

# Withdrawal/Redaction Sheet

## Clinton Library

| DOCUMENT NO.<br>AND TYPE | SUBJECT/TITLE                                                     | DATE       | RESTRICTION |
|--------------------------|-------------------------------------------------------------------|------------|-------------|
| 001. bio                 | Biographical sketch of Mary Emma Louise Vernon [partial] (1 page) | 09/10/1996 | P6/b(6)     |

### COLLECTION:

Clinton Presidential Records  
Domestic Policy Council  
Lyn Hogan  
OA/Box Number: 11027

### FOLDER TITLE:

Dr. Foster/Teen Pregnancy-1

2010-1083-S

rc119

### RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

- P1 National Security Classified Information [(a)(1) of the PRA]
- P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
- P3 Release would violate a Federal statute [(a)(3) of the PRA]
- P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
- P5 Release would disclose confidential advice between the President and his advisors, or between such advisors [(a)(5) of the PRA]
- P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

C. Closed in accordance with restrictions contained in donor's deed of gift.

PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).

RR. Document will be reviewed upon request.

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- b(1) National security classified information [(b)(1) of the FOIA]
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- b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

TEEN PREG: FOSTER  
\_\_\_\_ ANNOUNCMT.

06/25/96

TUE 14:54 FAX 202 401 5783

DEPUTY SECY  
DEPARTMENT OF HEALTH & HUMAN SERVICES

Chief of Staff

001



Washington D.C. 20201

## FACSIMILE

DATE \_\_\_\_\_

TO: (NAME, ORGANIZATION, CITY/STATE AND PHONE NUMBER):

*Lynn Hogan*

FROM: (NAME, ORGANIZATION, CITY/STATE AND PHONE NUMBER):

Kevin Thurm  
Chief of Staff  
DHHS

690-6133

RECIPIENT'S FAX NUMBER ( ) 6-7028

NUMBER OF PAGES TO SEND (INCLUDING COVER SHEET) 8

COMMENTS

*Call me when you've had a  
chance to review —*

DRAFT

Secretary Shalala and  
CDC Director

June 3, 1996

MEMORANDUM FOR CAROL RASCO

FROM: WHO FROM HHS?? *W. H. H. M.*  
Jeremy Ben-Ami

SUBJECT: Outreach Plan for Dr. Foster

Since Dr. Foster's position as Senior Advisor to the President on Teen Pregnancy and Expert Advisor to David Satcher and Secretary Shalala ~~was announced~~, he has engaged in a range of activities. Dr. Foster has been active with local and national groups on this issue as the President's liaison to the National Campaign to Reduce Teen Pregnancy. He has also maintained an active part-time public schedule, which has included speeches, Congressional testimony, site visits, and media interviews. In coordination with him we would like to focus more on an outreach program.

*To compliment these activities,*  
We define the outreach activities in two areas: speeches and site visits. Dr. Foster's schedule will continue to include appropriate meetings with the White House, HHS and CDC officials on teen pregnancy and youth policy in which he fulfills his advisory and consultant functions. In addition, following the summary is a proposed schedule of his activities over the next several months.

## 1. Public Speaking Role

*serves an important role in*  
Dr. Foster often speaks for the administration, carrying the President's message on teen pregnancy prevention. By being visible and active publicly, he is able to demonstrate the President's commitment to teen pregnancy prevention, while educating people about the Administration's approach to this issue. *(CHECK WITH MARY BETH ON THIS.)*

*have instituted*  
In coordination with the White House Office of Public Liaison, HHS and teen pregnancy groups, we are putting in place a system to help Dr. Foster pro-actively seek major opportunities to speak to national audiences and large groups.

