of Pennsylvania Coalition to Prevent Teen Pregnancy, Harrisburg, Pennsylvania

Supporting Documentation for Position Statements

I. Parents/guardians are the primary sexuality educators of their children.

- Strong parent/child relationships that promote open communication about sexuality help prevent teen pregnancy.
- Parents should be supported in obtaining the skills and knowledge necessary to provide their children with clear, accurate and developmentally appropriate information. They should be encouraged to engage in an ongoing dialog with their children to provide the information, skills and values they need to grow into happy, healthy and sexually responsible adults.
- Children want their parents to talk with them about values, relationships and sexuality.

Resources

Effects of a Parent-Child Communications Intervention on Young Adolescents' Risk for Early Onset of Sexual Intercourse by Susan M. Blake, Linda Simkin, Rebeccca Ledsky, Cheryl Perkins and Joseph M. Calabrese.

Talking with Kids About Tough Issues, Children Now and the Kaiser Family Foundation

Talking with Kids About Sex and Relationships, Children Now and the Kaiser Family Foundation

Shop Talk, Volume 5, Issue 24, Parent-Teen Communication and the Initiation of Sexual Intercourse, SIECUS

Ten Tips for Parents, National Campaign to Prevent Teen Pregnancy

II. Young people deserve comprehensive and accurate information about sexuality and reproductive health.

Sexuality education is a lifelong process of acquiring information and forming attitudes, beliefs, and values about identity, relationships and intimacy. It encompasses sexual development, reproductive health, interpersonal relationships, affection, intimacy, body image and gender roles. Sexuality education addresses the biological, sociocultural, psychological, and spiritual dimensions of sexuality from the cognitive, affective and behavioral domain including the skills to communicate effectively and make responsible decisions. Sexuality education seeks to assist children in understanding a positive view of sexuality, provide them with information and skills about taking care of their sexual health and help them acquire skills to make decisions now and in the future.

- Sexuality education does not increase teen sexual activity.
- More than eight out of every 10 Americans believe that, in addition to abstinence education, young people should be given information about protecting themselves from unplanned pregnancies and STI's.
- Programs should begin early and encompass the entire educational experience of the child.
- Education should include information on both abstinence and contraception that is medically accurate.
- The most effective sexuality education programs will increase a teen's capacity and motivation to prevent pregnancy.
- Research indicates that effective curricula have the following characteristics:
  - Clearly focus on reducing one or more sexual behaviors that lead to unintended pregnancy or HIV/STI infections
  - Behavioral goals, teaching methods, and materials were appropriate to the age, sexual experience, and culture of the students
  - Are base upon theoretical approaches that have been demonstrated to be effective in influencing other health related risky behaviors
  - Last a sufficient length of time to complete important activities adequately
  - Employ a variety of teaching methods designed to involve the participants had have them personalize the information
  - Provide basic, accurate information about the risks of unprotected intercourse and methods of avoiding unprotected intercourse
  - Include activities that address social pressures on sexual behaviors
  - Provide modeling and practice of communication, negotiation, and refusal skills
  - Select teachers or peers who believe in the program they are implementing and then provided training for those individuals.

Resources

Effective, Comprehensive Sexuality Education by Anna Hoffman—Advocates for Youth

Guidelines for Comprehensive Sexuality Education, National Guidelines Task Force

Abstinence Based vs. Abstinence Only Sexuality Education, New Mexico Teen Pregnancy Coalition

Support for Comprehensive Sexuality Education Reaches Highest Level, Advocates for Youth & SIECUS

Abstinence Plus, Editorial, Philadelphia Inquirer, January 7, 2001

Sexuality Education: Our Current Status, and an Agenda for 2010 by Susan Wilson, Family Planning Perspectives

Sex Education: Politicians, Parents, Teachers and Teens, The Guttmacher Report on Public Policy

Changing Emphases in Sexuality Education in U.S. Public Secondary Schools, 1988–1999 by Jacqueline E. Darroch, David J. Landry and Susheela Singh, Family Planning Perspectives

9 of 10 Minnesotans Support Sexuality Education in Schools, Press Release, MOAPPP

Tune In—New Mexico Attitudes on Sex Education, New Mexico Teen Pregnancy Coalition

Teach Abstinence: Not IF, But HOW!, Family Life Matters, review of conference by Network for Family Life Education

No Easy Answers by Douglas Kirby, Ph.D.

Consensus Statement on Adolescent Sexual Health, National Commission on Adolescent Sexual Health

Fact Sheet: The Next Best Thing: Encouraging Contraceptive Use Among Sexually Active Teens, National Campaign to Prevent Teen Pregnancy

Teenage Sexual and Reproductive Behavior in the United States, Kaiser Family Foundation

Myth or Fact? 1998 Kaiser Family Foundation Survey of Americans' Knowledge on Teen Sexual Activity and Pregnancy

Abstinence Only Education: Why First Amendment Supporters Should Oppose It, National Coalition Against Censorship

III. Policy and program development addressing teen pregnancy prevention should be based on current research and proven strategies.

The experiences of developing countries, the experience of the United States during the mid-1950's to the mid-1970's, and the results from a small number of evaluations of youth development programs all suggest that programs that focus upon education, employment, and life options for young people may markedly reduce adolescent pregnancy rates. Pregnancy prevention initiatives must have multiple effective components that address both adolescent sexual behavior as well as the other contributors to teen pregnancy including poverty, lack of opportunity, family dysfunction, as well as social disorganization.

- Having a scientific basis for an approach shifts the focus from opinions about the best way to prevent teen pregnancy or about the consequences of taking a particular action toward the firmer ground of facts and validated experiences
- We support gathering information about youth behavior from the youth themselves with instruments such as the Center for Disease Control's Youth Risk Behavior Survey
- Research has shown that teens need a wide variety of preventive strategies to choose healthy options to avoid pregnancy
- Research indicates that evaluated programs that have been found effective have common characteristics:
    - Information about abstinence and contraception
    - Theoretical basis that emphasizes skill building
    - Focus on active learning through experiential activities
    - Acknowledgment of social and media influence on behavior
    - Age appropriate information and activities
    - Developmentally appropriate information and activities
    - Culturally appropriate messages
    - Exploration of personal values and feelings
    - Training for those implementing programs
- We can learn from other industrialized nations who have been more successful in preventing pregnancies, abortions and births among teens.

Resources

No Easy Answers by Douglas Kirby, Ph.D.

Effective Comprehensive Sexuality Education, by Anna Hoffman, Advocates for Youth

Solutions: Getting Real About Teen Pregnancy, Communications Sciences Group

Start Early, Stay Late: Linking Youth Development and Teen Pregnancy Prevention, National Campaign to Prevent Teen Pregnancy

Fact Sheet: The Next Best Thing: Encouraging Contraceptive Use Among Sexually Active Teens, National Campaign to Prevent Teen Pregnancy

Teens on Sex: What They Say About the Media as an Information Source

Adolescent Sexual Health in Europe and the U.S.—Why the Difference? By Sue Alford and Ammie Feijoo, Advocates for Youth

Campaign Prospectus: Enlisting the Help of the Media to Reduce Teen Pregnancy, National Campaign to Prevent Teen Pregnancy

Can the Mass Media be Healthy Sex Educators? By Jane D. Brown and Sarah N. Keller

IV. Young people should have access to safe and confidential sexual and reproductive health care.

- Our first priority should always be to encourage teens to delay sexual activity. However, no matter how much encouragement we give to youth to say "no", many will still become sexually active
- We support the Pennsylvania law that ensures confidentiality to teens seeking pregnancy testing, contraceptive services and diagnosis and treatment of STI's
- Between 85–95 percent of sexually active adolescent females who use no birth control method become pregnant within one year of initiating intercourse.

