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May 18, 1998

Todd ?
Bob Sobieski

Kate Michelman
President, The NARAL Foundation
1156 15th Street, N.W.
Suite 700
Washington, DC 20005

Dear Ms. Michelman:

Thank you for sending me your recent report, "Teens in Crisis: A comprehensive Strategy to Protect Adolescent Health." I found it informative and believe the polcy recommendations have merit. I firmly believe that educating adolescents about sexuality and the potential consequences of sexual activity, physical and mental, is crucial to preventing HIV and STD infection. I would be pleased to speak to you further about these issues.

Sincerely,

Sandra L. Thurman
Director, Office of National AIDS Policy

THE NARAL FOUNDATION ***Promoting Reproductive Choices***

April 30, 1998

Sandra L. Thurman
National AIDS Policy Director
The White House
Washington, D.C. 20500

Dear Ms. Thurman:

On Friday, May 1st, I will participate in a conference on "Teenage Sexuality Activity and Contraceptive Use: An Update" sponsored by the American Enterprise Institute and the Henry J. Kaiser Family Foundation. This conference will explore recent studies that show a decline in teenage sexual activity and an increase in contraceptive use. Although these studies reflect positive trends, our nation continues to face a crisis in adolescent reproductive health.

Too many teenagers face unintended pregnancies each year, and too many teens contract sexually transmitted diseases. Moreover, too many of our youth lack the necessary information they need to make responsible decisions about their health and well-being.

Because I know you care about this urgent issue, I am forwarding you a copy of a recent report researched and published by NARAL and The NARAL Foundation. The report, entitled Teens In Crisis: A Comprehensive Strategy to Protect Adolescent Health, examines the benefits of comprehensive sexuality education and offers policy recommendations to address and improve the underlying conditions that foster teen pregnancy.

I would welcome your feedback on NARAL's report as well as the opportunity to discuss with you how we can advance policies and programs that will improve the overall health of our nation's teens. I look forward to hearing your thoughts.

Sincerely,

Kate Michelman

Kate Michelman
President

The NARAL Foundation

1156 15th Street, NW
Suite 700
Washington, DC 20005
(202) 973-3000

THE NARAL FOUNDATION *Promoting Reproductive Choices*

TEENS IN CRISIS:
A Comprehensive Strategy to Protect Adolescent Health

National Abortion and Reproductive Rights Action League
(NARAL/The NARAL Foundation)
Kate Michelman, President

Paper presented at the American Enterprise Institute for Public Policy Research
Conference on Teenage Sexual Activity and Contraceptive Use: An Update
May 1, 1998

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TEENS IN CRISIS:
A Comprehensive Strategy to Protect Adolescent Health

Recent surveys identify several positive trends concerning teenage sexual activity and contraceptive use. Between 1990 and 1995, the percentage of teen girls who had ever had sexual intercourse declined by five percent -- marking the first decline in more than 20 years.[1] In 1995, 78 percent of teen girls used contraception at first intercourse as compared to 65 percent in 1988 and 48 percent in 1982.[2] In addition, the teen pregnancy, birth and abortion rates have been declining.[3]

Although these findings are notable, the U.S. continues to face an adolescent reproductive health crisis. The rates of teen pregnancy and sexually transmitted disease (STD) and human immunodeficiency virus (HIV) infections among teens remain unacceptably high. More teens may be using contraception at first intercourse; however, teens continue to fail to use contraception consistently or appropriately. Moreover, the frequency of unwanted sexual intercourse among teen girls is alarming.

In searching for solutions to this adolescent reproductive health crisis, some individuals and groups have focused on abstinence-only education. An emphasis on abstinence-only education is misplaced. Abstinence education is an essential part of sexuality education, but abstinence should not be the only lesson taught. Sexuality education should teach teens to deal with peer pressure and pressure from partners to engage in sexual activity, but teens should also learn how to protect themselves if they do become sexually active.

Rather than focusing on abstinence-only education, the U.S. must demonstrate a national commitment to remedying this adolescent crisis through a multi-pronged approach. Such an approach would invest in the development of young women by valuing their lives, inspiring them to seek better futures, enhancing self-sufficiency, preparing them for higher education, providing job training and ensuring access to health care. We need to embark on a campaign to increase family planning funding, improve and expand access to contraceptives, and increase awareness of and access to emergency contraceptives. Finally, we must launch a national effort to require

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[1] The Alan Guttmacher Institute (AGI), "Teen Sexual Activity and Pregnancy," *Washington Memo*, no. 4 (May 21, 1997): 4.

[2] Kristen Anderson Moore, Anne K. Driscoll and Laura Duberstein Lindberg, *A Statistical Portrait of Adolescent Sex, Contraception, and Childbearing* (Washington, D.C.: The National Campaign to Prevent Teen Pregnancy, 1998), 23, *citing* 1995 National Survey of Family Growth (NSFG); Jacqueline Darroch Forrest and Susheela Singh, "The Sexual and Reproductive Behavior of American Women, 1982-1988," *Family Planning Perspectives*, vol. 22, no. 5 (Sept./Oct. 1990): 209, *citing* 1988 NSFG and 1982 NSFG.

[3] AGI, The Henry J. Kaiser Family Foundation (Kaiser Family Foundation) and National Press Foundation, "Teen Sex, Contraception and Pregnancy" (factsheet), *citing* Stanley K. Henshaw, "U.S. Teenage Pregnancy Statistics" (in-house trend analysis by AGI dated Aug. 15, 1997).

comprehensive sexuality education throughout our primary and secondary schools. This approach would protect teens by promoting abstinence while simultaneously providing teens with the contraceptive and STD/HIV prevention information they need to make responsible decisions if and when they become sexually active.

I. America is Facing a Crisis in Adolescent Reproductive Health.

Despite the positive trends identified in the 1995 National Survey of Family Growth and 1995 National Survey of Adolescent Males, the U.S. continues to face a crisis in adolescent reproductive health. Although some statistics demonstrate a decline in teen sexual activity, a decline in teen pregnancy and an increase in contraceptive use, other statistics present a bleaker view. The decline in teen sexual activity between 1990 and 1995 was slight. More than half of all teens aged 15 to 19 years old have had sexual intercourse.[4] First sexual intercourse is not always wanted. Almost one-fourth of teen girls report that their first experience with sexual intercourse was unwanted, while seven percent report that it was non-voluntary.[5] In addition, the teen pregnancy rate remains too high. Nationally each year, almost one million teenagers become pregnant.[6] Approximately 78 percent of all teen pregnancies are unintended, and over one-quarter of all teenage girls who have had sex are likely to give birth before age 20.[7]

Unintended teen pregnancy has many negative ramifications. Teenage girls have a higher risk of pregnancy complications -- including maternal mortality and morbidity, miscarriages and stillbirths, premature and/or low birthweight babies and nutritional deficiencies -- than adult women.[8] Adolescents often receive inadequate prenatal care and give birth to over 46,000 low birthweight babies each year.[9] The probability that a teen mother will graduate from high school by age 25 is less than 60 percent -- compared to 90 percent for those who postpone childbearing.[10] Twenty-eight percent of teen mothers are poor in their 20s and early 30s as compared to seven percent of women who have their first child after adolescence. Teen mothers

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[4] AGI, "Teen Sexual Activity and Pregnancy," 4; Moore, Driscoll and Lindberg, *A Statistical Portrait of Adolescent Sex*, 3-4, *citing* 1995 NSFG and 1995 National Survey of Adolescent Males (NSAM).

[5] Moore, Driscoll and Lindberg, *A Statistical Portrait of Adolescent Sex*, 11, *citing* 1995 NSFG.

[6] In 1994, the most recent year for which data is available, approximately 940,000 teen pregnancies occurred. AGI, Kaiser Family Foundation, National Press Foundation, "Teen Sex," *citing* Henshaw, "U.S. Teenage Pregnancy Statistics."

[7] Stanley K. Henshaw, "Unintended Pregnancy in the United States," *Family Planning Perspectives*, vol. 30, no. 1 (Jan./Feb. 1998): 26; AGI, Kaiser Family Foundation, National Press Foundation, "Teen Sex."

