

**DR. KRISTEN ANDERSON MOORE**

MR. VICTOR MEDRANO: Dr. Moore is a Social Psychologist and a Senior Scholar and Senior Program Area Director for Youth Development at Child Trends. She has been with Child Trends since 1982, studying trends in child and family wellbeing. The effects of family structure and social change on children, the detriments and consequences of adolescent parenthood, the effects of welfare and welfare reform on children and positive development.

Dr. Moore was the founding Chair of the Effective Programs and Research Task Force for the National Campaign to Prevent Teen and Unplanned Pregnancy and served as a member of the internal board of directors. In 2010, she was chosen researcher of the year by the Healthy Teen Network. Please join me in welcoming Dr. Moore. [applause]

DR. MOORE: Good morning. And I am delighted to be here. I wanted to start by giving an outline of my presentation. And this outline provides an overview of what I'm going to say. The first section providing information on overall trends in teen childbearing. In subsequent sections, we'll discuss various approaches to the prevention of teen childbearing and provide data on trends and patterns for each of these topic areas where available. And finally,

**DR. KRISTEN ANDERSON MOORE**

some historical data will be shared to provide a perspective on the issue. And I apologize for my voice. I'm recovering from a cold, but I'm going to make it through this talk.

First, overall trends. And, of course, the big story is that over the past several decades, there's been a pretty substantial decline in the teen birth rate. The second thing to note is that the decline has not been steady. Several upticks have occurred. And these are important reminders that teen pregnancy involves behaviors that can go up as well as down.

The incidents of teen childbearing varies a lot across groups. As this chart shows, the probability of a first birth increases notably over the teen years. The teen birth rate is much higher among older teens, and teens eighteen to nineteen account for about two-thirds of all births to teens.

However, the rate has been declining among younger teens, aged fifteen to seventeen, shown in blue at the bottom, as well as among older teens, age eighteen to nineteen, shown in red.

**DR. KRISTEN ANDERSON MOORE**

In addition, the teen birth rate has been declining among all race, ethnicity groups, White non-Hispanic teens, shown here in blue; Black, non-Hispanic teens, shown in red; Hispanic teens, who now have the highest rate, in green, but declining as well; American Indian teens, and Asian and Pacific Islander teens who have the lowest rates, but also have declining rates of teen childbearing.

Well, the teen birth rate also varies dramatically by state, with Southern states and Sun Belt states having the highest teen birth rates, followed by states that are contiguous to the South and the Midwest. States in the Northeast and the North Central states, such as Minnesota and North Dakota, have considerably lower rates.

Well, importantly, the decline in the teen birth rate reflects a decline in the teen pregnancy rate. In addition, the abortion rate is declining, along with the birth rate, all three.

While the rates of pregnancy and abortion and birth have all declined, the proportion of pregnancies that end in a live birth declined for a while and then increased with

**DR. KRISTEN ANDERSON MOORE**

only a slight overall decline across the decades. However, data are only available through 2006.

Well, as you all probably know, most teen pregnancies are unintended. This chart shows that about four in ten teen pregnancies are unintended and end in a birth, with a similar number ending in abortion. Only about one in five, 18 percent to be exact, of all teen pregnancies are intended, shown in red.

Similarly, only about one in five births to teens are repeat births, that is second, third or later order births. This proportion has declined over time which is a good thing since caring for one child is a substantial responsibility and caring for more than one is very challenging for teens.

Despite the decline in teen pregnancy, births to teens and repeat births to teens, the U.S. continues to have a considerably higher teen birth rate than other developed countries. We are shown in red. We are clearly an outlier. Some of the states with the lower teen birth rates that we saw earlier, Vermont, New Hampshire, Massachusetts, Minnesota, North Dakota, have birth rates

**DR. KRISTEN ANDERSON MOORE**

similar to that of the United Kingdom, which is the country next to the United States.

But for the most part, even the states with the lowest rates of teen births have teen birth rates that are higher than other industrialized countries. Moreover, the U.S. rate is more than three times higher than the teen birth rate in Canada and eight times higher than a country like Japan. So despite progress, there is much work to do.

Next, I want to share data on common research-based approaches to addressing teen childbearing. This is the ecological model which is the basis for a lot of our work at Child Trends. Research has found that many factors are related to teen sexual, contraceptive and childbearing behavior. These include proximal factors such as those in the first ring, including family, peers, partners and other individuals.