Resources

Adolescent Access to Confidential Health Services by John Loxterman, J.D., Advocates for Youth

Family Planning/Population Reporter, Vol. 6 No. 4

Family Planning and Adolescent Services, Family Health Council of Central Pennsylvania

Issues in Brief: Minors and the Right to Consent to Health Care, Alan Guttmacher Institute

Contraception Counts: Pennsylvania Information, Alan Guttmacher Institute

State Policies in Brief: Minors' Access to Contraceptive Services, Alan Guttmacher Institute

Serving Minors: Legal Guidance for Family Planning Providers by Susan Frietsche, M. Robin Maddox

Fact Sheet: The Next Best Thing: Encouraging Contraceptive Use Among Sexually Active Teens, National Campaign to Prevent Teen Pregnancy

The States in 1999: Actions on Major Reproductive Health Related Issues by Adam Sonfield, Anjali Dalal and Elizabeth Nash

V. The promotion of a culture that recognizes sexuality as normal and promotes respect and responsibility will lead to a reduction in negative consequences of sexual behaviors.

- Recognize that all persons are sexual and that sexuality is a natural, healthy part of living
- Model healthy sexual attitudes and behaviors
- Take responsibility for our actions
- Demonstrate respect and tolerance for others
- Teach that sexual relationships should never be coerced or exploitive
- Reject stereotypes about the sexuality of diverse populations
- Promote the rights of all people to accurate sexuality information
- Promote the development of healthy, non-sexual relationships.

Resources

Adolescent Sexual Health in Europe and the U.S.—Why the Difference? By Sue Alford and Ammie Feijoo, Advocates for Youth

Talking with Kids About Sex and Relationships, Children Now and the Kaiser Family Foundation

How to Talk To Your Kids About Anything, Children Now and the Kaiser Family Foundation

Ten Tips for Parents, National Campaign to Prevent Teen Pregnancy

Consensus Statement on Adolescent Sexual Health, National Commission on Adolescent Sexual Health

Reconceptualizing Adolescent Sexual Behavior: Beyond Did They or Didn't They? By Daniel J. Whitaker, Kim S. Miller and Leslie F. Clark

VI. Pregnant and parenting teens should have access to quality health care, education, and support services, with the main goal of promoting health and preventing repeat teen pregnancies.

All new parents are tested both financially and emotionally when their first child is born. For teen parents, the stresses are proportionately greater because they have not had the time to become fully independent adults. Teenage parents often experience inequity in education and encounter discrimination when they seek housing and jobs. Teenagers with children face a greater risk of not completing high school or finding the resources to pursue a college degree. More often than not, these young adults must nurture their children while living in poverty or on the edge of poverty.

- Repeat births to teenagers carry high individual and societal costs

• One-third of pregnant teens receive inadequate prenatal care; babies born to young mothers are more likely to be low birth weight, to have childhood health problems and to be hospitalized than are those born to older mothers
• In 1997, 1 of every 6 (17 percent) adolescents had no health coverage
• 50 percent of adolescents who have a baby become pregnant again within two years of the baby's birth
• In 1996, 22 percent of all births to 15–19 year old women in the U.S. were repeat births
• Households begun by teens account for 44 percent of the welfare caseload and over half of all welfare expenditures go to families started by a teen birth
• The federal government spends approximately $38 billion a year to families that began with a teen birth and invests only $138 million a year in preventing teen pregnancy
• Repeat childbearing is common in all race and ethnic groups

Resources

Why Invest in Teen Parents, Alliance for Young Families
Sex and America's Teenagers, Alan Guttmacher Institute
Facts prepared by Dr. Marianne E. Felice, UMASS, for Campaign for our Children, Inc.
Centers for Disease Control Fact Book 2000–2001
Births and Deaths in the United Sates, S. J. Ventura, K. D. Peters, J. A. Martin & J. D. Maurer, National Center for Health Statistics
Teen Pregnancy and Parenting Issues in Pennsylvania by Anastasia Snyder
Cost Study, Advocates for Youth

Statement of Kathleen M. Sullivan, Director, Project Reality, Glenview, Illinois

Project Reality, a 501(c)(3) not-for-profit organization, though not funded by any federal agency, is one of the largest abstinence education providers in the country. The attached annual Illinois Project Schools Report illustrates how we served 52,000 students in 350 schools in Illinois during the 2000–2001 school year. Our programs are a remarkably cost-effective approach to teaching abstinence until marriage as *the* healthiest lifestyle choice for adolescents, thus not only addressing the teen out-of-wedlock pregnancy problem but the emotional and medical problems associated with adolescent sexual activity.

Our successful experience in Illinois over the last 16 years is now beginning to be replicated in many other states as a result of the funding provided by Title V block grants through *The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (P.L. 104–193)*. Reauthorization of this provision, and a substantial increase in the appropriation for it, would be THE most cost effective approach to ensuring the emotional and physical health of our young people across the nation.

Statement of Project Reality, Glenview, Illinois

Illinois Project Schools Report 2000–2001

Project Reality, a 501(c)(3) not-for-profit organization, has been a pioneer in the national field of adolescent health education, developing, teaching and evaluating abstinence-centered programs in the public schools since 1985. Project Reality has administered three divisions for more than a decade under a grant funded by the State of Illinois Department of Human Services. Two divisions have sites throughout the state. The third is concentrated in the City of Chicago. In addition to abstinence curricula and related materials, in-service teacher training seminars are provided for all participating schools, as well as a variety of motivational speakers for school assemblies.

During the 2000–2001 school year, Project Reality conducted five ***REALITY CHECK*** rallies in four high schools in the Chicago area and 32 school assemblies and presentations throughout the state. These inspiring and educating events reached **16,535 teens** and 225 parents with an exciting reinforcement of the instructional program we provide in their schools.

In May 2001, Project Reality published and introduced an exciting and innovative new abstinence text ***A. C. Green's GAME PLAN Abstinence Program*** developed in conjunction with NBA "Ironman" A. C. Green.

The three divisions and a brief description are as follows:

Middle School Division, Statewide, Grades 6–10

Eight-unit series with strong medical emphasis. Values-based, abstinence-focused curricula that gives teens the information and training they need to discover for themselves that abstinence until marriage is the "best choice" and helps them reduce at-risk sexual behavior. Includes student workbooks and teacher manuals.

In 2000–2001, served 32,480 students in 217 schools

Senior High School Division, Statewide, Grades 10–12

A 15-unit program emphasizing the abstinence concept as the healthiest way of living. By stressing the composite approach of saying "No" to pre-marital sexual activity, drugs and alcohol, young people learn that maturity is learning how to think of others rather than self and to set long-range goals instead of indulging in immediate pleasure. Includes both a student workbook and a parent/teacher manual.

In 2000–2001, served 4,335 students in 33 schools

Chicago Division (Southwest Parents Committee), Grades 7–11

A two-part series presented by a seven-member team whose credentials include medical, educational and bilingual training. The presentations explain the emotional as well as physical benefits for adolescents who choose abstinence until marriage as "the healthiest lifestyle." Each session includes lively discussions, role-playing, and question and answer periods. Separate presentations for parents are provided.