## 2. Outreach to State and Local Communities

*addressing*  
Dr. Foster also serves as a liaison to local communities that have identified teen pregnancy as an issue of concern. These communities are at various stages in organizing their efforts: some want advice about how to initiate a program, while others want to let us know about their progress on a specific program and its positive effects on the community. *Dr. Foster is actively visiting communities, we are arranging for him to make about two trips per month to communities or programs that the Administration has funded. For each site visit, we have asked Dr. Foster to visit and tour a local program that is part of a community-wide network, have a working meeting with its organizers, and pursue speaking or media opportunities.*

*and to prioritize invite time for his time*

Specific grant programs from which we would choose our sites include those funded by CDC's Community Coalition Partnership Programs for Prevention of Teen Pregnancy and OPA's Adolescent Family Life Grants.

- **Community Coalition Partnership Programs for Prevention of Teen Pregnancy:** This program was launched by this Administration under CDC in September of 1995. At that time, we awarded 13 grants totaling \$6.5 million over two years to community coalitions to work with youth in preventing unwanted pregnancies. They aim to enable communities to develop plans for implementing and evaluating community-wide interventions that are innovative, comprehensive and sustainable.

NOTE: In informal conversations, CDC has said that site visits by Dr. Foster would be very helpful in generating local media about these community efforts. The majority of partnerships funded include good programs, but in many cases there is a low level of awareness in the region about these programs and the services they provide. ~~They~~ said that ~~particularly~~ radio coverage, for example, would be helpful in reaching out to community members.

- **Adolescent Family Life Grants:** In September of 1995, HHS's Adolescent Family Life Program awarded 15 grants totaling \$4.2 million dollars for comprehensive demonstration programs aimed at preventing early teenage sexual activity and reducing teenage pregnancies. These programs feature innovative ways to emphasize abstinence as the best way to prevent adolescent pregnancy and to encourage the involvement of parents in these discussions with their children. The program is administered by the Office of Population Affairs under Title XX. (Note: Many of these programs actually target secondary pregnancy prevention for parenting teens.)
- Other programs we have learned about that seem to be successful community-wide grassroots interventions that we would like Dr. Foster to visit.

Attached is a draft schedule of suggested travel for Dr. Foster that builds on both of these priority activities.

Dr. Foster will ~~review~~  
highlight community based programs  
during his site visits.

### 3. Media:

Similar to the process instituted to assist Dr. Foster in prioritizing requests for public appearances, we have developed a system for evaluating, with Dr. Foster's input, media requests. Over time, we seek to have a mix of ~~both~~ national coverage with regional and local press. In particular, we anticipate that

*CDCC/Robert*  
Suggested Activities for  
~~PROPOSED DRAFT SCHEDULE OF DR. HENRY FOSTER~~

Following is a list of sites and initiatives funded by HHS, *which might be appropriate for a visit by*  
~~these sites per month on an ongoing basis until the end of this year.~~  
~~Dr. Foster between now and the end of the year.~~

NOTE: This does not include previously scheduled engagements, and only attempts to outline suggestions for activities on behalf of the Administration in compliance with legal limitations on time allocated for such activities. We expect the Office of Public Liaison to request Dr. Foster as a speaker for additional conferences as well.

*The AFL program is currently funding*  
Emory University, Atlanta, GA: The Emory University School of Medicine is ~~using AFL grant~~ money to expand Postponing Sexual Involvement (PSI), a three-tier educational series developed by Marion Howard, to reach over 9,000 young men and women and their parents. The series emphasizes the need for age-appropriate abstinence messages which are continually reinforced from elementary school through high school. ~~PSI is known as a very successful model program that many other communities have tried to replicate.~~ Dr. Foster could visit a school where the curriculum is used.

*PSI is a well known program model and*  
~~While Dr. Foster is there, we could coordinate an activity/interaction with Juno Fonda and G-CAPP.~~

*also currently funded by the AFL program*  
Lula Belle Stewart Center, Detroit, MI: (AFL grant) This center provides prevention and care services for the low-income population in the urban Detroit/Wayne County area. Prevention efforts aim to increase both the knowledge base about pregnancy and disease prevention and communication between parents, adolescent, and pre-adolescent youth. (Note: I am unclear on whether this focuses on primary or secondary prevention, and need to verify.) *This focuses on primary and repeat pregnancy.*

NOTE: There are other programs in the area that Dr. Foster could reach out to that are not currently federally funded.