In addition, more distal factors show in the outer ring, such as family planning services, sex education, neighborhood factors and social policies can also affect behavior, though the effects of such distal factors may be smaller than or filtered through the more proximal factors.

**DR. KRISTEN ANDERSON MOORE**

Starting with expanding and strengthening sex education. As this slide shows, most teens do receive formal sex ed, 97 percent. And most, 90 percent, receive it before they have sex for the first time. However, students are more likely to receive education about saying no to sex and about STDs and HIV/AIDS than they are to receive information about methods of birth control. This chart shows data for males in blue and females in red. And the pattern is the same for both. The methods of birth control, the second to the left pair of bars, is the lowest, 62 percent for males and 70 percent for females.

In addition, girls are more likely to get some type of sex ed. Specifically, a greater proportion of females received formal sex ed on how to say no to sex compared to males. It's small, but 87 versus 81 percent. While teen girls were also more likely than teen boys to have received formal sex education about different methods of birth control, 70 percent to 62 percent. But they were equally likely to get information about HIV/AIDS and STDs.

Reducing and delaying sexual activity is another goal for many of most intervention programs. Not all sexually

**DR. KRISTEN ANDERSON MOORE**

experienced teens, shown in the top line, are currently sexually active. That is shown in the bottom line. This chart shows a decline that has occurred since 1990 in the proportion of students in grades nine through twelve who have ever had intercourse.

The proportion who have had sex recently, that is within the past three months, remains lower and a smaller decline has occurred in the proportion who have had recent sex than in the proportion who have ever had sex.

Well, as one would expect, the proportions of students who have ever had sex, shown in red, as well as the proportion who have recently had sex, shown in blue, increase as students become older.

Moreover, a small but significant proportion of students report they engage in very risky behaviors, such as sex before thirteen, eight percent of males shown in blue and three percent of females. And having sex with four or more persons during their life shown in the middle pair of bars, sixteen percent of males and eleven percent of females. And drinking alcohol or using drugs before they last had sex shown on the right, which is twenty-six percent of

**DR. KRISTEN ANDERSON MOORE**

males and seventeen percent of females. Any of these can increase the risk of pregnancy and STDs. So while somewhat low, it's still of great concern.

In addition, a significant minority of students report they first had sex with someone that they had just met, or they were just friends, or they were just going out once in a while . . . we refer to as casual sex. And that's shown in the middle panel here. Twenty-two percent of females and forty percent of males indicate that their first sex was in such a causal relationship.

However, recent data from the National Survey of Family Growth suggests that casual sex may have gone down a bit, at least among teen males between 2002 and the more recent survey 2006 through 2008. One in five females in both years, shown in red, were in a causal relationship when they first had sexual intercourse. Males in blue, however, were less likely in 2006 to 2008, 40 percent in the more recent time, a decline from 48 percent in 2002, to report that their first sexual experience occurred in a casual relationship. It's still twice as high, but the trend is just down a little.

**DR. KRISTEN ANDERSON MOORE**

One myth that needs correcting is that most teens have sex with much older partners. In fact, most sexual partners are the same age or a couple of years older. Very few partners at first sex are five or more years older.

Having said that, it is a matter of concern that 13 percent of girls had a first sexual partner who was five or more years older. While more than a third had a first sexual partner who was three or more years older.

Well, importantly, peer group competition is related to the risk of pregnancy over and above, in these analyses, the effects of other social and other demographic factors. This slide shows the percent of teens peer group who are low risk. So, in other words, on the far left, gives zero percent of your peer group, low risk, you're in a high risk situation.

And as this chart shows, teens with no risk adolescents in their peer group, on the far left, are considerably more likely to have become pregnant, 22 percent, than teens in peer groups where the majority are low risk. Shown on the far right, only six percent became pregnant in the group where the great majority of their peers are low risk.

**DR. KRISTEN ANDERSON MOORE**

A stepping stone, a stairway, a very linear trend-- increasing contraceptive use. This chart provides recent data on trend in use of birth control pills or Depo-Provera before last sex. Clearly, males in blue are less likely to report or to know that pills or Depo are being used.

The upward trend for pills and Depo is modest among females. But males have become more likely to report a partner who used pills or Depo, perhaps reflecting a greater willingness on the part of couples to discuss contraception.

The increase in condom use is more clear for males as well as females. Though here, females are less likely to report condom use than males are, 69 percent and 54 percent. And since 1995, both males and females report that they are less likely to have used no method at last intercourse. Seventeen percent of females report no method and seven percent of males report no method.