In 2000–2001, served 11,064 students and 961 parents in 99 schools

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Statement of REACH (Responsibility Education for Abstinence, Character & Health), Arcanum, Ohio

I am writing in support of the reauthorization of federal funding for abstinence education under Title V of the Welfare Reform Act. I write primarily as a concerned parent of two (soon to be 3) teenagers. I want to protect our children from the heartache, regret, and physical consequences of premarital sexual activity. As parents, we want to inform and inspire our children to commit to sexual abstinence until marriage and avoid risk behaviors in general.

That too, is the guiding principle for the organization I direct. R.E.A.C.H. is a non-profit organization founded by a group of concerned parents and professionals. We are also current recipients of Title V Abstinence Education Funding in Ohio. Our purpose is two-fold—to help parents, schools, and the community in promoting:

1) **Character Education** in children through education and the practical application of such basic principles as honesty, self-discipline, patience and respect for self and others. Strong character is the foundation for ethical and wise behavior. Our society has changed—even since we were young. Too often, self-sacrifice has been replaced by self-absorption, patience for immediate gratification, honesty for deception. We are experiencing a crisis of character in our nation, which is showing itself in a variety of irresponsible acts (violence, inappropriate sex, drug/alcohol abuse, etc). It is our character that determines our behavior. It's who we are when no one is looking. Character is the internal motivation demonstrated by our outward conduct. Character education says "You do not have the right to do wrong". It places personal responsibility and self control within the definition of freedom. It teaches and reinforces universal core ethical virtues within the context of family and community.

2) Character-Based **Abstinence Until Marriage Education** as the only safe and wise choice—physically, emotionally and socially. With the incidence of sexually transmitted diseases among teens reaching epidemic proportion, contraceptive education is NOT a medically safe solution to the problem. We must challenge youth to the higher standard of risk elimination (abstinence), not merely risk reduction (contraceptive education). R.E.A.CH is committed to help teens choose the healthy choice of character-based pre-marital abstinence. With the onslaught of messages from our sex-saturated society, youth often believe the lie that "everybody's doing it", when in actuality, everybody is NOT doing it. Recent research shows that teens want to hear a clear message of abstinence from parents and adults. Abstinence-until-marriage education gives youth the skills, knowledge, and motivation to say "no" to risky behavior, guilt, STDs and instant gratification and "yes" to future goals, self-control, self respect, and faithfulness within marriage.

REACH is in the midst of its third year of program services to Ohio. Funded under Title V, with the Darke County Educational Service Center as our fiscal agent, we serve both Darke & Preble Counties in Ohio. The community collaboration has increased each year as citizens, schools, and agencies recognize the value of character-based abstinence education. **Until funding under Title V** was approved, the rural counties we serve did not receive any comprehensive abstinence education. Today, however, we provide valuable services to every school in these two counties. REACH seeks to saturate both counties with the motivational and educational components of character and abstinence until marriage education, involving those sectors of society that exert the greatest influence over youth's lives: parents, schools, churches, peers, health care providers, and the media. Utilizing both knowledge and ideas of traditional and grassroots innovations, the goal remains to reduce sexual activity, pregnancy and birth rates among unmarried teens. This past year (2000–01), REACH served 21,465 students and adults.

As is true of all risk behaviors, premarital sexual activity is a symptom of a much deeper concern involving the character choices of that individual. Learning and internalizing the character strengths of self-control greatly decrease the onset of sexual activity. Primary and secondary risk prevention focus on skills and character asset building. Schools teach character based abstinence education in an age appropriate manner. Grades K–6 focus on foundational character education, with grades 7–12 building on character foundations for abstinence education. Character education, coupled with the social, psychological, economic and medical benefits for choosing premarital abstinence, help teens avoid risk behavior in favor of self sufficiency and the attainment of life goals. The choice of renewed virginity is discussed and offered as a valid choice for those who are already sexually active. Stress is given to the fact that, while we can't change what happened yesterday, we can decide what we do tomorrow. Additionally, abstinence commitment cards are used as an integral part of the REACH program. Studies confirm that those teens who make a pledge to abstinence until marriage—are much more likely to wait before becoming sexually active.

Professional training seminars give teachers, social workers, medical professionals, community youth advisors, peer leaders and parents workable strategies for steering youth toward a new or renewed commitment for abstinence.

Parent proficiency is a vital component of all REACH services. We focus on providing parenting information related to character training and abstinence education for parents to use with their own children. Media awareness sets the stage for requests for services and for raising the awareness of the need for parent involvement in developing assets in youth.

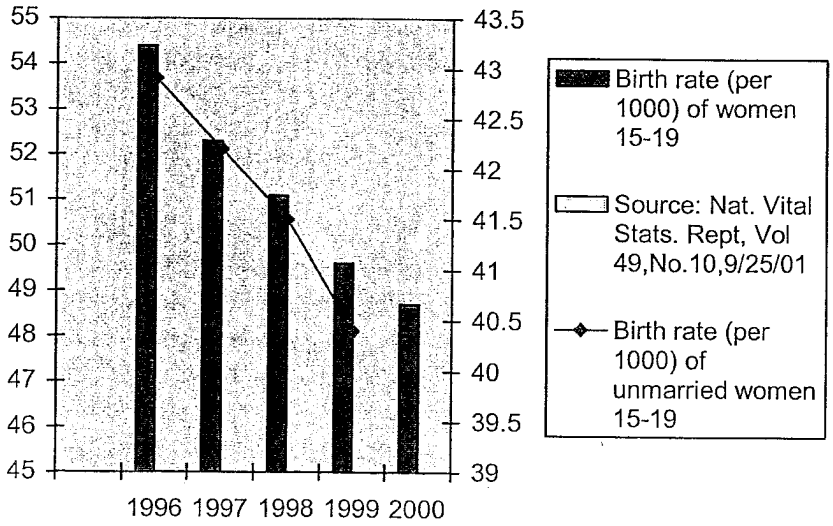
Each component is statistically evaluated using pre/post testing, exit surveys, and process evaluations. Special effort is made to appraise the success in reaching those members of the community who most need the character based abstinence message. Analysis of teen birth rates and STD rates are be used to measure project success. Since REACH began service provision, birth rates have decreased in the counties we serve.

Abstinence funding under Title V has made the difference in the quality of the message and the content of the teaching in our schools. In addition to the process results measured in terms of increased exposure to character-based abstinence content, children and youth in Darke and Preble counties in Ohio are sharing measurable changes in attitudes and reported behavior. We hired an independent team to evaluate the success of the REACH program for character based abstinence education. Consider these results:

- 50 percent of students surveyed made new abstinence until marriage pledges as a result of REACH services.
- The percentage of students seeing lots of benefits to waiting for sex until marriage increased significantly, girls feeling more strongly than boys in pre/post testing (54.5 percent to 62 percent) (p. 01)
- The percentage of students disagreeing that sex is okay if the partners agreed increased significantly, girls being influenced more than boys, and younger students believing more strongly in abstinence (55.7 percent to 63.8 percent girls)
- Both males and females said they will wait for marriage to have sex, girls and younger students believing more strongly
- The majority of students stated positive reactions to the REACH program (56 percent rated excellent or good) (58 percent claimed it helped in their commitment to abstinence)
- Parents in our service area almost universally support the "abstinence until marriage" practice for their children (phone survey—90 percent)

• Responses to motivational speakers supporting abstinence until marriage was overwhelmingly positive. Over sixty (60) percent stated commitment for abstinence, forty-five (45) percent indicated that as a result of REACH services, they were going to make positive changes in their personal lives, and over thirty (30) percent said they would start respecting those they date. Once again, females and younger students responded more positively.