Truman Medical Center, Kansas City, MO (AFL Grant): Kansas City's Teen Mentors of Mothers (MOMS) program at the Truman Medical Center provides support and assistance in accessing community services for pregnant and parenting adolescents through culturally-matched mentors. Mentors meet weekly with teens to aid in problem-solving about managing the difficulties of early childbearing. Support groups are also organized specifically for male partners, younger siblings and grandparents. (Again, I need additional information on the extent to which activities focus on primary prevention.) *Only repeat pregnancies. It is a care program providing service to pregnant and parenting teenagers*

*Working with Adolescents in Time (WAIT):* Kansas City, MO (CDC) The Maternal and Child Health (MCH) Coalition of Greater Kansas City is the lead organization for this grant, and for an existing teen pregnancy prevention community coalition called Adolescent Pregnancy Prevention Committee. The Coalition has already been highly successful in a number of community collaborative efforts, including immunizations. Areas selected for implementation of the grant are in Wyandotte County, Kansas and Jackson County, Missouri where the teen birth rates are 50% above national average. The area also encompasses the empowerment zone in MO and KS. It is a high crime and poverty area that has a high concentration of African American adolescents--whose birthrate is said to be over double that of their white counterparts. *This community is highly*

recommended by CDC for Dr. Foster visit. *out*

University of Arkansas/Arkansas Dept. of Education (AFL Grant): The Sex Can Wait program educates students about pregnancy prevention in the 16 districts in rural Arkansas, where in some counties the rate of teen pregnancy is among the highest of any identifiable group in the world. The program's approach includes outreach to minority populations, parental education to promote family communication about sexuality, contraception, STD's and HIV/AIDS, and male involvement to promote male responsibility in pregnancy and parenting.

✓ Family Planning Council of Southeastern Pennsylvania, Inc.: Philadelphia, PA (CDC): Family Planning Council is a private-non profit organization serving the five-county Philadelphia area. As the Title X family planning grantee for Philadelphia, the Council directs a network of health agencies that provide comprehensive family planning services to over 102,000 low-income individuals. The Council started the Health Resource Center Program (HRC) in 1991. Its goal is to reduce rates of unintended pregnancy, STD and HIV by establishing school-based, drop-in centers where students receive education, counseling, and condoms with referrals for health services and contraceptive care. It is now operating in 11 Philadelphia schools, and works with health care providers, a health-related telephone hotline, the Public Schools System and the Department of Public Health to implement it.

Five of the 11 schools with HRCs are located in neighborhoods with extremely high teen birth rates; these neighborhoods are the focus of the grant. The neighborhoods are in North Central Philadelphia, and are culturally diverse high crime and poverty areas. They also include two Empowerment Zones. The Council proposes to expand the existing partnership by creating local coalitions convened by each HRC, which will include teens, faculty from the highschool and feeder middle schools, parents and service agencies. They have developed a plan to prevent teen pregnancy and specific goals for implementation. The Philadelphia site was highly recommended by CDC for Dr. Foster to visit.

Other specific programs recommended in Philadelphia, that may not be part of this effort:  
Program sponsored by Big Sisters of Philadelphia  
BEBASHI (Blacks Educating Blacks about Sexual Health Issues)

Mercy Hospital, Pittsburgh, PA (AFL Grant): Mercy Hospital is coordinating a continuum of services to meet the physical, emotional, psychological and educational needs of pregnant and parenting teens, while expanding school-based prevention education programs. (I need to get more information on this one to see how much of a primary prevention focus it has.)

✓ Family Health Council Adolescent Resource Network, Pittsburgh, PA (CDC): FHC is a private non-profit that provides services including family planning, prenatal and obstetrical care, nutrition, pediatrics, state licensed adoption and community sexuality related education. They have a major initiative in Allegheny County to prevent teen pregnancy (Adolescent Resource Network), and another to reduce women's risk of HIV/AIDS infection. FHC has also received two other grants from CDC through the PA Department of Health that are based on coalition building: one focuses on STDs among teens and the other supports the creation of a network of providers and community based organizations to do breast and cervical cancer screening and education.