[8] National Research Council, *Risking the Future: Adolescent Sexuality, Pregnancy, and Childbearing*, Cheryl D. Hayes, ed. (Washington, D.C.: National Academy Press, 1987), 10, 123-24.

[9] Susheela Singh, Jacqueline Darroch Forrest and Aida Torres, *Prenatal Care in the United States: A State and County Inventory*, vol. I (New York: AGI, 1989), 10; Centers for Disease Control and Prevention (CDC), U.S. Department of Health and Human Services (HHS), "Report of Final Natality Statistics, 1995," *Monthly Vital Statistics Report*, vol. 45, no. 11(S) (June 10, 1997): 70.

[10] Namkee Ahn, "Teenage Childbearing and High School Completion: Accounting for Individual Heterogeneity," *Family Planning Perspectives*, vol. 26, no. 1 (Jan./Feb. 1994): 18.

are also more likely to have lower family incomes in later life.[11] In addition, the daughters of teen mothers are more likely than other girls to become teen mothers themselves,[12] thus perpetuating the cycle of poverty.

With respect to contraceptive use among teens, the landscape is similar. Contraceptive use at first intercourse has risen considerably among teen girls, yet many teens still fail to protect themselves adequately against unintended pregnancies and HIV/STDs. Findings from the 1995 National Survey of Adolescent Males demonstrate that fewer than half of all teen males who have had sex used condoms every time that they had sex during the last year. Moreover, the likelihood that a teen male will use a condom 100 percent of the time decreases with age.[13] For instance, research found that "[s]elf-reported condom use is at 63% in 9th grade and steadily declines with each grade to 50% for high school seniors, probably because young women begin to use the pill as an alternate birth control method."[14]

The failure to use contraceptives consistently and appropriately, in a manner that provides adequate protection against STDs and HIV, is significant given the high rates of STD/HIV infection among teens. Annually in the U.S., three million teens are infected with a STD.[15] Approximately 25 percent of sexually active teens are infected with a STD each year.[16] Teens have the highest infection rates for many STDs -- including gonorrhea and chlamydia.[17] In addition, one in four new cases of HIV infection occur in people younger than 22 years of age.[18] Yet, 40 percent of all sexually experienced teens report that they *never* have had a conversation about HIV/AIDS or other STDs with a sexual partner, and 34 percent report that they *never* discussed birth control.[19] Given the high rates of infection, it is clear that teens still need considerable education concerning how best to protect themselves if and when they become sexually active.

American adolescents' sexual activity does not vary widely from that of teens in other

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[11] AGI, *Sex and America's Teenagers* (New York: 1994), 61-62; National Research Council, *Risking the Future*, 130.

[12] Moore, Driscoll and Lindberg, *A Statistical Portrait of Adolescent Sex*, 36, *citing* 1995 NSFG.

[13] Moore, Driscoll and Lindberg, *A Statistical Portrait of Adolescent Sex*, 25-26, *citing* 1995 NSAM.

[14] Chris Collins, "Dangerous Inhibitions: How America is Letting AIDS Become an Epidemic of the Young" (Feb. 1997) <http://www.caps.ucsf.edu/capsweb/publications/adolmono.html> (4/2/98).

[15] CDC, HHS, *Division of STD/HIV Prevention Annual Report, 1992*, 29.

[16] AGI, *Sex and America's Teenagers*, 38.

[17] Division of STD Prevention, CDC, "1998 Guidelines for Treatment of Sexually Transmitted Disease," *Mortality and Morbidity Weekly Report*, vol. 47, no. RR-1 (1998) <http://www.cdc.gov/nchstp/dstd/STD98TG.HTM> (4/2/98).

[18] Philip S. Rosenberg, Robert J. Biggar and James J. Goedert, "Declining Age at HIV Infection in the United States," *The New England Journal of Medicine*, vol. 330, no. 11 (Mar. 17, 1994): 789.

[19] Kaiser Family Foundation and *YM* Magazine, *National Survey of Teens: Teens Talk about Dating, Intimacy, and Their Sexual Experiences*, Summary of Findings/Toplines (Spring 1998), 10.

developed countries; however, American teens are less likely to use contraception, more likely to get pregnant and more likely to contract a STD.[20] Too many teens lack the information and skills they need to postpone premature sexual activity and to protect their health.

II. Abstinence-Only Education Fails to Address Adequately This Adolescent Reproductive Health Crisis.

A. Abstinence-Only Education Is on the Rise.

Recently abstinence-only education has captivated the attention of lawmakers. The emphasis on only abstinence in sexuality education has taken a variety of forms. In 1996, Congress passed welfare reform legislation that establishes an abstinence-only education entitlement program. Administered through the Maternal and Child Health Block Grant (MCHBG) program, this legislation allocates federal funds to programs that have abstinence education as their "exclusive purpose." Beginning in fiscal year 1998, this program will provide $50 million in grant money each year for five years. Participating states must match every four dollars of federal grant money with three dollars of non-federal funds.[21] All 50 states have applied for the funds.[22]

Under the federal law, the term "abstinence education" means an educational or motivational program which: (1) "has as its exclusive purpose, teaching the social, psychological, and health gains to be realized by abstaining from sexual activity;" (2) "teaches abstinence from sexual activity outside marriage as the expected standard for all school age children;" (3) "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;" (4) "teaches that a mutually faithful monogamous relationship in context of marriage is the expected standard of human sexual activity;" (5) "teaches that sexual activity outside of the context of marriage is likely to have harmful psychological and physical effects;" (6) "teaches that bearing children out-of-wedlock is likely to have harmful consequences for the child, the child's parents, and society;" (7) "teaches young people how to reject sexual advances and how alcohol and drug use increases vulnerability to sexual advances;" and (8) "teaches the importance of attaining self-sufficiency before engaging in sexual activity."[23]

The Adolescent Family Life Act (AFLA) also provides federal funds to support education

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[20] Elise F. Jones et al., *Teenage Pregnancy in Industrialized Countries* (New Haven: Yale University Press, 1986), 118-19, 207, 214-15, 231-34 (study by AGI).

[21] 42 U.S.C.A. § 703(a) (West 1991); 42 U.S.C.A. § 710 (West Supp. 1997); Office of State and Community Health, Maternal and Child Health Bureau, "Application Guidance for *The Abstinence Education Provision of the 1996 Welfare Law, P.L. 104-193*, New Section 510 of Title V of the Social Security Act" (May 1997), 2.

[22] "Federal Abstinence-Only Programs -- What Will They Look Like?," *Sexuality Information and Education Council of the United States (SIECUS) Advocates Report*, vol. 4, no. 3 (Summer 1997): 1.

[23] 42 U.S.C.A. § 710 (West Supp. 1997).

programs that teach abstinence. Enacted in 1981, the AFLA program provides grants to public and nonprofit organizations to support abstinence education and programs that provide direct services for pregnant and parenting teens.[24] For FY 98, Congress appropriated $16.709 million for AFLA, compared to $6.250 million for FY 94, an increase of 167 percent.[25]

The emphasis that Congress has placed on abstinence-only education sets a bad precedent for the states, possibly draining money and energy from comprehensive sexuality education programs. Only nineteen states and the District of Columbia require schools to provide sexuality education.[26] Moreover, of those states specifying the required content of sexuality education, 10 require the inclusion of abstinence education but not information about contraception.[27]

B. Abstinence-Only Education Fails to Ensure that Adolescents Receive Needed Information.

Abstinence-only programs stress that abstinence is the only acceptable behavior for adolescents. They fail to provide information regarding prevention of pregnancy and HIV/STDs beyond urging that teenagers abstain from sexual activity. Often, such programs declare that all people must abstain until marriage. They frequently base their message on fear, using scare tactics rather than factual, medically accurate information. If information regarding contraception or STD/HIV prevention methods other than abstinence is included, such information generally includes only failure rates.

The lessons learned in adolescence stay with people their entire lives. By failing to require comprehensive, complete and accurate information about contraception and prevention of pregnancy and STDs/HIV, abstinence-only education actually endangers adolescents' health and well-being. Nearly 50 percent of all pregnancies in the U.S. are unintended, and over half of unintended pregnancies end in abortion.[28] Deficiencies in sexuality education directly contribute to the unacceptably high rates of unintended pregnancy.