This chart shows the flip side, the proportion of never married, sexually active teens who used any method of contraception at last intercourse. The trend is up.

**DR. KRISTEN ANDERSON MOORE**

Though there is clearly room for further improvement, with 93 percent of males and just 84 percent of females.

Well, one of the approaches with strong evidence of effectiveness is early childhood programs. A decade or more later, several rigorously evaluated, early childhood programs have been found to reduce teen childbearing or risky behaviors associated with teen pregnancy.

However, over this time period, we see only a slight increase in the proportion of children enrolled in early childhood programs. Moreover, we see disparities by poverty level. The proportion in preschool is lower among preschool children below the poverty line, shown in blue, who tend to be at greater risk of teen pregnancy relative to children in more affluent families.

Youth development, my own area. We find that a number of youth development programs have also been found that investing in improving the lives and prospects of children and youth in out of school time programs can reduce risky sex and teen pregnancy.

**DR. KRISTEN ANDERSON MOORE**

Again, however, low income adolescents are less likely to be involved in youth development programs, such as sports, clubs or other activities. As shown in the bar on the far right in this slide, 30 percent of youth below 200 percent of the poverty line were not in any activities, compared with just ten percent of youth in more affluent families. In other words, three times as many were not in any programs.

But participation is not enough. Quality also matters. An analysis Child Trends did, using data from America's Promise Alliance, found that being in a low quality youth development, out of school time program was the same as being in no program at all. That is, youth in a low quality program and youth in no program had similar outcomes and lower outcomes in youth in medium and higher quality programs. And, as shown in this chart, among all teens twelve to seventeen, about a quarter are in low quality or no programs at all, the two bars on the left.

Strengthening families. Well, as most of you probably know, family structure has changed dramatically in the United States. And the proportion of teens raised by their

**DR. KRISTEN ANDERSON MOORE**

two married parents is considerably lower than it was several decades ago, the line in the blue at the top.

Using data from the National Survey of Family Growth, this slide depicts the proportion of teen females who have had sex in 1988, 1995, 2002 and 2006 through '08 by family structure. At the top in red are kids raised by both biological or adoptive parents, in the bottom all other family structures.

The proportion having had sex has declined in both groups. But the proportion who have had sex is consistently higher among those teens shown in red who do not live with both of their biological or adoptive parents.

This chart shows the same patterns for males, a decline in the proportion who've had sex overtime. But teen males who live with both of their biological or adoptive parents are consistently less likely to have had sex. Again, shown in blue.

In addition, teens born to a mother who was herself a teen mother are considerably more likely to have sex themselves as a teen. And this is one way that the decline in teen

**DR. KRISTEN ANDERSON MOORE**

childbearing in the U.S. can be seen as building on itself with fewer children born to teen mothers, fewer are in this relatively high risk group.

A similar trend is evident for males. The decline in the proportion who have had sex is clear for both groups. But the sons of teen mothers in blue are consistently more likely to have had sex as a teen.

Well, family relationships and parent involvement also matter. We hear a lot of negative messages about how bad parent/adolescent relationships are. But most parents feel very close to their children, shown in blue, the top line. These data are from the National Survey of Children's Health and show going from age six up to age seventeen, the proportion of parents who report feeling very close to their children. And as you might expect, the proportion does decline a little bit as adolescents become older. But it is still 76 percent at age seventeen.

Similarly, most parents report that they can talk about things that really matter with their child and even with their teen shown in red. At age seventeen, it's 67 percent. Where the drop off occurs in these data is the

**DR. KRISTEN ANDERSON MOORE**

proportion of parents who report meeting all of their children's friends. During the teen years, only a little more than a quarter of parents report that they've met all of their children's friends.

Reducing poverty. Poverty has been linked to a higher likelihood of teen childbearing. And though the U.S. saw a reduction in poverty in the late 1990s, rates, as I believe all of you know, are up again.

Unlike poverty, parent education levels have been increasing. However, like poverty, parent education is linked with teen childbearing. The bottom line in this chart shows that the probability of the first birth is lower for adolescent with better educated mothers in green. The top line shows the higher risk. And it's considerably higher birth for adolescents whose mothers did not complete high school.

Improve education for teens themselves. The educational achievement of teens themselves is also associated with the risk of early sex, pregnancy and childbearing. The good news is that some progress has been achieved in reducing dropout rates over time. This decline has occurred for

**DR. KRISTEN ANDERSON MOORE**

Hispanics, shown in the top line in green, for Blacks, the middle line, and for Whites shown in the lowest line.