*Both are services to prevent first and repeat pregnancies.*

*It has a major*

*FHS*

The targeted area is the Rivers Corridor Communities. The goal is to plan an effective, urban primary pregnancy prevention program for teens for implementation over a 2-year period resulting in a 10% decrease by 2000. They are working with community partners, including: Blue Cross, Children's Hospital, and Magee-Women's Hospital. They also aim to improve coordination with the Philadelphia site.

*in teen pregnancy*

*only issue here is that goals are not mentioned in other sections*

*aiming for a*

NOTE: For both Pennsylvania sites, I am fairly confident that Lynn Yeakel will want to coordinate somehow with Dr. Foster.

✓ City of Milwaukee Health Department: Milwaukee, WI (CDC): Although there are many teen pregnancy prevention programs in Milwaukee, rates have remained high because efforts have been fragmented. The CDC grant money is being used to continue and expand efforts already started by the Milwaukee Metropolitan Adolescent Pregnancy Prevention Consortium, which is serving as the lead agency for a consortium of over 70 provider agencies, parents and teens, school and elected officials, and the religious community.

Another program to note:

Urban League of Milwaukee Male Adolescent Responsibility Project: This is a primary prevention program targeted at middle school male students. It aims to instill a sense of pride in their heritage and hope for their future.

*currently funded by the AFL program*

Inwood House Project, Bronx or Brooklyn, NY: This project will expand a current program called TEEN CHOICE to operate in three urban junior high schools with high teen pregnancy rates in Brooklyn and the Bronx. TEEN CHOICE works with abstinent students to postpone sexual involvement, and teaches sexually active students how to protect themselves from pregnancy and disease. Parents are involved with the program, which promotes improved communication between parents and children on sexuality issues.

✓ Illinois Caucus for Adolescent Health, Chicago, IL (CDC): The Illinois Caucus is a non-profit organization focusing on policy advocacy and public education to improve the health of adolescents, particularly teen parents and those at high risk for pregnancy. It is a state-wide membership group with foundation funding, that is using the CDC grant to work with three communities to develop coalitions to prevent teen pregnancy. Communities served are Westtown (62% Latino), Humboldt Park (50% African American, 50% Latino) and Near Westside (67% African American). The Caucus has a significant community base and is staffed by community residents. The Coalition implementing the grant is made up of 7 community-based groups: Erie Teen Health Center, Vida Sida, Youth Services Project, Chicago Commons, Mile Square Health Center, West Side Future and Chicago Boys and Girls Clubs Horner Center. The Coalition is specifically working to establish or improve: a case management system for young people who have not become pregnant or caused a pregnancy, parent/child communication programs, male responsibility programs, integration of pregnancy prevention and HIV/STDs prevention, and peer education programs.

*out*

In addition, a specific program in the area that has been highly recommended from a separate source but that is probably not in one of the communities funded by the grant.

**The Springfield Urban League, Inc. Adolescent Responsibility Program:** This is a comprehensive primary prevention program for 90 adolescent males and females aged 7-17 that aims to foster responsible behavior and development of intrapersonal skills and self-esteem. The program draws support from volunteer "positive role models" who teach the classes, serve as chaperons, tutor, etc. The program has the following components:

- Education, mentoring and tutoring which includes 38 sessions held weekly for two hours each. ~~Glasses are led by volunteers.~~
- Parenting support group for parents of program participants.
- A community awareness campaign directed at adults and teens.