C. Abstinence-Only Programs Have Not Been Proven To Be Effective.

Evidence is lacking that abstinence-only education programs are effective in reducing teen sexual activity. The National Campaign to Prevent Teen Pregnancy recently released a study which concludes that "there does not currently exist any scientifically credible, published

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[24] 42 U.S.C.A. §§ 300z - 300z-10 (West 1991).

[25] Office of Population Affairs (OPA), "Adolescent Family Life Program: Funding History Table, FY 1983-1998" <http://www.hhs.gov/progorg/opa/afl-hist.html> (3/16/98).

[26] As of January 1, 1998, these states are: AL, AR, DE, DC, GA, HI, IL, IA, KS, MD, MN, NV, NJ, NC, RI, SC, TN, UT, VT, WV. *Who Decides? A State-by-State Review of Abortion and Reproductive Rights*, 7th edition (Washington, D.C.: The NARAL Foundation/NARAL, 1998), xiii.

[27] As of January 1, 1998, these states are: AL, AZ, CO, IL, IN, LA, MI, OK, TX, UT. *Who Decides?*, xiii.

[28] Henshaw, "Unintended Pregnancy in the United States," 24.

research" that demonstrates that abstinence-only programs delay or reduce sexual activity. After reviewing six abstinence-only studies that had been published to date, the Campaign's survey finds that "[n]one of these studies found consistent and significant program effects on delaying the onset of intercourse, and at least one study provided strong evidence that the program did not delay the onset of intercourse. Thus, the weight of the evidence indicates that these abstinence programs do not delay the onset of intercourse." The report cautions, however, that "this evidence is not conclusive" due to the "significant methodological limitations" of the evaluations. The Campaign has called for "investments in high-quality program evaluation."[29] Another review of 23 individual studies also has concluded that there is insufficient evidence to determine whether school-based abstinence-only programs delay the initiation of intercourse or affect other contraceptive or sexual behavior.[30]

The federal government has been funding abstinence-only education through AFLA since 1981 without any clear evidence that such programs are effective. Throughout AFLA's 17 year history, the program's evaluation component has lacked a long-term, methodologically sound mechanism to evaluate the effectiveness of abstinence programs. One group of researchers found that claims of effectiveness of federally-funded abstinence-only programs are "unwarranted," stating:

> We are aware of no methodologically sound studies that demonstrate the effectiveness of curricula that teach abstinence as the only effective means of preventing teen pregnancy. Instead, the best evaluations of abstinence-only programs find no cause for optimism. None of the best studies found positive changes in behavioral variables such as rates of sexual activity, pregnancies, or STDs.[31]

Recently, a panel on HIV convened by the National Institute of Health (NIH) criticized the MCH abstinence-only entitlement program, stating "[a]bstinence-only programs cannot be justified in the face of effective programs and given the fact that we face an international emergency in the AIDS epidemic."[32]

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[29] Douglas Kirby, *No Easy Answers: Research Findings on Programs to Reduce Teen Pregnancy* (Washington, D.C.: The National Campaign to Prevent Teen Pregnancy, 1997), 47, 25, vi.

[30] Douglas Kirby et al., "School-Based Programs to Reduce Sexual Risk Behaviors: A Review of Effectiveness," *Public Health Reports*, vol. 109, no. 3 (May/June 1994): 339, 352.

[31] Brian L. Wilcox et al., "Federally Funded Adolescent Abstinence Promotion Programs: An Evaluation of Evaluations," 8-9 (paper presented at the biennial meeting of the Society for Research on Adolescence, Boston, Mar. 10, 1996).

[32] National Institutes of Health (NIH), "Interventions to Prevent HIV Risk Behaviors," NIH Consensus Statement Online, vol. 15, no. 2 (Feb. 11-13, 1997): in press <http://odp.od.nih.gov/consensus/statements/cdc/ 104/104_stmt.html> (4/27/98).

III. Abstinence-Only Education May Be Fear-Based, Biased, Medically Inaccurate and Dangerous.

Promotion of fear-based, abstinence-only curricula as the answer to the teen pregnancy problem is dangerous and counterproductive. These curricula often present misleading or medically inaccurate material, deny critical and potentially life-saving information to sexually active teens, and may even lead some teens to believe that precautions are futile. A Louisiana court found that portions of one such curriculum, *Sex Respect*, violated a state statute mandating that all sexuality instruction be factually accurate and religiously neutral.[33] However, some schools still use this curriculum, which has been modified only slightly as a result of the court ruling.

Nationwide, more than 2500 school systems have adopted the *Sex Respect* curriculum.[34] The curriculum contains many stereotypes and generalizations. For example, it teaches that:

> A male can experience complete sexual release with a female even if he doesn't particularly like her. A female, however, experiences more sexual fulfillment with a person she trusts and who is committed to her. . . . In most cases, girls are more interested in emotional warmth and closeness. These natural tendencies in females can, however, be weakened by a poor father-daughter relationship. Because girls who aren't on good terms with their fathers feel an unmet need for male affection, they are more likely to get involved in premarital sex.[35]

In addition, *Sex Respect* teaches that "[i]f premarital sex came in a bottle, it would probably have to carry a Surgeon General's warning, something like the one on a package of cigarettes. There's no way to have premarital sex without hurting someone."[36]

Other fear-based curricula contain similar inaccuracies and stereotypes. The curriculum *Choosing the Best* actually may discourage condom use by suggesting that proper condom use is incompatible with romance. The curriculum states that "[f]or condoms to be used properly, over 10 specific steps must be followed every time which tends to minimize the romance and spontaneity of the sex act." In addition, *Choosing the Best* erroneously suggests that condoms

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[33] *Coleman v. Caddo Parish School Board*, 635 So. 2d 1238 (La. Ct. App. 1994).

[34] "What is SEX RESPECT®?" <http://www.lochrie.com/sexrespect/GeneralIntro.html> (3/17/98).

[35] Coleen Kelly Mast, *Sex Respect®: The Option of True Sexual Freedom*, student workbook (Bradley, IL: Respect Incorporated, 1990), 6-7.

[36] Mast, *Sex Respect®*, 35.

are ineffective in preventing STDs.[37] *Teen Aid*, another prevalent curriculum that relies heavily on scare tactics, teaches that "[s]everal factors have been advanced to explain why subsequent children [of a woman who has had an abortion] are battered. Some of the mechanisms are . . . after one has aborted a child, an individual loses instinctual control over rage."[38]

IV. America Must Promote Comprehensive Sexuality Education Policies to Protect Adolescent Reproductive Health.

A. The Need for Comprehensive Sexuality Education.

As a general matter parents should have the primary responsibility of teaching their children about the risks and responsibilities of sexual activity and how to prevent unintended pregnancy and STDs. Yet many parents do not provide sexuality education at home.[39] Many parents lack the information to teach these lessons and cannot explain STDs and contraception to their children. Others may feel uncomfortable discussing sex or may deny that their children are sexually active. A mere 11 percent of teens receive most of their STD information from parents and others in the family.[40] In addition, some teens simply are not receptive to communicating with their parents about sex.[41] As a result of shortcomings in both family communication and sexuality education, teenagers often are grossly misinformed and inadequately prepared to deal with issues involving sex and may remain so throughout adulthood.

In addition to parents, schools also have a responsibility to provide accurate and comprehensive sexuality education. Comprehensive sexuality education should encourage young people to abstain from premature sexual involvement by acknowledging the value of abstinence while not devaluing or ignoring those young people who have had or are having sexual intercourse. Comprehensive health and sexuality education should be age and developmentally appropriate, starting early and continuing throughout school. Such education should define sexuality as a normal and healthy part of life while providing an opportunity for young people to explore their values and beliefs. It should emphasize decision-making skills and prepare teens to deal with controversial issues by supplying factually accurate information and support. It should help participants develop the self-esteem, personal responsibility, relationship skills and respect for self and others that are necessary to withstand pressure to have sex or to

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[37] Bruce Cook, *Choosing the Best*, Student Manual (Atlanta, GA: Choosing the Best, Inc., 1995), 26-27.

[38] Steve Potter and Nancy Roach, *Sexuality, Commitment and Family* (Spokane, WA: Teen Aid, Inc., 1989), 255.