The charts that follow visually demonstrate the positive results of abstinence until marriage education:



A COMPARISON OF STRATEGIES FOR ADDRESSING TEENAGE SEXUAL ACTIVITY

	Risk elimination	Risk reduction
Common name	''Abstinence Until Marriage''	''Safer Sex''.
Success indicator	Reserve sexual activity for marriage	Increase usage of condoms.
Effectiveness in the **reduction of out of wedlock pregnancy/birth**.	**100 percent effectiveness** (no sexual activity=no pregnancy). ''Abstinence and decreased sexual activity among sexually active adolescents are primarily responsible for he decline during the 1990's in adolescent pregnancy, birth and abortion rates.'' [1].	Up to 24 percent of teens relying on condoms become **pregnant in the first year of use.[2]** Furthermore, **''out of wedlock birthrate among sexually experienced and sexually active female teens has increased** since 1988, despite a significant increase in condom use by this cohort''.[3]
Effectiveness in the prevention of STDs (sexually transmitted diseases).	If two virgins marry each other and remain faithful, **no STDs will be transmitted.[4]**.	**Condom usage provides no risk elimination for any sexually transmitted disease.** There is, however, an 85 percent risk reduction for HIV, as well as some risk reduction for gonorrhea for men. This effectiveness however is only noted when condoms are used correctly and consistently—100 percent of the time. There is no condom protection for the sexual transmission of HPV, one of the most common STDs and the cause of 99 percent of cervical cancer, a cancer causing the death of almost 5000 American women a year (more women than die of AIDS). **No effectiveness** has been demonstrated in the effectiveness of condoms against five other STDs (chlamydia; syphilis, chancroid, trichomoniasis, genital herpes).[5]
Effectiveness in the **delay of onset of sexual activity before marriage**.	Those who made a pledge for abstinence **delayed sex 1 to 2 years longer than their peers.[6] Teens who personally commit to abstinence until marriage delay sex significantly compared to those who don't.[7]**.	**Earlier sexual debut translates into more lifetime sexual partners and a consequential increased risk of acquiring an STD** Students in Sweden (a country held as a model for comprehensive sex education) are beginning sexual activity at earlier and earlier ages, even though contraceptives are easily accessible to all.. Although these findings can't necessarily be generalized, the results are noteworthy.[8]
Funding for each strategy	$50 million per yr for 5 years [9]	$700 million per year.[10]

[1] ''The Declines in Adolescent Pregnancy, Birth and Abortion Rates in the 1990s: What Factors Are Responsible'', Consortium of State Physicians Resource Councils, January 1999. [2] Fu H, Darroch JE, Haas T and N Ranjit N. ''Contraceptive Failure Rates: New Estimates from the 1995 National Survey of Family Growth'' Family Planning Perspectives, 1999, 31 (2):56–63. [3] ''The Declines in Adolescent Pregnancy, Birth and Abortion Rates in the 1990s: What Factors Are Responsible'', Consortium of State Physicians Resource Councils, January 1999. [4] C. Everett Koop, MD, former US Surgeon General: ''When you have sex with someone, you are having sex with everyone they have had sex with for the last ten years, and everyone they and their partners have had sex with for the last ten years.'' [5] (National Institutes of Health report: ''Scientific Evidence on Condom Effectiveness for STD Prevention'', June 12,13, 2000). [6] Beerman, P., Bruckner, H.. ''Promising the Future: Virginity Pledges as they affect the Transition toFirst Intercourse'' American Journal of Sociology, Jan. 2001. [7] National Institutes of Health News Release, ''Virginity Pledge Helps Teens Delay Sexual Activity'' January 4, 2001. [8] Forsberg, Margareta, ''Adolescent Sexuality in Sweden—A research review 2000'', Swedish National Institute of Public Health). [9] Section 510 of Title V, Abstinence Education Funding of the Welfare Reform Act of 1996. [10] Scott Evertz.

Abstinence education raises the bar of expectations for young people by challenging them to choose abstinence until marriage, while other programs only focus on pregnancy prevention and reducing the teen birth rate. Far from being a 'just say no' model, abstinence education focuses on the whole person—physically, emotionally, socially—encouraging them to set future goals and make good decisions related to all life choices, not the least of which is a commitment to abstinence. A choice for abstinence is really about saying, "yes" to the rest of your life. Any successful society relies on the very strengths that are built in abstinence education, for life achievements are gained by exchanging self gratification for consideration of others; instant satisfaction for self control. Strengthening and developing character is an integral component, since responsibility, respect, and self worth are all tied to the choice of premarital abstinence. Abstinence education teaches resistance skills, resiliency strengths and asset building techniques. It encourages and equips parents to take an active role in teaching their children the value of abstinence, since the abstinence paradigm believes that parents should be the primary sex educators of their children. The wisest usage of taxpayer money includes abstinence education. **Abstinence education only costs about $25 per person.** Each teen who chooses abstinence rather than sexual activity will save taxpayers much more than that 25-dollar investment. Every teen who doesn't get pregnant—because they choose abstinence, saves taxpayers a minimum of $14,000 each year. Each teen that doesn't get an STD because they choose abstinence saves taxpayers a minimum of $400 in basic STD treatment each year. That's quite a return on investment! $25 investment for a savings of about $15,000 per student!

Beyond a strictly financial savings, however, don't we want to encourage our next generation to choose the best future for themselves, and their children? Study after study agrees that children born within marriage stand a better chance for future success and parents who are married are more financially secure—allowing them to build a good nest for their babies—and reducing the burden on taxpayers for financial support.

For too long, we adults have not believed that teens have the self control and character strength to wait on sex. We have encouraged behavior that is not safe, adding, "make sure you use a condom." Abstinence education raises the bar of expectations for our youth. Abstinence education says, "You have value; you have potential; you have the capacity to make the healthiest decisions for your life—saving sex for marriage" and then we provide the skills and encouragement to do just that.

Abstinence Education isn't "just say no" education. It's so much more comprehensive and positive than that. It helps children develop character so they have the inner strength and drive to make good choices, not only in the area of sexual activity, but in many life decisions. Abstinence Education is effective. Consider sample comments we received after being in schools in Darke & Preble Counties: "Before (you came), I was thinking of committing suicide . . . but after (wards), I realized that I have a whole life ahead of me," and another, "You were an inspiration. You made me think twice about my future decisions. I'm glad you came" and yet another, "I thought about sex and doing it, but now I'm going to save myself", and finally, "I found it the most impacting presentation I've seen since I began attending school".

For the many reasons stated above, I encourage you to continue funding for abstinence education. Compared to the numerous federal dollars going toward family planning, the funding for abstinence education is negligible. In the interest of health for our children, I encourage funding reauthorization for abstinence education at an amount that reaches parity with family planning dollars. If you desire any additional information about the success of abstinence education in our state, I would be happy to supply it.