✓ **Trustees of Health and Hospitals of the City of Boston; Boston, MA (CDC):** This is the "hub" organization in Boston, where the Adolescent Pregnancy Prevention and Intervention Network was formed as a new initiative. It is a public/private effort by the Boston Department of Health and Hospitals, the Boston Public Schools and the Alliance for Young Families to pool resources among the many teen pregnancy prevention programs in Boston, targeting 5 neighborhoods where teen birth rates are highest. (Alliance for Young Families is a non-profit consortium of human service and health care agencies in MA that work to prevent teen pregnancy, promote adolescent health and meet the service needs of pregnant and parenting teens and their children. One of its four programs is the Boston Initiative for Teen Pregnancy Prevention which coordinates a broad-based 300 member citywide coalition promoting postponement of early childbearing through responsible decision-making.) ~~This site was highly recommended by CDC.~~ *out*

Examples of specific sites *in the Boston area* that Dr. Foster could visit include:

**The Urban League of Eastern Massachusetts' Youth Education and Development Program; Roxbury, Massachusetts:** This is primarily a school-based program that started 8 years ago, working with African American and Latino males (8-15) in the Roxbury, Dorchester, Jamaica Plain and Mattapan areas. The program serves boys who come from single parent families with incomes at or below the poverty level, and aims to provide a vision for participating boys for their futures as students, workers, and parents by developing confidence, academic and employability skills, values and a sense of responsibility. The Director of this program participated in a meeting with the President and Dr. Foster this year.

**Geiger-Gibson Community Health Center; Dorchester, MA:** Teen Pregnancy Prevention and Healthy Start Programs has historically served pregnant and parenting teens, but has added a focus on prevention of primary and secondary pregnancies through case management services. With an emphasis on education, the program aims to teach girls and boys to set goals and avoid anything like young motherhood or fatherhood, violence or drugs that might get in the way.

*out* **City of Rochester Bureau of Human Services; Rochester, NY (CDC):** (This one would be better for Dr. Foster to visit later on according to CDC.)

**Planned Parenthood of Central Washington; Yakima, WA (CDC):** (This one is not as far along as the others, and a visit from Dr. Foster should come later on according to CDC.)

There are additional programs around the country that we could recommend that are not funded by these programs; for example:

Girls Incorporated of Metro Denver. The national Girls Incorporated Preventing Adolescent Pregnancy is one of the programs included in *The Best Intentions*, compiled by the Institute of Medicine. The Denver chapter has adapted the program, which includes four age appropriate curricula address the needs of girls 9 to 18, covering: developing parent-daughter communication, assertiveness skills and the ability to say "no," awareness of contraception and disease protection, and career and education planning. The program was started in 1989, serves Hispanic (53%), African American (16%) and White (16). In addition to their own facility, Girls Inc of Metro Denver sponsors teen pregnancy prevention programs in middle and elementary schools in Denver. It works with other community organizations, such as Girl Scouts, Boys and Girls Clubs, and a community health center.

Statement of  
Dr. Henry Foster  
Senior Advisor to the President on Teen Pregnancy  
and Youth Issues

Congressional Black Caucus Legislative Weekend  
Issue Forum: Teen Pregnancy Prevention

September 12, 1996

Thank you, Representative Clayton. I am pleased to be here at the 26th Annual Legislative Conference of the Congressional Black Caucus, and to have the opportunity to speak about an issue that has so much impact on our communities and our country -- teen pregnancy prevention.

For almost four decades, as a teacher, as a university leader, as a practicing obstetrician/gynecologist, I have dedicated my life to bringing healthy lives into this world -- and to helping people reach their full potential.

And I bring this commitment and enthusiasm to my role as the President's Senior Advisor for Teen Pregnancy and Youth Issues and liaison to the National Campaign to Prevent Teen Pregnancy -- a recently-formed nonprofit nonpartisan initiative supported entirely by private donations and led by a diverse group of prominent Americans.

In this role, I've enjoyed a number of great opportunities:

The opportunity to learn more about the Clinton Administration's comprehensive strategy to prevent teen pregnancy -- which includes

demonstration grants to communities, state-of-the-art research, and a strong prevention message from the top.

The opportunity to see first-hand innovative prevention strategies being developed at the grass-roots level, many of which have federal support. This includes the outstanding and innovative collaborations supported by the CDC's Community Coalition Partnership Programs for the Prevention of Teen Pregnancy, and the Adolescent Family Life Demonstration Grant program administered by the Office of Population Affairs.