[39] *Teens Talk About Sex: Adolescent Sexuality in the 90's* (New York: SIECUS, 1994), 35-36 (survey of high school students commissioned by *Rolanda* in association with SIECUS).

[40] Committee on Unintended Pregnancy, Institute of Medicine, *The Best Intentions: Unintended Pregnancy and the Well-Being of Children and Families*, Sarah S. Brown and Leon Eisenberg, eds. (Washington, D.C.: National Academy Press, 1995), 128-30; Committee on Prevention and Control of Sexually Transmitted Diseases, Institute of Medicine, *The Hidden Epidemic: Confronting Sexually Transmitted Diseases* (Washington, D.C.: National Academy Press, 1997), 89-90.

[41] *Teens Talk About Sex*, 35-36.

insist on using contraceptives and disease prevention measures if they choose to be sexually active. Such education should provide scientifically accurate information on abstinence, STD/HIV prevention methods and contraceptive methods -- including their use and effectiveness. Finally, comprehensive sexuality education should furnish information on life options for teens, including education and job planning.

B. The Positive Effects of Comprehensive Sexuality Education.

Unlike the evaluations of abstinence-only programs, evaluations of comprehensive sexuality education and other programs discussing both abstinence and contraception have demonstrated positive effects. Opponents of sexuality education often contend that teaching teens about how to protect themselves if they decide to be sexually active leads to sexual activity. However, their claim is unfounded. The evaluations of sexuality education, AIDS education, school-based clinics and condom availability programs featured in the National Campaign to Prevent Teen Pregnancy's review demonstrate that such programs do not escalate teen sexual activity.[42] A review commissioned by the World Health Organization indicates that sexuality education programs "either had no effect on levels of sexual activity . . . or they delayed initiation of intercourse, and/or reduced pregnancy/abortion/ birthrates in instruction recipients."[43] Studies commissioned by the U.S. Department of Health and Human Services demonstrate that sexuality education "does not cause adolescents to initiate sex when they would not otherwise have done so."[44]

In addition, several studies demonstrated positive outcomes such as increased knowledge, delay in onset of sex, reduction in the frequency of sex, or increased contraceptive use.[45] For instance, the National Campaign to Prevent Teen Pregnancy's study concludes that "[n]early all sex and AIDS education programs that have been evaluated have produced some outcome deemed socially desirable by our society."[46] The Campaign's study also found that in-school multi-component programs, which include education and contraceptive provision, and some "community-wide" programs that focus on pregnancy prevention, disease prevention and improved access to contraceptives may increase contraceptive use and/or decrease pregnancy rates. Limited studies of youth development programs also indicate that such programs may

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[42] Kirby, *No Easy Answers*, 25-26, 47.

[43] Anne Grunseit and Susan Kippax, "Effects of Sex Education on Young People's Sexual Behavior" (World Health Organization, 1994), 3.

[44] Kristin A. Moore et al., *Beginning Too Soon: Adolescent Sexual Behavior, Pregnancy, and Parenthood*, Executive Summary (Washington, D.C.: Child Trends, Inc., June 1995), xiii.

[45] Kirby, *No Easy Answers*, 47. Another review of 23 individual studies found that specific sexuality and AIDS/STD education programs that discuss both abstinence and contraception may have a number of positive effects on adolescents, including postponing initiation of intercourse, reducing the frequency of intercourse and increasing the use of contraceptives. Kirby et al.,"School-Based Programs to Reduce Sexual Risk Behaviors," 339, 352-53.

[46] Kirby, *No Easy Answers*, 47.

decrease adolescent pregnancy and birth rates.[47] In addition, many AIDS education programs have greatly increased contraceptive use through increased condom use.[48]

C. Public Support for Sexuality Education.

By a wide margin, Americans support sexuality education in schools. Eighty-two percent of American adults surveyed support requiring the provision of sexuality education in schools.[49] Another recent survey found that 82 percent of adults believe that educating teens about contraception is very important. Eighty-seven percent believe STD prevention education is very important. A mere 13 percent of adults believe that "teaching teenagers to abstain from sex until marriage is extremely realistic."[50] When given the opportunity to remove their children from sexuality education programs, no more than one to five percent of parents actually do so.[51]

V. Policy Recommendations.

The U.S. must demonstrate a national commitment to reducing teen pregnancy and the rates of STD/HIV infection through a multi-pronged approach that would: (1) improve the underlying conditions associated with teen pregnancy; (2) provide early and developmentally appropriate health and sexuality education programs; (3) provide all students with comprehensive sexuality education; (4) improve access to contraceptives; and (5) prevent diversion of funding from effective programs to abstinence-only education.

A. Improve Conditions Associated with Teen Pregnancy.

The U.S. must address and improve the conditions associated with teen pregnancy such as hopelessness, alienation and lack of future options. We must encourage comprehensive programs that invest in the development of girls and women. We must ensure equality of education and promote the skills and behavior that will allow young women of all races and social classes to take charge of their lives and their reproductive destinies.

Research shows that some teens demonstrate a considerable "ambivalence" towards pregnancy and contraception. Feelings of hopelessness, particularly among poor teens, may prevent some teens from having the motivation necessary to prevent pregnancy. Researchers also have suggested that many teen girls have unresolved issues concerning identity and security,

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[47] Kirby, *No Easy Answers*, 48.

[48] Kirby, *No Easy Answers*, 27.

[49] Data from survey conducted by Lake Sosin Snell Perry & Associates and American Viewpoint for Planned Parenthood Federation of America (PPFA) (Oct. 1997).

[50] Data from survey conducted by Bruskin/Goldring Research sponsored by the *Durex* Truth for Youth™ campaign (Sept. 1997).

[51] Debra W. Haffner and Diane de Mauro, *Winning the Battle: Developing Support for Sexuality and HIV/AIDS Education* (New York: SIECUS, 1991), 42.

limited aspirations and histories of childhood sexual abuse -- all of which help create a general sense of powerlessness that contributes to premature sexual activity and pregnancy. For girls with few alternatives and hopes for a better future, childbearing may offer feelings of fulfillment and achievement.[52]

Moreover, girls often lack educational and other opportunities that would enhance their life skills and provide improved life options. In education, for example, female students' participation in math and sciences declines as they advance in higher education. Vocational education remains sex-segregated. In 1992, only 23 percent of trade and industry course enrollees were female while 70 percent of health enrollees were female. Such disparities are significant given the fact that traditional "female" coursework is correlated to lower-wage jobs.[53] In addition, a wage gap still exists, with women earning only 74 percent as much as men.[54] Finally, although participation in organized sports can provide teens with role models, improve self-esteem, increase self-confidence, reduce certain health risks, and potentially reduce sexual activity and teen pregnancy,[55] athletic opportunities for girls remain inequitable as compared to boys. Only 23 percent of operating budgets for athletics and 38 percent of college athletic scholarship funds are received by female college athletes.[56]

The U.S. also must address sexual abuse, social subordination, depression and stereotypes demanding that women be passive and acquiescent. In a recent survey, 21 percent of high school girls reported that they had been abused physically or sexually. Twenty-three percent of girls, as compared to 16 percent of boys, demonstrated symptoms of depression. Twenty-nine percent of teen girls reported having suicidal thoughts. While boys demonstrate increased self-confidence as they grow older, girls become less self-confident. In fact, one-fourth of older girls surveyed stated that they disliked or hated themselves.[57] Furthermore, with respect to sexuality, girls often lack the skills to protect themselves adequately. The rate of HIV infection is increasing faster among young women than among any other group.[58] Too many teen girls report that although first intercourse may not have been coerced, it was not wanted.[59] Moreover, approximately 38 percent of teen girls' first voluntary sexual partners are three or more years older. Because

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[52] Committee on Unintended Pregnancy, *Best Intentions*, 161-66.

[53] National Coalition for Women and Girls in Education, *Title IX at 25: Report Card on Gender Equity* (Washington, D.C., 1997), 29, 16-17.

[54] National Committee on Pay Equity, "The Wage Gap: 1996" (factsheet).

[55] American Association of University Women (AAUW), "Equity in Athletics," Jan. 1997 (factsheet); The President's Council on Physical Fitness & Sports, *Physical Activity and Sport in the Lives of Girls*, Executive Summary (May 1997), 12-13, 22-23.