Please help us impact the next generation for health, and success by funding abstinence education, Thank you.

Statement of William (Bill) Wood, Charlotte, North Carolina

In my spare time, I volunteer to help families and children in the State of North Carolina and around the country. I am a principal custodian of a 10 year-old girl and this statement does not necessarily represent the views, or the opinions of any other group or individual other than me.

Forward

For the first time in American History, we stand at the edge of a cliff, facing the almost certain possibility of falling off the edge if we do not act swiftly, decidedly, and with certainty. This precarious position is not from outside terrorist attacks, though certainly the infamy of the horrible atrocity of September 11th will never be forgotten; this precarious position is one where we stand directly at the crossroads of creating the self-sustained internal destruction of our country by the rising tide of illegitimacy, now exceeding ONE–THIRD of all child births [1] coupled with the directly related problem of divorces affecting 50 percent of marriages.

It is imperative that our legislators and all Federal and State elected representatives take swift, decisive, and certain actions to shore up marriage, and to immediately stem the tide of divorce. Otherwise, just as the Titanic sunk to the bottom of the ocean with a relatively small breach in its hull, so America faces the very real possibility of becoming a footnote to a once great Nation in future history books.

This paper is for the millions of voiceless children represented by this issue who are not able to offer their own testimony. It is not meant to be more child centered propaganda by special interests claiming to represent children. Yet these special interests somehow routinely miss the mountains and volumes of social studies data proving that their "deadbeat" special interest policies joined with "deadbeat" government actions are the direct cause of the suffering of those children. Both the unwed teen mothers, and the children of those mothers alike suffer from these "deadbeat" special interests.

Introduction—Roots must be identified

I am particularly partial to a quote by American Author Henry David Thoreau (1817–1862), where he says;

> *There are a thousand hacking at the branches of evil to one who is striking at the root.*

We can easily spend a lifetime "hacking at the branches" of illegitimacy, but until we begin to "strik[e] at the root," the problem will persist and will continue to grow worse. Getting close to "the root" requires that we look at what illegitimacy is in order to understand how to change it.

> *illegitimacy—The state or condition of a child born outside a lawful marriage.—Also termed bastardy*.[2]

Illegitimacy by its very definition and meaning is narrowly defined as a condition of childbirth outside of marriage. Therefore, any discussion, program, and issue that is intended to deal with illegitimacy must address marriage (and conversely divorce) or it does not deal with the roots of illegitimacy. For some special interests, the subjects of marriage and divorce are particularly charged with a tremendous amount of acrimony and hatred for anyone daring to suggest that marriage must be promoted and divorce must be curtailed.

The Tide on Teen Pregnancy—our modern mess

Single motherhood, once lauded by the feminist icon "Murphy Brown," has thoroughly produced its cultural "poisoned fruit" (Candace Bergen and the feminists attacked then Vice President Dan Quayle for his support of the traditional family.[3] Though Dan Quayle's support of the traditional family was derided, his warning was quite prophetic in hindsight. Recently this issue was revisited by The Wall Street Journal;

> *[I]n the years since Mr. Quayle first raised the issue in his "Murphy Brown" speech, the number of single-mother families has grown by 25 percent, to 7.5 million. And though there has been some good news—teen pregnancies have leveled off, as has the African-American illegitimacy rate—the levels remain quite high.*
>
> *Indeed, by almost any measure (the likelihood of teenage pregnancy, of going to prison, of dropping out of school, of taking drugs) the risks escalate dramatically for those who grow up without a biological father in the home.*

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[1] National Center for Health Statistics, 1999.

[2] Black's Law Dictionary. Abridged Seventh Edition, pg 598. West Group (2000)

[3] June 1992, Vice President Dan Quayle criticized the TV show Murphy Brown for promoting single motherhood. Chaos ensued and he was incessantly ridiculed by Hollywood and the media. Candace Bergen wins an Emmy for her portrayal of Murphy Brown and begins another career giving commencement speeches on University campuses. [Author commentary] With the complete absorption of feminist, anti-family, anti-father philosophy so deeply entrenched in Hollywood, the media, and gaining a stranglehold over the courts, is it any wonder that families are being destroyed, children are suffering, and our culture is decaying?

National Center for Health Statistics reports that today nearly seven out of 10 African-American children are illegitimate—with the rates for Hispanics and non-Hispanic whites having risen, respectively, to 42 percent and 22 percent. Clearly this problem crosses racial barriers.[4]

Putting those numbers in human terms, we are approaching 7 out of 10 African-American children being born outside of marriage, just over 2 out of 5 Hispanics, and just over 1 out of 5 Caucasians. The raw numbers and huge percentage of illegitimate births is frightening. For example, according the a recent Washington Times article;

A record 1.3 million babies were born out of wedlock in 1999, marking the first time that a full one-third of all U.S. births were to unwed mothers, the federal government said yesterday.
The greatest failure of welfare reform is that the governors have grievously neglected the issue of marriage[,]. . . adding that only four governors, including President Bush during his the governorship of Texas, have promoted marriage in any way.
The sole reason that welfare exists is the collapse of marriage—it is a huge national tragedy that this country spends $1,000 subsidizing single parenthood for every $1 it spends trying to promote marriage and prevent illegitimacy.[5]

With Illegitimacy rates around 70 percent in the African-American community, where is the outrage, the demands, and the demonstrations by the Black Caucus or its leaders? If they will not represent the African-American Community then who will? What of the Hispanic leadership? The consequences of continued silence on these issues is frightening and devastating for their constituency.

What Social Science tells us about some of the causes of Illegitimacy

White teenage girls in 1988, without fathers at home, were 72 percent more likely than their father-present peers to become single mothers, while there was a 100 percent increase for black teenage girls,[6] other studies also reported up to a 600 percent increase in teenage illegitimate births.[7] In contrast, more involved fathers protect girls from engaging in first sex, lower the risk of using illicit substances, and also reduce the risk of violent behavior."[8] This protection "from engaging in first sex," or promoting abstinence, is the most certain way to reduce teenage pregnancy. Father-absence in teenage boys creates a 77 percent[9] to 100 percent[10] increase in the overall likelihood of fathering an illegitimate child and therefore, as the research has shown, perpetuating the father-absence cycle for another generation (or generations to come). Father-absence causes difficulty for girls in building a stable family in adulthood.[11] Teenage girls run a 92 percent greater risk of continuing the divorce cycle.[12] Fast forward to 1999 data and 71 percent of pregnant teenagers lack a father.[13]

How can the tide of illegitimacy be stemmed without addressing underlying issues such as "[d]aughters in single mother homes hav[ing] more negative attitudes toward men in general and their fathers in particular."[14] Or, "girls whose parents divorce may grow up without the day to day experience of interacting with a man who is attentive, caring and loving. The continuous sense of being valued and loved as a female seems an especially key element in the development of the conviction that one is indeed femininely lovable. Without this regular source of nourishment, a girl's sense of being valued as a female does not seem to thrive."[15] And another study "suggest[s] that father loss through divorce is associated with diminished self-con-