However, not much improvement has been documented for achievement. Reading achievement is shown here. And there hasn't been much improvement, especially for teens shown in green. Similarly, there hasn't been a lot of improvement for teens in math achievement.

Well, in sum, there are some positive trends that suggest teen childbearing may decrease. For example, falling dropout rates for teens and increased education for parents. Plus, some increases in the proportion of children involved in early education and youth development programs. However, other trends are less promising, such as poverty, educational achievement and family structure.

Moreover, many of the programs and interventions associated with delaying sex, pregnancy and parenthood are less frequent among disadvantaged children and youth. But historical comparisons suggest that we take the long view. Sometimes change can be achieved by fiat.

**DR. KRISTEN ANDERSON MOORE**

For example, the welfare rolls dropped substantially after welfare reform in 1996 implemented time limits and varied sanctions. However, legislation cannot directly affect teen sex and pregnancy.

Another example is infant mortality, which has declined dramatically over the course of a century from 100 deaths per 1,000 infants to just seven.

And smoking. I suspect that forty years ago that smoking at a meeting like this would be commonplace. It has taken decades, but rates have declined substantially. Reducing teen childbearing is similarly proving to be a long-term effort. Congratulations on your work and hang in there.  
[applause]

LEAH TOUSSAINT: My name is Leah Toussaint. And I'm coming from Oakland Park, Florida. And my question is basically regarding the last thing that you spoke about, about legislation affecting behavior. And we see that with seatbelt use, click it or ticket, you know, the campaigns for that, we see a change in behavior.

**DR. KRISTEN ANDERSON MOORE**

And I see with the welfare, I guess what I'm saying is it lowers the cost. The cost right now is so low for bad behavior. But with the welfare reform, we saw the cost for I guess you could say difficult choices go down. So, I'm wondering if you noticed that that legislation did have an effect on choices in teen pregnancy.

DR. MOORE: What I wanted to say is that it can't directly change behavior that is as personal as sexual behavior and contraceptive use. I think it is one of those distal behaviors that often works through other behaviors, peer relationships, partner relationships. So it's not ... we don't have a lot of information about how those things have their effects.

For example, state policies. I mean, there is a little bit on the seatbelt laws, drinking age for alcohol use, cigarette taxes. There's a little bit on there, but we don't have as much information on this particular topic. I suspect there are some effects. But the other more proximal influences generally seem to have the strongest effects.

LEAH TOUSSAINT: Thank you.

**DR. KRISTEN ANDERSON MOORE**

DR. MOORE: Thank you.

NANCY COPPOLA: Nancy Coppola, Bronx, New York. I was just wondering, for the numbers that you gave where you spoke of the fact that a large percentage of the parents feel that they can still talk to their children. Do you have the reverse data for that? Do the children perceive it the same way? Do they feel that they can talk to their parents? Or is that just simply the parents' perception?

DR. MOORE: Great question. Yes, we have done analyses of that with the National Longitudinal Survey of Youth, the 1997 cohort. The parents were asked a similar series of questions. And we find exactly the ... I mean, the kids were asked the same questions. I mean, it's quite stunning. Because I know that that's kind of the relationship between parents and kids in this country gets really bad perspective. But kids also report that they like their parents. They like spending time with them. They talk with them. The exception is fathers who do not live with their children, considerably lower. But when the parents live with their children, the kids are pretty positive about them. It's countercultural almost, but that's what we find kids reports.

**DR. KRISTEN ANDERSON MOORE**

NANCY COPPOLA: Great. Thank you.

DR. MOORE: Thank you.

STARR SILVER: Hi, Starr Silver from Clearwater, Florida. I have two questions. The first is with regard to youth development and quality. How was quality defined?

DR. MOORE: Quality was defined by the reports from the adolescents and the parents on safety. And we used the Judy Roth and Judy Brooks Scottin's definition of whether the kids felt involved whether they had caring relationships with the adults in the program and whether they were involved in decision-making, parent and kid reports.

STARR SILVER: Thank you. The second question is are youth today defining sex, having sex, differently? I've heard that oral sex attitudes towards oral sex, some kids don't feel that that even is sex. So when you're presenting data, how is sex defined? And are kids more generally seeing sex in a different context these days?