And perhaps most uplifting, the opportunity to join the President in challenging all caring adults to listen to our young people, help them form positive goals, and give them the support to achieve them.

And make no mistake, that part includes helping our young people remain abstinent and postpone pregnancy until they are ready to care for both themselves and their children.

Why is teen pregnancy such a big problem?

Early sex and early pregnancy so often compounds problems already evident in the lives of these teenagers -- exposure to poverty, violence, drug use, HIV/AIDS, and so many other negative outcomes.

Because children born to teen parents are more likely to be poor,

... are twice as likely to be abused or neglected ...

... are more likely to have serious health problems ...

... are more likely to drop out of school ...

... and are more likely to become teen parents themselves.

And because there is nothing more in the national self-interest than the protection and nurturing of children and our future leaders.

That's why I launched the "I Have a Future" program in Nashville, Tennessee back in 1986 -- and there's a lot we can learn from this effort to promote abstinence and reduce teen pregnancy.

The fact is, too many children today believe that their only hope is having babies.

We've got to replace that with a dream of hope and unlimited achievement.

That's the philosophy behind the "I Have a Future" program.

Our program is anchored in Nashville's public housing developments. The program emphasizes abstinence and involves all family members and the entire community.

Everybody from parents to politicians and from the clergy to business leaders has a role to play.

There are three parts to the program:

First, we equip young women and young men with the basic information they need about health, human sexuality, and drug and alcohol use so they understand the benefits of abstinence and the consequences of early sexual activity and other risky behaviors.

Second, we provide a comprehensive array of adolescent health services, with a focus on abstinence and academic achievement.

And third, and most important, we help young people enhance their life options through activities that improve their job skills, self-reliance, values and self-esteem.

We also take the time to understand the unique aspects of young peoples' lives, and to help them build up their self-esteem.

And the program is working.

This past school year, of the 24 program participants who are graduating from high school, 16 went on to college, and four joined the armed services. Eight of these college-bound students are African-American males.

It's a difficult process that takes time and requires lots of people -- but it does work.

This shows you what one community can do when it comes together and makes teenage well-being a real priority -- and I believe this kind of success is possible in every community.

But let me be clear: What works in Nashville may not work in Chicago or Charlotte.

It will be up to local communities to decide what's best for them.

This is one example of where the National Campaign to Prevent Teen Pregnancy can play a vital role. A key part of its strategy is to support and stimulate state and local action, and to make sure that local community efforts are based on research about what works.

As part of my role as liaison to the National Campaign, I will continue to work with communities and community leaders like yourselves across the United States to help them develop their own successful programs that help young people avoid the pitfalls and instead achieve their greatest potential.

And make no mistake, as President Clinton has said, "We've got to ask our community leaders and all kinds of organizations to help us stop our most serious social problem: the epidemic of teen pregnancies and births where there is no marriage."

There are no easy answers to this national tragedy.

... but we must have the courage to take on this tough battle

-- and the commitment to demand results.

Let's not forget, we have made some progress. The most recent figures show teen pregnancy and birth rates declining.

According to the Centers for Disease Control and Prevention, the birth rate for teens aged 15-19 declined 4 percent from 1991 to 1993.

The birth rate for teens aged 15-17 declined 2 percent from 1991 to 1992, and remained stable in 1993.

And teen pregnancy rates declined from 1991 to 1992 in 30 of the 41 reporting states.

But we still have a long way to go.

We must send a clear and consistent message to teenage boys and girls that they should abstain from sex.

But most important, we must give them reasons to want to postpone early sexual activity.

And we must expect them to succeed.

We all must to come together to solve this problem. This forum is the right step in the right direction.

Thank you.