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[4] The Dad Deficit. Dan Quayle was still right. June 15, 2001. The Wall Street Journal.
[5] Unwed mothers set a record for births by Cheryl Wetzstein. The Washington Times. April 18, 2001.
[6] S. McLanahan. Demography 25, Feb. 1988, p. 1–16.
[7] Y. Matsuhashi et al. (1988). J Adolescent Health Care 10, 409–412.
[8] K. Harris et al. Paternal involvement with adolescents in intact families: The influence of fathers over the life course, presented at the annual meeting of the Am. Sociol. Assoc., New York, N.Y., August 16–20, 1996; Univ. of North Carolina at Chapel Hill, Chapel Hill, N.C., 27516, p. 28.
[9] W. Marsiglio Family Planning Perspective 19 Nov/Dec, 1987, 240–251.
[10] B. Christensen. The Family in America. Vol 3, no. 4 [April 1989], p.3.
[11] S McLanahan, L Bumpass. (July, 1988). Am J Sociol, 4, 130–152.
[12] Warren Farrell presentation at NCMC conference, 1992
[13] U.S. Dept. of Health & Human Services press release, Friday, March 26, 1999
[14] Brody and Forehand, Journal of Applied Psychology, 1990
[15] Kalter, American Journal of Orthopsychiatry, 1987

cepts in children . . . at least for this sample of children from the midwestern United States."[16]

The trend of illegitimacy requires the presence of a father in the daily lives of children. It is not just "participation" of a father in the lives of children. It is primarily the "presence" of a father:

> ***"The decline of fatherhood is a major force behind many of the most disturbing problems that plague America: crime and juvenile delinquency; premature sexuality and out-of-wedlock births to teenagers; deteriorating educational achievement; depression, substance abuse, and alienation among adolescents; and the growing number of women and children in poverty . . .***
>
> *Fathers are the first and most important men in the lives of girls. They provide role models, accustoming their daughters to male-female relationships. Engaged and responsive fathers play with their daughters and guide them into challenging activities. They protect them, providing them with a sense of physical and emotional security. Girls with adequate fathering are more able, as they grow older, to develop constructive heterosexual relationships based on trust and intimacy. . .*
>
> *Why does living without a father pose such hazards for children? Two explanations are usually given: The children receive less supervision and protection from men mothers bring home, and they are also more emotionally deprived, which leaves them vulnerable to sexual abusers . . . Even a diligent absent father can't supervise or protect his children the way a live-in father can. Nor is he likely to have the kind of relationship with his daughter that is usually needed to give her a foundation of emotional security and a model for nonsexual relationships with men . . .*[17]
>
> *"Fathers who actively engage in joint activities and interaction with adolescents promote their educational and economic achievement and fathers who maintain a close stable emotional bond with adolescents over time protect adolescents from engaging in delinquent behaviors."*[18]

Additional information about the impact of father involvement shows they "play a significant role in terms of adolescent functioning"[19] "teach them values,"[20] and "[enhance] their career development, moral development, and sex role identification."[21] "The continuing involvement of divorced fathers in families where mothers maintain physical custody has become recognized as an important mediating factor in the adjustment and well-being of children of divorce"[22] and "frequent contact with the father is associated with positive adjustment of the children."[23] "[A fathers] involvement with children diminishes some of the negative consequences of living with a single mother".[24]

Jonetta Rose Barras, a Washington D.C. columnist, in her recent book,[25] describes the lasting impact of fatherlessness on her and other women.

> *"Promiscuous fatherless women are desperately seeking love. Or we are terrified that if we give love, it will not be returned. So we pull away from it, refusing to permit it to enter our houses, our beds, or our hearts. To fill the void that our fathers created, we only make the hole larger and deeper.*
>
> *"If it is true that a father helps to develop his daughter's confidence in herself and in her femininity; that he helps her to shape her style and understanding of male-female bonding; and that he introduces her to the external world, plotting navigational courses for her success, then surely it is an indisputable conclusion that the absence of these lessons can produce a severely wounded and disabled woman."*

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[16] Children's Self Concepts: Are They Affected by Parental Divorce and Remarriage Thomas S. Parish, Journal of Social Behavior and Personality, 1987

[17] D. Popenoe. "Life without father." In: C. Daniels, ed. Lost fathers: The Politics of Fatherlessness in America. (New York: St. Martin's Press, 1998).

[18] H. Biller, Paternal Deprivation: Family, School, Sexuality, and Society (Lexington, Mass.: D.C. Heath, 1974), p.114.

[19] Thomas and Forehand, American Journal of Othopsychiatry, 1994

[20] Seltzer, Journal of Marriage and the Family, 1991

[21] Dudley, Family Relations, 1991

[22] Ahrons, and Miller, American Journal of Orthopsychiatry, 1993

[23] Ibid. Ahrons and Miller

[24] Seltzer, Shaeffer & Charing, Journal of Marriage & the Family, 1989

[25] Jonetta Rose Barras. Whatever Happened to Daddy's Little Girl?: The Impact of Fatherlessness on Black Women. One World Ballantine (2000). As noted by the author of "http://wheres-daddy.com/index.html" "Where's Daddy? The Mythologies behind Custody-Access-Support."

What about blended or "re-constituted" families?

While not a substantial portion of the problem, increases of child sexual abuse is certainly a contributing factor.[26] Child abuse occurs most frequently within stepfamilies, and, in fact, most sexual abuse occurs in stepfamilies.[27] Sexual abuse of girls by their stepfathers can be at a minimum six or seven times higher,[28] and may be up to 40 times [29] that of sexual abuse by biological fathers in intact families. There seems to be little substitute for the presence of a caring biological father. Children living with a mother and stepfather fared poorly on most indicators.[30] When it comes to the risk of abuse with unrelated males, Barbara Dafoe Whitehead explains:

> *"Stepfathers also pose a sexual risk to children, especially stepdaughters. They are more likely than biological fathers to commit acts of sexual abuse, and are less likely to protect daughters from other male predators. According to a Canadian study, children in stepfamilies are forty times as likely to suffer physical or sexual abuse as children in intact families."* [31]

It is worth noting that stepfathers cannot make up for the lack of a biological father. In fact, Maggie Gallagher notes:

> *"Children in stepfamilies do no better on average than children in single-parent homes . . .Failing to understand the erotic relations that are at the heart of family life, they [sociologists] failed to predict what, sadly and surprisingly, later research strongly suggested: Remarriage is not only not necessarily a cure; it is often one of the risks children of divorce face."* [32]

Between the years of 1975 and 1990, welfare incentives and feminist marriage hatred served to severely damage the foundations of American families. During this period, as entrenched feminist experiments denigrating marriage and fatherhood have excluded fathers from their children's lives, we find the marriage rate falling and the divorce rate rising. SAT scores had even fallen to all-time lows while teen births and the crime rate exploded. The divorce rate, teen birth rate, and the crime rate each doubled between 1975 and 1990. SAT scores fell in 1975 and then dipped below 900 for the first time in 1980. They have remained at that low level.[33]

Congress recently passed a program calling it a "Fatherhood" program, giving 150 Million dollars for the central focus and purpose of turning fatherhood into a paycheck. In reading the Testimony by Robert Rector of the Heritage Foundation,[34] it would appear that lip service was paid to the issue of fatherhood, but apparently a father-child relationship is completely useless. The only "counting" done in the "Fathers Count Act" is the counting of the amount of money that can be extracted from men. This in spite of the studies showing "[r]eceipt of child support does not appear to make a significant difference" and "the presence of a step-parent does not significantly improve a child's situation."[35] Or what about, 90 percent of fathers with joint custody pay the ordered child support. 79.1 percent of fathers with visitation rights pay the ordered child support. 44.5 percent of fathers with no visitation rights pay the ordered child support.[36] One must wonder, why the focus on increasing child support compliance when it is not the crisis that illegitimacy and fatherlessness is. It is both fascinating and bewildering that this appears to be the Congressional view of Fatherhood. What is funded in the "Fathers Count Act" to

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[26] A Sedlak (August 30, 1991). "Supplementary Analyses of Data on the National Incidence of Child Abuse and Neglect" (Rockville, Md.: Westat) table 6–2, p. 6–5. see also, Gomes-Schwartz, Horowitz, and Cardarelli, Child Sexual Abuse Victims and their Treatment, 1988 (69 percent of victims of child sexual abuse came from homes where the biological father was absent)

[27] David M. Fergusson, Michael T. Lynskey, and L. John Horwood, (1996). "Childhood Sexual Abuse and Psychiatric Disorders in Young Adulthood: I. Prevalence of Sexual Abuse and Factors Associated with Sexual Abuse," Journal of the American Academy of Child and Adolescent Psychiatry, Vol. 34, pp. 1355–1364.