[56] National Coalition for Women and Girls in Education, *Title IX at 25*, 11.

[57] The Commonwealth Fund, *The Commonwealth Fund Survey of the Health of Adolescent Girls* (Nov. 1997), 1-3 (survey conducted by Louis Harris and Associates for the Commonwealth Fund); The Commonwealth Fund, "Facts on Mental Health: The Commonwealth Fund Survey of the Health of Adolescent Girls," Sept. 1997 (factsheet).

[58] Collins, "Dangerous Inhibitions."

[59] Moore, Driscoll and Lindberg, *A Statistical Portrait of Adolescent Sex*, 11, *citing* 1995 NSFG.

consistent condom use by males decreases with age, because older male partners may often control the decision-making concerning contraception and because popular culture teaches girls to be passive with respect to sexual decision-making, many teen girls may be unable to direct and control the contraceptive use that is essential in protecting their lives and health.[60] These statistics are alarming, although not surprising given the biases and stereotypes commonly facing girls today.

Given this social context, it is imperative that the U.S. support a multi-pronged approach to adolescent reproductive health that develops skills, provides opportunities, improves girls' self-esteem and improves the status of women. Evaluations of several programs in the U.S. that combine self-esteem enhancement with skills building have demonstrated positive results. For example, the Teen Outreach Program (TOP) provides a combination of volunteer services with classroom discussions of topics such as decision-making skills, life options, and human growth and development. Studies of TOP have consistently indicated that the program effectively reduced pregnancy rates, possibly because the volunteer experiences helped teens consider their futures.[61] In addition, programs run by Girls Incorporated, which combine sexuality education with health services, build skills and teach girls how to handle peer pressure and be assertive. Evaluation suggests that participation in a combination of Girls Incorporated programs decreases the likelihood of becoming pregnant.[62]

The United States should study and learn from international models of women's empowerment. At the 1994 United Nations International Conference on Population and Development (ICPD) in Cairo, worldwide participants developed a program of action that underscores the links between girls' education, maternal and child health, poverty, economic development and the environment. Recognizing that improving the quality of life for women and their families has a direct impact on development, participating nations developed a strategy to enhance women's status, beginning with comprehensive health care -- including reproductive health care and family planning -- and education for women and girls.[63]

B. Provide Early and Developmentally Appropriate Sexuality Education Programs.

The U.S. must ensure that adolescents receive developmentally appropriate sexuality education at an early age. Evaluations suggest that sexuality education programs have a greater

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[60] Moore, Driscoll and Lindberg, *A Statistical Portrait of Adolescent Sex*, 13, 24, 26, *citing* 1995 NSFG and 1995 NSAM; UNAIDS, *Impact of HIV and Sexual Health Education on the Sexual Behavior of Young People: A Review Update* (Joint United Nations Programme on HIV/AIDS, 1997), 25-26.

[61] Kirby, *No Easy Answers*, 42.

[62] Advocates for Youth, "Programs at a Glance: Effective, Comprehensive Sexuality Education," July 1997 (factsheet), *citing* B.C. Miller, ed., *Preventing Adolescent Pregnancy: Model Programs and Evaluations* (Newbury Park, CA: Sage Publications, 1992).

[63] AGI, "The Cairo Consensus: Challenges For U.S. Policy at Home and Abroad, " *Issues in Brief* (Mar. 1995): 1-2.

impact if such education is received before the commencement of sexual activity. One explanation for this phenomenon is the fact that it may be easier to guide new behavior than to alter pre-existing behavioral patterns.[64] Given these findings, and the fact that approximately 25 percent of all 15-year-olds have engaged in sexual intercourse,[65] it is essential that sexuality education start at an early age. Moreover, sexuality education should be developmentally appropriate for various ages and build on earlier lessons.

C. Provide Comprehensive Sexuality Education.

At a minimum, the U.S. must provide all students with comprehensive sexuality education. Such education should include, but not be limited to, abstinence. It should be age and developmentally appropriate, beginning in elementary school and progressing through high school. Importantly, comprehensive sexuality education should give teens the skills they need to say "no," to discuss sexuality and to protect themselves from unintended pregnancy and STD/HIV infection. According to one survey, effective programs include these elements.[66]

Nevertheless, thirty-one states do not require schools to provide sexuality education and sixteen states do not require STD and/or HIV/AIDS education.[67] Often, even if such education is provided, states fail to require that it include all necessary information. Of those states specifying the content that sexuality education must include, 10 require that sexuality education teach abstinence but do not require the inclusion of information about contraception.[68]

The percentage of American teens receiving in-school HIV education increased by 59 percent between 1989 and 1995. This increase may have contributed to the increased use of contraceptives and the decline in teen pregnancy. Yet many teens still did not receive complete prevention information. A mere 37 percent of health education teachers provided instruction concerning correct condom usage while only 56 percent provided information on HIV testing and counseling.[69] Clearly, much more work remains to be done to ensure teens' access to the full range of information regarding sexuality education and STD/HIV prevention.

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[64] UNAIDS, *Impact of HIV and Sexual Health Education*, 24.

[65] Moore, Driscoll and Lindberg, *A Statistical Portrait of Adolescent Sex*, 3-4, *citing* 1995 NSFG and 1995 NSAM.

[66] Kirby, *No Easy Answers*, 47. This survey notes that effective programs: (1) are age and developmentally appropriate; (2) focus on the reduction of one or more sexual behaviors leading to unintended pregnancy or HIV/STD infection; (3) last a duration of time sufficient to complete many activities; (4) encompass an array of teaching techniques which enhance student involvement and cause personalization of the information; (5) address peer pressure; (6) provide opportunities for students to practice and learn communication, negotiation and refusal skills; (7) provide fundamental, accurate information concerning the risks of unprotected sex and methods of prevention; (8) utilize and train instructors or peers who believe in the program.

[67] NARAL, "State Sexuality and STD/HIV Regulations," Jan. 1, 1998 (factsheet). These figures are current as of January 1, 1998.

[68] These states are: AL, AZ, CO, IL, IN, LA, MI, OK, TX, UT. *Who Decides?*, xiii. These figures are current as of January 1, 1998.

[69] Collins, "Dangerous Inhibitions."

D. Improve Access to Contraceptives.

The U.S. must improve access to contraceptives. No one should have an unintended pregnancy for want of access to contraceptives. First, the U.S. must improve access to contraceptives by increasing family planning funds. Currently, three in 10 individuals receiving contraceptive services from publicly-funded family planning clinics are under 20 years old. Without publicly-funded services, the number of teen births would increase by 25 percent and teen abortions would increase by 58 percent.[70] In addition to preventing a dramatic increase in teen pregnancy, publicly-funded contraceptive services are cost-effective. Because many teens receiving these services are, or would become Medicaid recipients if pregnant, "every public dollar spent on contraception saves $3 that would otherwise have to be spent for pregnancy-related and newborn medical care alone."[71] Title X -- the cornerstone of the federal family planning program -- should be expanded boldly to provide access to far more women.

Second, private insurance coverage for contraceptives must be provided. Insurance coverage for prescriptive contraceptives would increase access to more effective contraceptive methods and would give a greater number of women the tools to plan, space and time pregnancies. This would reduce unintended pregnancy and the need for abortion. It is unfair for insurers to cover prescriptions while refusing to cover contraception.

Third, increased awareness of and access to emergency contraceptives must be a component of the multi-pronged approached to prevent unintended teen pregnancy. Use of emergency contraceptive pills (ECPs) reduces a woman's chance of becoming pregnant by 75 percent when a specific dose is taken within 72 hours of unprotected sex and a second dose is taken 12 hours after the first dose.[72] Increased use of emergency contraceptives could have a dramatic impact on unintended teen pregnancy and the need for abortion. In addition, accessing emergency contraception would put teens into contact with family planning providers, from whom they could receive other services and counseling. For those who remain sexually active, emergency contraception thus would provide a bridge to ongoing contraception and disease prevention.

E. Prevent Diversion of Funding From Effective Programs to Abstinence-Only Education.

The U.S. must stop diverting funds from effective programs to abstinence-only education. Although abstinence-only education has garnered much attention, evidence is lacking to

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[70] AGI, "Title X and the U.S. Family Planning Effort," *Issues in Brief* (Feb. 1997): 2-3.