## Clinton Library Transfer Form

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| Subgroup/Office of Origin | Domestic Policy Council                    | Subseries         |           |
| Folder Title              | Dr. Foster/Teen Pregnancy-1                | OA Number         | 11027     |
|                           |                                            | Box Number        |           |
| Description of Item(s)    | 6/22/96 ABC News Dr. Foster, VHS recording |                   |           |

**Donor Information**

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***TEEN PREGNANCY***



Mary  
Vernon

***BRIEFING MATERIALS***

***26TH ANNUAL***

***CONGRESSIONAL BLACK CAUCUS FOUNDATION***

***LEGISLATIVE CONFERENCE***

***September 12-13, 1996***

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**Congress of the United States**  
**House of Representatives**  
**Washington, DC 20515-3301**

September 4, 1996

Dr. Henry Foster  
Health Policy Fellow  
Association of Academic Health Professionals  
1400 16th Street, NW  
Suite 410  
Washington, D.C. 20036

Dear Dr. Foster:

I am delighted that you are available on September 12, 1996 to participate in my Congressional Black Caucus Issue Forum on Teenage Pregnancy Prevention. The forum will be from 2:30 - 4:00 PM in Room 27 of the D.C. Convention Center. It is my hope that this forum will raise the awareness level of this issue and challenge those in attendance to become activity engaged in this endeavor.

The first panel is comprised of Dr. Mary Vernon, Medical Officer at the CDC in Atlanta; Dr. Gloria Jackson Bacon, of the Alt Geld Clinic at the Alt Geld Housing Project in Chicago; and Gail Elizabeth Wyatt, PHD, of the Department of Psychology at UCLA. You will be on the second panel along with two teenagers. I have asked each teenager to make three points about teen pregnancy. I would like for you to summarize and wrap-up the program and include the National Campaign to Prevent Teen Pregnancy.

To maximize our ninety minutes, you and the first panel speakers will be allotted ten minutes for your presentations. Each teenager will be allotted five minutes so that the remaining time (20 - 25 minutes) can be devoted to audience participation for questions, answers and discussion. A copy of the tentative agenda is enclosed for your review.

Again, I am pleased that you have agreed to be on the program and I look forward to seeing you on September 12th. If you need additional information or if I may assist you in any way please contact my office at 202/225-3101 and speak with Susan Kelly

Sincerely,

*Eva M. Clayton*  
Eva M. Clayton  
Member of Congress

EMC:sek  
enclosure

LOUIS STOKES

11TH DISTRICT, OHIO

MEMBER,

COMMITTEE ON APPROPRIATIONS

SUBCOMMITTEES:

RANKING MEMBER,

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MEMBER,

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# Congress of the United States

House of Representatives

Washington, DC 20515-3511

August 29, 1996

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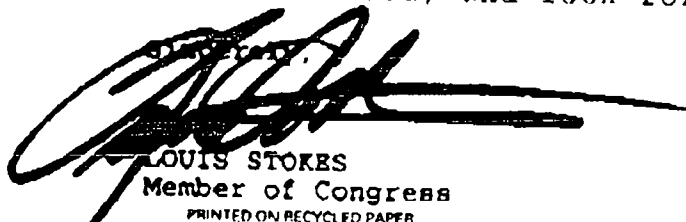
Dr. Henry Foster  
Meharry Medical College  
1005 D.B. Todd Blvd.  
Nashville, TN 37208

Dear Dr. Foster:

As Chairman of the Congressional Black Caucus (CBC) Health Braintrust, I appreciate your agreeing to participate in the violence prevention forum of the upcoming braintrust. The Health Braintrust brings together health experts and advocates from across the country to assist in formulating the nation's health policy and agenda, especially as they relate to improving the health of minorities.

Entitled "A Cry for Help: The Violence Epidemic," the forum will be held on Friday, September 13, 1996, 9:00 a.m. to 12:30 p.m., in Washington, D.C. at the Washington Convention Center. As a leader in violence prevention and teen pregnancy prevention, you have helped to bring attention to these critical health problems and the relationship between the two of them. As you have suggested, your presentation, entitled "The Calming Storm," will focus on this perspective, and overcoming barriers to control and prevention. Throughout the presentation, you should place major emphasis on solutions and recommendations for addressing these health problems. You are allowed a total of eight minutes for your presentation. As dialogue between the panelists and audience is key to the forum's success, I must impress upon each presenter the need to tailor their entire presentation not to exceed the specified time allotted, in order to allow sufficient time for discussion. Information provided during this forum will be used by the CBC to craft legislation, and by others present to better educate and mobilize their communities to improve women's health and to control and prevent violence.