[28] Diana E. H. Russell, (1984). "The Prevalence and Seriousness of Incestuous Abuse: Stepfathers vs. Biological Fathers," Child Abuse and Neglect, Vol. 8, pp. 15–22.

[29] See Wilson and Daly, "The Risk of Maltreatment of Children Living with Stepparents," p. 228.

[30] National Center for Health Statistics, June 1991.

[31] M Daly, M Wilson. Homicide (N.Y.: Aldine de Gruyter, 1988), p.89.

[32] M. Gallagher, (1996). The abolition of Marriage: How We Destroy Lasting Love. DC., Regnery Pub, Chapter 6.

[33] Index of Leading Indicators, Washington Times, 1994

[34] THE FATHERS COUNT ACT OF 1999. Testimony by Robert Rector of the Heritage Foundation before the Ways and Means committee. October 5, 1999. available online at; http://www.heritage.org/library/testimony/test100599 . html

[35] K. Harris. Reuters. Fathers' Care Benefits Children. N.Y., August 25, 1998.

[36] Census Bureau report. Series P–23, No. 173

create father-child involvement? Who is the real deadbeat? Why is Congress so enmeshed in its support of anti-marriage, anti-father special interests, and government programs that uselessly expend BILLIONS of taxpayer dollars[37] each year that no one wants to "rock the boat?"

For more extensive information on the issue of the current fatherlessness problem, please see my recently submitted Congressional Testimony on the US House of Representatives web site, Serial Number 107–38, June 28, 2001, regarding Fatherhood proposals;

http://waysandmeans.house.gov/humres/107cong/6–28–01/record/chillegalfound.htm.

Also, please see the companion legal brief raising Constitutional issues related to fatherlessness that was submitted for the record in this same hearing, but ended up excluded from the official printed record at;

http://personal.clt.bellsouth.net/woodb01/Custody/Equal__custody__statement__of__william__wood.htm

Excerpts from California Governor Wilson's Focus On Fathers Summit (1995), sheds some light on the issues:

Wade Horn, National Fatherhood Initiative: Our 3 decade experiment with fatherlessness has failed. 23 million children will be sleeping in fatherless homes tonight. The divorce rate tripled between 1960 and 1980. 40 out of 100 families divorce now compared to 16 out of 100 in 1960. Illegitimacy has followed a geometric progression from 10.7 percent in 1970 to 33 percent today. 40 percent of children in fatherless homes have not seen their fathers for more than 1 year. 58 percent have never been in their fathers homes. 75 percent of single parent families live in poverty versus 20 percent of 2-parent families. Single-parent households produce: 60 percent of repeat rapists, 72 percent of murderers and 70 percent of long-term imprisoned. This is not an attack on mother-headed households. Fathers just do things differently and this can't be replaced with AFDC, Welfare, etc. Divorce has severe consequences on children. We must change the way we look at it. We are running out of time because soon the majority of children will be raised in single-parent families. The issue is father contact, not money.

In reviewing this commentary by the current Secretary of the Health and Human Services Organization, is it any wonder that anti-marriage, anti-family, and anti-father factions were so adamantly opposed to his appointment? In the face of all of the social studies data demonstrating the complete and utter destruction of children, families, and our future (our Constitutional "posterity"); Who was the opposition to his appointment really supporting?" When will someone actually speak for the children; the teenage mothers and their offspring, rather than supporting such culturally corrosive, completely failed, anti-father/anti-marriage programs and interests? Who is the real "deadbeat" here?

Hogan Hillings: We must promote father presence. Fatherlessness is a problem which feeds itself—a fatherless child grows up without a male role model and then has difficulty being a father to his own children. Fatherlessness is not a passing fancy that will go away. Human costs are larger than the dollar costs and the dollar costs are enormous. [Look at the] enormous size of the welfare and prison budgets.

1. Teen pregnancy must be stigmatized through education and responsible media.
2. Families must be strengthened because families are the best environment for children.
3. Policies must be developed to encourage and permit parenting by fathers.
4. Strengthen laws holding parents responsible for children's actions.
5. Develop male role models for the children of mother-headed households.

From the same summit, in the section "Causes and Cures for Fatherless Children" reveals an interesting view of our current "divorce-promotion" system (we call it "no-fault");

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[37] The Office of Child Support Enforcement expends taxpayer funds of nearly 5 BILLION dollars per year to continue a government run system that is essentially a "mess" based on garbage data, draconian, and arguably unconstitutional tactics as elaborated in previous testimony that I have submitted. Serial No. 106–107—H.R. 1488, The "Hyde-Woolsey" Child Support Bill, March 16, 2000, beginning on Page 94. Can be viewed online at; http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=106__house__hearings&docid=f:71291.pdf

Several public policies have been criticized by father's rights lobbyists as harming the crucial father-child relationship. Some public policies that exacerbate fatherlessness and abnormal childhood development are:

1. The use of so called "no-fault" divorce laws. This has made divorce easy and typically results in children having less time with their fathers.[38] *Marvin Mitchelson, a famous lawyer who specializes in man and woman relations, has been quoted as saying "The (present) easy grounds (for divorce) and no-fault system of divorce (in some states) mean that anyone can go to court and get a divorce with very little effort." . . . Some states still don't have no-fault laws, and those that do might consider repealing them for the childrens' sake.*

2. Awarding sole physical custody of children after divorce to one parent instead of joint physical custody. Several states have tried to make joint custody the default, and some states, like Washington, even permit joint custody over one parent's objection. Joint physical custody helps children get the fathering they need to develop normally.[39]

3. The non-enforcement of visitation agreements. This permits bitter exspouses to deny children visits with their fathers. Encouragingly, Arizona, Colorado and Illinois have passed laws that enforce visitation.

4. The immunity enjoyed by bitter divorcing spouses who file contrived restraining orders to separate children from their fathers. For example, a Massachusetts "2090A" restraining order prohibits children from having reasonable visitation and adequate fathering, and this is routinely justified by unproven allegations. California has recently passed a law, SB 558, which will hopefully allow more fathering in that state. It makes false convictions of child abuse a justification for change of custody.

5. The practice of putting children in day-care when divorced fathers are willing to care for them. Some states, like Virginia and California, have introduced legislation dubbed "Mrs. Doubtfire" bills that encourage children to be cared for by their fathers instead of sending them to day care facilities.