[71] AGI, Kaiser Family Foundation and National Press Foundation, "Myth or Fact? The Real Deal on Teen Sexuality," Mar. 11, 1998 (Q & A factsheet), 3.

[72] James Trussell, Charlotte Ellertson and Felicia Stewart, "The Effectiveness of the Yuzpe Regimen of Emergency Contraception," *Family Planning Perspectives*, vol. 28, no. 2 (Mar./Apr. 1996).

demonstrate its effectiveness. As a result, we must be prudent in channeling funds to more effective programs.

VI. Conclusion

NARAL hopes that the findings of the 1995 National Survey of Family Growth and National Survey of Adolescent Males reflect positive trends in teen sexual activity and contraceptive use that will continue in future years. However, America still faces a crisis in adolescent reproductive health. To ensure further decline in teen sexual activity and pregnancy rates and increase contraceptive use, we need a national commitment to reducing unintended teen pregnancy and the rates of STD/HIV infection. We must address the conditions associated with teen pregnancy such as hopelessness, poverty, alienation and lack of future options. We must guarantee comprehensive sexuality education for all teens. We must improve access to contraceptives. Finally, we must ensure funding for comprehensive sexuality education programs. Only through a multi-pronged approach can we protect the health and lives of America's youth.

April 28, 1998

THE WHITE HOUSE

WASHINGTON

May 27, 1998

Joseph F. O'Neill, M.D., M.P.H.
Associate Administrator
HIV/AIDS Bureau
Health Resources and Services Administration
Room 7-05, 5600 Fishers Lane
Rockville, Maryland 20857

Dear Joe:

We have received a letter from Mr. Maurice Evans of Frederick, Maryland, concerning difficulties he is having with receipt of Ryan White funded services. He says that he has communicated with the Frederick County Health Department and the Department of Social Services for help and has not received a satisfactory response to his concerns. I would appreciate it if you would look into the issues raised by Mr. Evans and respond to him directly. His address is: P.O. Box 606, Frederick, Maryland 21702 and his telephone number is (301) 696-9073.

Thank you for your assistance.

Sincerely,

Thanks, Joe!

Todd Summers
Deputy Director
Office of National AIDS Policy

THE WHITE HOUSE

WASHINGTON

May 29, 1998

Joseph F. O'Neill, M.D., M.P.H.
Associate Administrator
HIV/AIDS Bureau
Health Resources and Services Administration
Room 7-05, 5600 Fishers Lane
Rockville, Maryland 20857

Dear Joe:

Attached is additional correspondence with respect to the recent letter that we sent you concerning problems Mr. Evans was having with Ryan White CARE Act funds.

Thank you for your assistance.

Sincerely,

Todd Summers
Deputy Director
Office of National AIDS Policy

Thanks, Joe!

State of Maryland

Frederick County Health Department

JAMES E. BOWES, M.D., M.P.H.
Health Officer, Frederick County

350 Montevue Lane
Frederick, Maryland 21702

May 18, 1998

Maurice Evans
P.O. Box 606
Frederick, MD 21702

Dear Mr. Evans:

This letter is to assure you that you are eligible and may continue to receive Ryan White services through Frederick County Health Department. These services include case management, primary medical services, nutritional evaluation, dental services, emergency pharmacy assistance, and volunteer services.

We certainly do wish to continue to help you. Please call 301-694-1752 to speak to your case manager, or you may meet with Becky Faughander on Wednesday, May 27, 1998 at 2:00 pm to coordinate any services you may need.

Thank you for bringing this matter to my attention.

Sincerely,

Stephanie Steinbart RN MPH

Stephanie Steinbart, R.N., M.P.H.
Program Supervisor
301-631-3344

cc: Sandy Thurman
Governor Parris Glendening
Sue Hecht
Steven Mood
James Bowes
Becky Faughander

FREDERICK COUNTY MARYLAND 1748

HIV/AIDS Bureau

JUN 30 1998

Mr. Maurice Evans
P.O. Box 606
Frederick, Maryland 21702

Dear Mr. Evans:

Thank you for your letter of May 12 to Ms. Sandy Thurman, requesting that the Office of National AIDS Policy look into issues regarding your difficulties in reapplying for care and treatment services previously provided to you by the Frederick County Health Department (FCHD) under the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act. A member of my staff in the Division of Service Systems (DSS) attempted to contact you on June 8 and 9, but were unable to reach you at those times.

In a subsequent conversation with Ms. Gail Williams-Glasser, Health Services Administrator with the Maryland AIDS Administration, Ms. Williams-Glasser told the DSS contact person that she was aware of your situation and that on May 18 FCHD sent you a letter confirming that you are eligible for and may continue to receive CARE Act services through the FCHD. The information in the letter also included the telephone number to call to speak with your case manager as well as the option to meet with Ms. Becky Faughander on May 27 to coordinate any services that you may need. I was pleased to learn that on May 27 you met with Ms. Stephanie Steinbart, Program Supervisor, Trisha Grove, Case Management Supervisor and Ms. Faughander, Case Manager, to assess your needs and coordinate your care, and that to date you have received several services, including dental, medical, and pharmaceutical assistance. In your call to my staff member on June 10 you confirmed that you are indeed receiving satisfactory services from the FCHD.

Consumer satisfaction with services and access to care through the CARE Act are important to this office. I trust that your ongoing relationship with local providers will be beneficial to maintaining your health status.

Sincerely,

W. Aspden

for Joseph F. O'Neill M.D., M.P.H.
Associate Administrator

cc: Libby Hartnett, Grants Management Officer
Gail Williams-Glasser, Health Services Administrator,
Maryland AIDS Administration

Prepared by:HRSA/HAB/DSS/MVranas:jem:6-08-98:WP:a:\evans.ltr:Doc No:P980602001

THE WHITE HOUSE

WASHINGTON

May 28, 1998

Max Covemaker
1650 1st Ave
Silvis IL 61282-1014

Dear Mr. Covemaker:

I want to thank you and the other signatories to the petition for your support for the "Ricky Ray Hemophilia Relief Fund Act of 1997."

I am aware of the devastating impact that the HIV epidemic has had upon the citizens of this country who are living with hemophilia and would like to express my thanks to Ms. Kennison for sharing her story with the President. I know how difficult it must be to strive to care for someone you love.

I certainly understand the high costs of health care for many in this country and the financial burden which a long-term illness places on our nation's families. The Clinton administration has diligently worked to ensure that quality health care is available to all citizens.

The administration is closely watching the progress Congress is making with regard to the "Ricky Ray Hemophilia Relief Fund Act of 1997." We remain committed to insuring that all those living with HIV/AIDS get the care they need.

Again, thank you for your work to end this epidemic.

Sincerely,

Sandra L. Thurman
Director
Office of National AIDS Policy

n:\letters\rickyray.ltr

THE WHITE HOUSE

WASHINGTON

May 28, 1998

Roberta Kennison
750 25th St.
East Moline, Illinois 61244-1862

Dear Ms. Kennison:

Thank you for your letter expressing your support for the "Ricky Ray Hemophilia Relief Fund Act of 1997."

I am aware of the devastating impact that the HIV epidemic has had upon the citizens of this country who are living with hemophilia and would like to express my thanks to you for sharing your story with the President. I know how difficult it must be for you and your family as you strive to care for someone you love.

I certainly understand the high costs of health care for many in this country and the financial burden which a long-term illness places on our nation's families. The Clinton administration has diligently worked to ensure that quality health care is available to all citizens.

The administration is closely watching the progress Congress is making with regard to the "Ricky Ray Hemophilia Relief Fund Act of 1997." This office will continue to monitor the proposed legislation and will ensure that the President is made aware of the status of the Bill.

Again, thank you for your letter.