**DR. KRISTEN ANDERSON MOORE**

DR. MOORE: Well, we don't have historical information on that. So we can't do trend data whether ... I mean, a lot of this information is very clearly defined as sexual intercourse. And I think as people are designing their instruments for data collection in these projects, I think it is difficult to ask about the different types of sex. But it might be prudent to do so because there is some ambiguity around that now.

STARR SILVER: Thank you.

TRISH BRADLEY: Good morning. My name is Trish Bradley. I'm from Philadelphia, Pennsylvania. And I was interested in your slide regarding youth development and the impact between low quality youth development programs and no intervention at all or no programs. Can you talk about that a little bit? I was a little shocked behind that.

DR. MOORE: What was the last part of your sentence?

TRISH BRADLEY: About it was almost the same. You said it was as if low quality development program had no impact with the young person versus not being participating at all in a youth development program. And I was interested in that.

**DR. KRISTEN ANDERSON MOORE**

DR. MOORE: We looked at three adolescent outcomes. We looked at their educational positive development. We looked at their social competence and we looked at risky behaviors. And for all three of those adolescent outcomes, it was pretty stunning that being in a high quality program was usually the highest, the best outcomes for kids. And that finding, by the way, holds when you statistically control for social and demographic variables.

And then the kids who were in the medium quality programs were less likely to have ... or more likely to have better outcomes. And then there were those in the low quality programs and those in no programs. And there was really no statistically difference between the two of them.

We were doing roundtables with people running a program and this woman described it as 100 kids, one adult and a basketball. And there are programs out there like that.

TRISH BRADLEY: So that's your definition of low quality. Okay.

DR. MOORE: Well, not in our study. But that was her anecdotal description. Our study was the parent and the child

**DR. KRISTEN ANDERSON MOORE**

reports, safety, adult involvement relationships and decision making.

TRISH BRADLEY: Thank you.

BILL SACKENFIELD: Bill Sackenfield, Tallahassee, Florida. The disparity for the U.S. versus other developed countries is probably wider than teen pregnancy than almost any other MCH indicator that I'm aware of. Do we have further clarity now of what we need to learn from our world colleagues to really address this issue beyond some of what you've already talked about?

DR. MOORE: Well, I think that's a really good question. I think there's a lot we can learn from state variation as well as international variation. Actually, I think one of the interesting things about it is that other countries have very different approaches.

For example, in Japan, adolescents are expected to study very hard and not have sex. And they are certainly not expected to have children at a young age. And so that's a very different approach than say Sweden or the Netherlands where sexual activity, not at an extremely young age, but

**DR. KRISTEN ANDERSON MOORE**

in sort of middle adolescents is accepted as long as contraception is used.

And both of those approaches seem to produce low rates of teen pregnancy and teen childbearing. And somehow that does suggest that there is some kind of a national consensus about this issue and what to do. And I would certainly say, well, as Sarah Brown always says, you know, the adults are arguing while the teens get pregnant. We don't have a unified approach. There is a great deal of disagreement and sensationalism even. So that would be my opinion. We don't have research that would definitively share that conclusion. But it's a really important question.

CAMILLE ASHLEY: Hi, Camille Ashley from Tennessee. Some of your data, you started seeing some trends around 2000 with some changes. And around that period, and again, this is a controversial topic with the abstinence only. But we started seeing significant money towards abstinence only approaches. Can you address any possible correlation you might see in some of the data slides that you showed today?

**DR. KRISTEN ANDERSON MOORE**

DR. MOORE: I missed the first part of your question, the trend in?

CAMILLE ASHLEY: Well, some of your slides showed that there was a ... you started seeing some changes in some of the practices and behaviors of kids around 2000, late nineteen, you know, '95 to 2000, we started seeing some funding, significant funding, for abstinence only. Do you see or can you address any possible correlation there? I know it's a controversial topic. But that's when there's significant funding that started kind of happening with that approach.

DR. MOORE: Yeah, well, we really need, I think, research that looks at state level policies and social and economic variables and how they're related to adolescent behavior. It was very interesting to me that the teen birth rate went down in every single state. And then it went up in every single state. And then it went down in every single state. And it looks like we might be a common culture, you know, that there were some overall trends going on.

And I think many people that I have talked to in the area would feel that it does have something to do with media and

**DR. KRISTEN ANDERSON MOORE**

social values, as well as services and opportunities and disparities. That it's a very, very complex question. Obviously, as the earlier question suggested, we'd really like to know whether there are particular state policies that are more supportive of various changes. At this point in time, I would say it is pretty much conjecture. I worked on a report on this question for the National Campaign to Prevent Teen and Unplanned Pregnancy. And we had a group of people who were part of an expert advisory council. And there wasn't anyone who was absolutely convinced that they had the answer.