Conclusion

We are at a fork in the road in American History, we have been attacked from outside by terrorist forces bent on destroying our country, our culture, and our way of life. Yet inside, special interests who routinely use intentionally deceptive child-centered propaganda are causing little lives to be destroyed and are destabilizing our culture and our nation for generations to come. Only History will tell which forces, those external, or from within our own shores, will have more devastating or far-reaching consequences. Will we win the culture war that has been quietly escalating for decades with children and families as their ultimate casualties?

We can no longer afford to tolerate the special interest advocates of culturally corrosive and child destroying ideologies, promoting their anti-marriage, anti-father, "promiscuous free-for-all". No longer can we turn a "blind-eye" to single-parenthood, and engage in "Hollywood-esque" ridicule of those who would see the tragedy of single-parenthood for what it is.[40] Nor can we turn a blind-eye to the continuing carnage of generation after generation of failed welfare policies, failed "no-fault" divorce [41] experiments, and the social studies data showing the causal links to the de-

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[38] 67 to 75 percent of all divorces are initiated by the female partner: 74 to 80 percent of unilateral (non-mutual) divorces—Maggie Gallagher, The Abolition of Marriage: How We Destroy Lasting Love, Washington, DC: Regnery, 1996, who cites Frank F. Furstenberg, Jr. and Andrew J. Cherlin, Divided Families: What Happens to Children When Parents Part, Harvard University Press, 1991, p. 22. Ilene Wolcott and Jody Hughes, "Towards Understanding the Reasons for Divorce," Melbourne: Australian Institute of Family Studies, Working Paper No. 20, June 1999, as quoted in The Australian, 5 July 1999. Beuhler, "Whose Decision Was It?" Journal of Marriage and the Family, Vol. 48, pp 587—595, 1987. Braver & O'Connell, Divorced Dads, Tarcher Putnam, 1998, p. 34. Lynn Gigy & Joan Kelly, "Reasons for Divorce: Perspectives of Divorcing Men and Women," Journal of Divorce and Remarriage, Vol. 18, 1992. Braver, Whitley, Ng, "Who Divorced Whom? Methodological and Theoretical Issues," Journal of Divorce and Remarriage, Vol. 20, 1993.

[39] Please see my previously submitted legal brief on the Constitutional issues related to this. It was submitted for the June 28, 2001 Fatherhood proposal hearings but was excluded from the printed record. It can be seen online here; http://personal.clt.bellsouth.net/woodb01/Custody/Equal__custody__statement__of__william__wood.htm

[40] See earlier notes on Dan Quayle and the "Murphy Brown" incident.

[41] In fact, if one seriously considers the idea of "no-fault" it is a complete logical fallacy as practiced. "No-fault" simply means that the individual who is willing to shred the marriage contract bears absolutely no consequences for its destruction, or the attendant negative consequences for all of the parties. "No-fault" is an absolute guarantee that the "fault" will be

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struction of children. Our Constitution and the oaths that all elected officials take mandate that we must take a hard look at these issues, and make hard decisions for the "posterity" of our Nation. That posterity is our children and their children for generations to come. What examples and life-lessons will they pass on?

This Congress must also consider very seriously its place in History. Every administration and every Congress holds some place in the History books. Looking back some 50, 100, or more years from now, what will be the historical judgment and verdict of this Congress? With so great a resource of detailed social studies data available universally pointing to signs that we are taking our children in the wrong direction, what will you do? How will you stand up and support your constituent's children, and their children? How will the history books show your grandchildren you dealt with this hidden internal crisis?

Recommendations (several of them extracted from, or adapted from Governor Wilson's Focus on Father's Summit)

1. Make supporting marriage—not just marriage neutrality—the goal. Healthy marriages benefit the whole community. Conversely, when marriages fail, huge personal and public costs are generated. If we can help more marriages to succeed, it would be foolish and wrong-headed to settle for policies that are merely neutral about marriage. There is no neutrality with a state ensuring the end of the marriage contract through a "no-fault" fiction when one party objects to the end of a marriage.

2. Respect the special status of marriage. Do not extend the benefits of marriage to couples who could marry, but choose not to. Offering the social and legal benefits of marriage to cohabiting couples unfairly and unwisely weakens the special option of marriage.

3. Reconnect marriage and childbearing. Do not discourage married couples from having children as they choose, and encourage young men and women to wait to have children until they have made good marriages, not just until they have high school diplomas or turn twenty-one.

4. Do not discourage marital interdependence by penalizing unpaid work in homes and communities. Couples should be free to divide up labor however they choose without pressure from policies that discriminate against at-home parenting and other activities that serve civil society.

5. Promote both the ideal of marital permanence and the aspiration couples today have for more satisfying marriage relationships.

Require a portion of the TANF funds to be used to promote marriages and father involvement.[42] Award special "bonus grants" of TANF funds to foster marriage promotion ideas such as when, in 1999, then Texas Governor George W. Bush signed a bill increasing the marriage licensing fee by $5.00 to create a premarital education manual for distribution to all marrying couples and to fund new premarital and marital education research. In addition, then Governor Bush's bill directed county clerks to keep a register of premarital educators for supply to potential spouses and outlines suggested course content for premarital education.

Find ways to encourage states to enact pro-marriage and anti-divorce programs. In 1998 and 1999, governors in three states—Louisiana, Utah, and North Carolina—signed marriage proclamations, recognizing the importance of marriage to the public good. Sign a Federal Marriage proclamation and a Congressional Resolution recognizing the importance of marriage.

Reward those states that are successful in reducing divorce and encouraging marriage with additional TANF Fund block grants or other incentives. To successfully stem the tide of family instability could save the taxpayers untold BILLIONS AND BILLIONS of dollars in chemical dependency programs, welfare programs, child support collection programs, prison and jail construction, courthouse construction

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transferred to the party who does not desire or seek the destruction of the social contract of marriage. Because in "no-fault" the non-moving, non-divorcing party who often is TRULY NOT AT FAULT is crushed by the state divorce machine that guarantees the divorcing party in the action that they will receive that divorce with the full force and weight of the state divorce machinery in the courts.

[42] 5 Wm. & Mary J. Women & L. 1 (1998)—HOW JUDGES USE THE PRIMARY CARETAKER STANDARD TO MAKE A CUSTODY DETERMINATION. Page 37. "Compared with those [children] raised in intact two-parent families, adults who experienced a parental divorce had lower psychological well-being, more behavioral problems, less education, lower job status, a lower standard of living, lower marital satisfaction, a heightened risk of divorce, a heightened risk of being a single parent, and poorer physical health." (as cited from Paul R. Amato, Life-span Adjustment of Children to Their Parents' Divorce, in 4 The Future of Children page 146. (1994))

(and their additional staffing), and other assorted costs in productivity and generational dependency.

Federal and State governments have an obligation of promoting "a more perfect union . . . establish[ing] justice . . . insur[ing] domestic tranquility . . . promot[ing] the general welfare . . . and secur[ing] the blessings of liberty to ourselves and our posterity".[43] What better way to make good on this Constitutional principle for our children and grandchildren than to strengthen and promote marriage and family while reducing divorce.

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[43] As excerpted from the preamble of the US Constitution. This preamble sets these principles forth as the GUIDING PRINCIPLES FOR ALL CONSTITUTIONAL INTERPRETATION.