Sincerely,

Sandra L. Thurman
Director
Office of National AIDS Policy

n:\letters\rickyray.ltr

THE WHITE HOUSE

WASHINGTON

5-23-98
DATE

MEMORANDUM

FOR: ONAPC

FROM: SUE J. SMITH SJS
DIRECTOR, AGENCY LIAISON

SUBJECT: REFERRAL OF CASEWORK

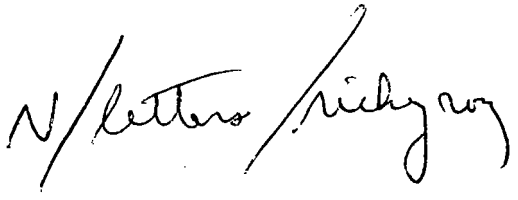
I am forwarding the attached letter to your office for appropriate action. Please send us a copy of your written response or your telephone report along with the writer's original correspondence and envelope to the following address:

Ms. Sue J. Smith
Director, Agency Liaison
Room 6, OEOB
The White House
Washington, D.C. 20502

If you have any questions, call my office at 202/456-7486.

Thank you for your help.

Robert Soliz



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b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

Dear President Clinton,

We, the undersigned, strongly urge you to support and sign House Bill 1023/Senate Bill 358, **The Ricky Ray Hemophilia Fund.** These relief payments would provide a small, but important, assistance in caring for the Hemophilia/HIV of those unsuspectingly infected by government-approved blood they believed was safe.

Thank you for your consideration.

Name Roberta Kennison **Address** 250 25th St. E. Moline IL. 61244

1. MAX COVEMAKER 1650 1st AVE SILVIS. IL
2. Nate Chrz 242 Rudy Rd Geneseo IL
3. Scott Nelson 441 oak Drive Geneseo Ill
4. Pat Cavanagh 9805 239 n Port Byron Ill
5. John Gill 408 West Drive, East Moline Ill.
6. Tony Williams 900 12 ST Silvis
7. Tony S Tree 2355-1st E. M.
8. Bud Price Box 144 Barstow Ill 61236
9. (illegible) Covemaker 2413 12 st. Silvis
10. Jack J Vogler 621-11st. Silvis Ill. 61282
11. Tom McClaine 22927 Port Byron ILL 61275
12. (illegible) Stratton 3620-15th AVE CT. MOLINE, ILL.
13. Celine Zwiller 1339-12th St. Rock Island. Ill. 61282
14. Roy Miller 1339-12TH St Rock Island.
15. Anthony Wright 4558 7th Egst moline IL 61244

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Thank you for your consideration.

Name Roberta Kennison **Address** 250 25th St. East Moline, IL. 61244

1. Shannon Saunders 710 W. 10th Ave, Milan, ILL. 61264

2. [illegible]

3. Paulette Chaser 714½-4th Ave Moline, ILL 61265

4. Angela Patterson 2940 5th Ave. Rock Island, IL 61201

5. Shellee Billingsley 16618 Barstow Rd. E. Moline, IL 61244

6. Rachel Matthews 1528 12th St Rock Island, IL 61201

7. Johnette Hillie 1041 12th st. Rock Island, IL. 61201

8. Carol Rockwood 751-14ST #3 Moline Ill 61265

9. Steve Dreeder 1691-320 RD. Aledo, IL 61231

10. Anne Kurth 5021 School House Rd. Bettendorf, IA 52722

11. Theresa Schelin 209 Fairway Circle - Eldridge, Iowa 52748

12. LaShonda Anthony 639 38th St. Rock Island, IL 61201

13. Linda Jones 1800 7th St. 11A, East Moline, Il 61244

14. Jerry Dreeder 1691-320TH Aledo, Ill 61231

15. Linda J. Gray P.O. Box 611 Colona Ill. 61241

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Thank you for your consideration.

Name Roberta Kennison **Address** 250 25th St. E Moline, IL. 61244

1. Mike Gallo 925-11 Ave Ct. #4 Silvis Ill 61282
2. Bobbi-Sue Hunton 4704 - 11th Ave D Moline Ill 61265
3. Jean McFarland 620 1ST AVE. EAST MOLINE, IL 61244
4. Clarence Kyf 1204-15th St - Silvis, Ill. 61282
5. Homer Swate 803 1/2 15 Ave Moline Ill 61265
6. marion J Perkins P.O. 701 matherville Ill 61
7. Bruce Wacker 221 W Mersa Blue Grass Ia 52726
8. Ted A. Ware P.O. Box 453 COLONA IL. 61241
9. TROY L PARVIN 4701 5ST EAST MOLINE ILL 61244
10. LARRY HAMPTON 6422 9 AV E T.R. ILL 61284
11. John Herbert 1536 29th ST. ROCK ISLAND, IL. 61201
12. Paul Ledyo 1812 Valley Pl. Davenport, Iowa 52806
13. Lonnie C Williams 647 17th ave E Moline Ill
14. Leo Rodriguez 638 38 AV. E MOLINE
15. Gregorio Barrera 1140 5 AV. MOLINE.

Dear President Clinton,

We, the undersigned, strongly urge you to support and sign House Bill 1023/Senate Bill 358, **The Ricky Ray Hemophilia Fund.** These relief payments would provide a small, but important, assistance in caring for the Hemophilia/HIV of those unsuspectingly infected by government-approved blood they believed was safe.

Thank you for your consideration.

Name Roberta Kennison **Address** 750-25-4351 E. Moline, IL 61244 1800 7th St.

1. Jack McClelland E. Moline IL
2. [illegible] 1806 W. 3 ST. COAL VALLEY IL
3. Greg [illegible] 3069 4th St. Apt 8 moline IL 61265
4. [illegible] 116 9TH ST Silvis, IL 61282
5. [illegible] Box 24 [illegible] 61244
6. [illegible] 1102-8th St. Ct. Silvis Ill. 61282
7. Daniel Rossi 425-1st E. Mol, Il
8. Esther Rossi 425-1st E. Mol, Il.
9. Dick Hewitt 225-37 AVE EAST MOLINE, IL
10. [illegible] 416 30th ST Moline
11. Zeke Terronez 3105-4th St. A. E. Moline
12. [illegible] 1234 18th. ST. E. MOLINE
13. Fred J Richardson 108 Island Ave E Moline
14. Joyce A. Richardson 108 Island Ave E Moline, Il.
15. Ralph Corvin Matherville Box 668 61263

Page No.______

Dear President Clinton,

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Thank you for your consideration.

Name Roberta Yennsen **Address** 750 25th St. E. Moline IL. 61244

1. [illegible] 4605 5 St. E MOLINE 61244
2. [illegible] 4605 5th East Moline 61244
3. W. Ann Zeller 834 27½ Ave Em Silvis 61282
4. Richard Boell 1802-15th St A Moline Ill 61265
5. Gay Lehmann 18958 Grant River RD P.V. IA
6. [illegible] 513-10th ST. A Silvis ILL
7. Lorry J. Murdick 1927-9½ ST ROCK ISLAND IL
8. Linda Alexander 830-1st ave. Apt 80 E. Mol. IL. 61244
9. Ron Fridley 830-1st ave. Apt 93 E. Mol. IL 61244
10. Dan Lambrecht 355 23RD st East Moline, IL 6124
11. Paul Schiera R4 Box 118 Apt 8 East Moline IL. 61244
12. Angela Geyer 1314 4th St Moline IL 61265
13. Daniel Sjquist 703 2nd St Colona IL 61241
14. Iris Givens 156-10th St. Silvis, Ill 61282
15. Joe Givens 156-10th St. Silvis, Ill 61282

Dear President Clinton,

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Thank you for your consideration.

