



State of Connecticut
GENERAL ASSEMBLY



Commission on Children

Connecticut General Assembly Public Health Committee

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Testimony of Elizabeth C. Brown
Legislative Director
Connecticut Commission on Children

Senator Handley, Representative Sayers, and members of the Committee, I am here today to testify in favor of Senate Bill 461, An Act Concerning Teen Age Pregnancy Prevention Programs.

The bill demonstrates Connecticut's commitment to promoting the healthy development of all children and adolescents residing in Connecticut. Research has shown that early childbearing has significant social, health, economic, and psychological costs for young parents and their children. More than 80% of teenage mothers and their children end up living in poverty. School dropout, low birth weight and premature babies, child abuse and neglect, childhood health problems and single parent families are often associated with teen pregnancy.

Connecticut's teen birth rate has declined by 27% over the last ten years, a rate of decline quite similar to the national average at 26%. The state's teen birth rate, however, has been much slower to decline among certain subgroups, falling only 12% among 18- to 19-year olds, and only 13% among Hispanic teens. Further, in some individual towns and cities, the percentage of births to teens has actually *increased* over the last several years (Richter, 2005).

Research has shown that with strong support, education, career preparation, work opportunities, health education, counseling and medical care, adolescents can be helped to delay parenthood until they are prepared emotionally and financially to support and raise a family.

The link between teenage parenthood and poverty is well documented (Maynard, 1996). It is in the interest of the State of Connecticut, and several state agencies that serve this population, including the Departments of Health, Education, Children and Families and Social Services, to take an active role in preventing early parenthood.

Substantive research in the last ten years has identified effective program models for teen pregnancy prevention. At the same time, research has also revealed approaches to teen pregnancy prevention that do *not* work (Kirby, 2004).

The Commission recommends that the limited dollars targeted for this purpose be invested in proven teen pregnancy prevention models in those communities with the highest incidence of births to teenagers (Richter, 2004; Appendix A).

In the 2004 report, “Emerging Answers: Research Findings on Programs to Reduce Teen Pregnancy,” nationally known researcher Douglas Kirby analyzed evaluation data from a variety of teen pregnancy prevention models utilized throughout the United States (Kirby, 2004). Kirby presented a review of the scientific literature concerning teen pregnancy prevention strategies that had been properly evaluated to determine which strategies were effective and which simply didn’t work.

Models That Work

First: One model stood out above the others and was cited in particular for its positive effects over a long period of time: the comprehensive Children’s Aid Society-Carrera Program. The evaluation, which included random assignment, multiple sites and a large sample size, was the most rigorous ever conducted on a teen pregnancy prevention program. Positive effects, most notably, reducing the actual incidence of teen pregnancy, were demonstrated to last for as long as three years, far longer than any other evaluated program.

Second: Evaluation of a second teen pregnancy prevention model, Service Learning programs, while more modest in scope and shorter-term than the comprehensive Children’s Aid Society-Carrera Program, yielded strong evidence of actual reduction of teen pregnancy rates while the youth are involved in the program. The *Teen Outreach Program* and *Reach for Health Program* utilize a Service-Learning model that involves youth in their communities and provides structured time and opportunities for discussion and reflection. Allen and Philliber (2001) note that while the *Teen Outreach* program is typically a broad-based primary prevention program that has been effective with widely diverse youth populations, it is high-risk youth who stand to reap the greatest benefits from this intervention. O’Donnell, et al (2001) report that use of the *Reach for Health* program led to reductions in both sexual initiation and sexual activity among middle school youth two years after participants completed the program.

The Commission applauds the Committees efforts to address this issue and urges funding for the implementation of research based programs that have proven to be effective.

Thank you for the opportunity to testify this morning.