You know, it's (a) complex. There are probably some overarching effects that are nationwide and then some very individual effects. I think it's a very important question. Right now, we're focusing on individual programs.

And I'm a youth development person. I'm really excited about all the work that is going on on individual programs. But we refer to it as EBPs, Evidence Based Programs, Evidence Based Practices and Evidence Based Policies. And right now, we're really building a scientific base as all of you here in the Tier One attest, the programs that can

**DR. KRISTEN ANDERSON MOORE**

be effective. And we need to know a lot more about the practices and the policies.

CHARLES EDY: Charles Edy from Atlanta, Georgia. You reported on some data showing that a smaller percentage of students have access or have been exposed to educational programs that included condoms or more comprehensive birth control methods.

I guess my question is, is there some data addresses those kids who know about condoms, know about contraceptives, but simply choose not to use them anyway? And the percentage of young people who are becoming pregnant, but were aware of these other options, but for whatever reason, whether myths within the community. It doesn't feel good. I'm too big for a condom, whatever the reason might be, chose to ... as I have heard from some guys ... but still chose not to use a contraception.

So a program for them would have to address that in some other way rather than simply informing them about the condoms and other birth control methods that the conversation around why it may still not be such a great idea to have sex outside of ... to become pregnant as a

**DR. KRISTEN ANDERSON MOORE**

teenager. Anyway, I just wondered what the data showed about that.

DR. MOORE: Well, that is one of the conundrums that I think drives the field. I think that, by and large, adolescents know that contraception exists. But there is also a lot of misinformation about contraception. Child Trends did some qualitative interviews with community college students who are older and they're in community colleges. So they ought to be more informed. And the misinformation about contraception was really quite remarkable. So that when you don't find young people using condoms consistently or contraception consistently, clearly there are barriers.

And it's kind of a cost benefit ratio. Some of it, of course, is the cost, literally the cost. But some of it, even in the community college group was concerned that their parents would discover they were sexually active. You know, there was a willingness to take a chance. I mean, all the things that you mentioned, I don't know that we have quantitative data that says that says 14 percent of it is due to this and 13 percent is due to that.

**DR. KRISTEN ANDERSON MOORE**

But there are a lot of barriers to consistent contraceptive use. And I might note that those who don't use contraception at all account for a very disproportionate number of all pregnancies. And those who use them inconsistently account for a lot of the remainder. I mean, nature is very efficient. Pregnancy will happen unless there is real consistent use of effective methods.

JUDITH CLARK: Judith Clark, Honolulu, Hawaii. National data has very limited use for those of us who work on the local level in terms of needs assessment program planning and evaluation. And I want to make a plea for making this kind of data available, at least on a county level. So that it becomes more useful to practitioners in the field.

I would also like to comment that the federal government's practice of putting Asian and Pacific Islanders in the same category is both inaccurate and useless, as the two populations are not similar on any educational, social service or health indicator that I am aware of.

In my state, Asians make up 55 percent of the population and account for less than 10 percent of teen pregnancies. Pacific Islanders are 20 percent of our population and make

**DR. KRISTEN ANDERSON MOORE**

up two-thirds of teen pregnancies. And that's true in almost every health and social service indicator.

DR. MOORE: Thank you. And I'm sure our statistical colleagues are taking note. Are there other questions? Thoughts? I think it's very much clear that local data are critical for this. And I might draw your attention to the National Survey of Children's Health which provides state level data. Of course, the youth risk behaviors surveillance system provides state level data for youth who are in school. But more local data are not very available.

VICTOR: Any other questions for Dr. Moore? Well, I'd just like to thank all of you for ... those of you who came up and asked questions, I sat here and I want was quite impressed by the depth of your questions. I'm sure that many of you have similar type questions. Maybe you just didn't have an opportunity or felt you could come up. But I encourage you to continue to ask these questions from Dr. Moore and others of us within the Office of Adolescent Health, because they are probing questions. And they certainly fall with your program. And we want to try to help you answer those questions in order to make your programs that

**DR. KRISTEN ANDERSON MOORE**

much better. So once again, help me thank Dr. Moore for  
being here this morning. [applause]

**(END OF TRANSCRIPT)**