Name Roberta Kennison **Address** 750-25th St. East Moline, IL. 61244

1. Kenneth Thomas 1559 10th Ave E M
2. Debra J McM 155 7th Ave Moline IL.
3. Dan Brown 9212 Knoxville Road Mitchell
4. Larry Ballegeer 2903 5th Street East Moline, IL
5. SANDY L HASKINS 2311 45ST MOLINE ILL 61244
6. Terry Sutliff 405 STEWARD ST EAST MOLINE, IL
7. Conrad Cannon 300 Island Ave E. Moline
8. Larry Hutton 3196 US Hwy 6 Coal Valley, IL 61240
9. Kathy Carruthers East Moline, IL 61244
10. Floyd Sutliff 463 STATE ST E. M
11. Marva Nottling 1426-45th St Rock Island, IL 61201
12. Michele Fitzsimmons 1331 12th Ave Moline IL 61265
13. Albert M. Carlson 825-17th St. Moline, IL. 61265
14. Rick B. Nelson 2406 31st St. A Moline, IL 61265
15. Barb Thompson 1330-15th St Mol. IL
16. Kathy Spence 726-17th Ave Moline, IL
17. Gale Flynn 2348 29th St Moline IL

Page No._____

18. Susan McNally 1202-49th St. Moline, IL

71st District

Representative **Mike Boland**
605 17th Ave., Suite 2
East Moline, IL 61244

PRESIDENT BILL CLINTON
THE WHITE HOUSE
WASHINGTON DC 20500

MAY - 5

THE WHITE HOUSE

WASHINGTON

MEMORANDUM FOR DR. RICHARD FEACHEM

From: Todd Summers
Deputy Director
Office of National AIDS Policy
(202) 632-1090

Date: May 7, 1998

Re: IAVI Proposal for HIV Vaccine Purchase Fund

Sandy asked that I reach out to get your informal reaction to the IAVI proposal for an HIV Vaccine Purchase Fund that would be coordinated through the World Bank. (I have attached a copy of their proposal, but assume that you got a copy from Seth Berkeley.)

Sandy's meeting tomorrow with Drs. Varmus, Fauci, and Baltimore to talk about the President's HIV Vaccine Initiative, and it would be good for us to know if you think the IAVI concept is sound, and what pitfalls/ concerns you might have.

Can you call me (456-2444) or Sandy (456-2441) before you leave? Sandy is away until this evening, but you can leave a message on her voicemail.

Thank you!

THE WHITE HOUSE

WASHINGTON

May 5, 1998

Memorandum for Michael X. Imbroscio
Associate Counsel to the President
488 OEOB

From: ~~Sandra Thurman~~ Todd Summers

Regarding: Certification of Document Request of April 14, 1998 .

This certification is in response to the document request memorandum from Charles F.C. Ruff dated April 14, 1998. By signing this document, I certify that I have directed all the individuals in the White House Office employees of the Office of National AIDS Policy to search their files as well as the office's files. To the best of my knowledge, these files have been reviewed and all potentially responsive documents have been provided.

On behalf of the White House Office employees of the Office of National AIDS Policy:

~~Sandra Thurman~~
Todd Summers, Deputy

THE WHITE HOUSE

WASHINGTON

April 29, 1998

Memorandum for Sandra Thurman

From: Michael X. Imbroscio
Associate Counsel to the President

Regarding: Certification of Document Request of April 14, 1998

On April 14, 1998, Charles F.C. Ruff circulated to the staff of the White House Office and the Office of the Vice President a document request memorandum. The memorandum requested all responses by April 28, 1998. To certify that the files of your office have been searched, please sign the attached certification and return it to me as soon as possible.

Thank you for your cooperation.

THE WHITE HOUSE

WASHINGTON

May 5, 1998

Memorandum for Karl A. Racine
Associate Counsel to the President
479 OEOB

From: ~~Sandra Thurman~~ Todd Summers

Regarding: Certification of Document Request of April 16, 1998

This certification is in response to the document request memorandum from Cheryl D. Mills dated April 16, 1998. By signing this document, I certify that I have directed all the individuals in the Office of National AIDS Policy to search their files as well as the office's files. To the best of my knowledge, these files have been reviewed and all potentially responsive documents have been provided.

On behalf of the Office of National AIDS Policy:

~~Sandra Thurman~~
Todd Summers, Deputy Director

THE WHITE HOUSE

WASHINGTON

April 30, 1998

Memorandum for Sandra Thurman

From: Karl A. Racine
Associate Counsel to the President

Regarding: Certification of Document Request of April 16, 1998

On April 16, 1998, Cheryl D. Mills circulated to all staff of Executive Office of the President a document request memorandum. The memorandum requested a response by April 27, 1998. To certify that the files of your office have been searched, please sign the attached certification and return it to me as soon as possible.

Thank you for your cooperation and for complying with the request for documents..

Data Entry Form

Letter ID	Writer First Name	Writer Last Name	Received Date	Subject
10818	Maurice	Evans	5/13/98	Req. for Assist.

☐ Response Required?

Response Type	Response Date	Responder ID	Responder Name	Action Promised

Action Completed	Action Date	Addressed To

Notes

Sarah, any idea who this might go to?--Lisa

Sender's Organization	Sender's Street1	Sender's Street2

Sender's City	Sender's State	Sender's Zip

THE WHITE HOUSE

WASHINGTON

May 27, 1998

Joseph F. O'Neill, M.D., M.P.H.
Associate Administrator
HIV/AIDS Bureau
Health Resources and Services Administration
Room 7-05, 5600 Fishers Lane
Rockville, Maryland 20857

Dear Joe:

We have received a letter from Mr. Maurice Evans of Frederick, Maryland, concerning difficulties he is having with receipt of Ryan White funded services. He says that he has communicated with the Frederick County Health Department and the Department of Social Services for help and has not received a satisfactory response to his concerns. I would appreciate it if you would look into the issues raised by Mr. Evans and respond to him directly. His address is: P.O. Box 606, Frederick, Maryland 21702 and his telephone number is (301) 696-9073.

Thank you for your assistance.

Sincerely,

Todd Summers
Deputy Director
Office of National AIDS Policy

Thanks, Joe!

THE WHITE HOUSE

WASHINGTON

May 27, 1998

Maurice Evans
P.O. Box 606
Frederick, Maryland 21702

Dear Mr. Evans:

We have received your letter expressing concerns about the administration of the Ryan White funded services in Frederick County. I have asked Dr. Joseph O'Neill, Associate Administrator, HIV/AIDS Bureau, Health Resources and Services Administration, to look into your concerns. That Bureau administers the Ryan White program.

I want to assure you that the intent of our HIV/AIDS policies and programs is to save lives and reduce the suffering of people living with HIV/AIDS, and I believe that overall, these policies and programs have worked. In instances where they are not working, or where they are not being implemented in the manner in which they were intended, we need to hear about it, and I thank you for taking the time to write to us.

Sincerely,

Todd Summers
Deputy Director
Office of National AIDS Policy

Data Entry Form

Letter ID	Writer First Name	Writer Last Name	Received Date	Subject
10835	Stephanie	Steinbart	5/22/98	cc: Letter to Evans

☐ Response Required?

Response Type	Response Date	Responder ID	Responder Name	Action Promised

Action Completed	Action Date	Addressed To

Notes

Sender's Organization	Sender's Street1	Sender's Street2
Frederick Cty Health Dept.		

Sender's City	Sender's State	Sender's Zip

THE WHITE HOUSE

WASHINGTON

May 29, 1998

Joseph F. O'Neill, M.D., M.P.H.
Associate Administrator
HIV/AIDS Bureau
Health Resources and Services Administration
Room 7-05, 5600 Fishers Lane
Rockville, Maryland 20857

Dear Joe:

Attached is additional correspondence with respect to the recent letter that we sent you concerning problems Mr. Evans was having with Ryan White CARE Act funds.

Thank you for your assistance.

Sincerely,

Todd Summers
Deputy Director
Office of National AIDS Policy

Thanks, Joe!

State of Maryland

Frederick County Health Department

JAMES E. BOWES, M.D., M.P.H.
Health Officer, Frederick County

350 Montevue Lane
Frederick, Maryland 21702

May 18, 1998

Maurice Evans
P.O. Box 606
Frederick, MD 21702

Dear Mr. Evans:

This letter is to assure you that you are eligible and may continue to receive Ryan White services through Frederick County Health Department. These services include case management, primary medical services, nutritional evaluation, dental services, emergency pharmacy assistance, and volunteer services.

We certainly do wish to continue to help you. Please call 301-694-1752 to speak to your case manager, or you may meet with Becky Faughander on Wednesday, May 27, 1998 at 2:00 pm to coordinate any services you may need.

Thank you for bringing this matter to my attention.

Sincerely,

Stephanie Steinbart RN MPH

Stephanie Steinbart, R.N., M.P.H.
Program Supervisor
301-631-3344

cc: ✓Sandy Thurman
Governor Parris Glendening
Sue Hecht
Steven Mood
James Bowes
Becky Faughander

FREDERICK COUNTY MARYLAND 1748