Please fax a copy of your biographical sketch and your organization's mission statement to Ms. Fredette West, the Health Braintrust Coordinator, by September 10th. Our fax number is [202] 225-1339. Also, please bring 150 copies of your prepared statement to the forum. Should you need to deliver material to us, our address is 2365 Rayburn House Office Building, Washington, D.C. 20515. If you have any questions and/or concerns regarding the forum, please do not hesitate to contact Ms. West, at [202] 225-7032. Again, I thank you, and look forward to your participation.



LOUIS STOKES  
Member of Congress  
PRINTED ON RECYCLED PAPER

LS/fdw

26th Annual Congressional Black Caucus Legislative Weekend  
Issue Forum: Teenage Pregnancy Prevention  
Thursday, September 12, 1996 2:30 - 4:00 PM  
D.C. Convention Center - Room 27  
900 9th Street NW  
Washington, DC

TENTATIVE AGENDA

2:30 - 2:35

WELCOME AND INTRODUCTION OF MODERATOR  
Representative Eva M. Clayton

2:36 - 2:45

MODERATOR'S REMARKS AND INTRODUCTION OF PANELIST

**FIRST PANEL**

2:46 - 3:15

Dr. Mary Vernon, Medical Officer, Division of Adolescent and School Health, Centers for Disease Control and Prevention, Atlanta, who will define the problem.

Gayle Elizabeth Wyatt, PHD Professor Dept. Psychology at UCLA, who will address the psychological reasons, consequences of adolescent behavior.

Dr. Gloria Jackson Bacon, of the Alt Geld Clinic in the Alt Geld Housing Project in Chicago, who will speak on what it is like on the front line and what works.

**SECOND PANEL**

3:16 - 3:35

Two teenagers, from Advocates for Youth, each teen will have five minutes to make three points about teen pregnancy.

Dr. Henry Foster, the Presidential Advisor on Teen Pregnancy and the White House Liaison to the National Campaign to Prevent Teen Pregnancy, who will wrap-up the program.

**QUESTION and DISCUSSION PERIOD**

3:35 - 4:00

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FRIDAY, SEPTEMBER 13, 1996

Session II: "A Cry for Help: The Violence Epidemic

Registration: 8:00 a.m. - 9:00 a.m.

Forum Time: 9:00 a.m. - 12:30 P.M.

Location: Washington Convention Center - Room 32

WELCOME & OPENING REMARKS MEMBERS OF CONGRESS

PRESENTERS

- A REPRESENTATIVE OF THE EMBASSY OF SOUTH AFRICA  
TBA
- ROY L. SCHEIDER HOSPITAL, V.I.  
DR. JOE POBLETE, COMMISSIONER
- ASSISTANT DEAN, OFFICE OF GOVERNMENT & COMMUNITY PROGRAMS  
PROFESSOR, PUBLIC HEALTH PRACTICE, HARVARD SCHOOL OF PUBLIC  
HEALTH  
DR. DEBORAH PROTHROW-STITH
- ACTING DIRECTOR, DIVISION OF VIOLENCE PREVENTION,  
DR. JAMES MERCY
- NATIONAL CAMPAIGN TO PREVENT TEEN PREGNANCY  
DR. HENRY FOSTER, LIAISON
- FREE MIND GENERATION, INC.  
MS. KENYA NAPPER, FOUNDER & PRESIDENT
- MAD DADS, INC.  
MR. EDDIE STATON, NATIONAL PRESIDENT & CO-FOUNDER
- DIRECTOR, CENTER ON THE FAMILY  
DR. BOBBIE ALLEN HENDERSON

**BRIEF BIOGRAPHY**

**Mary E. Vernon, M.D., M.P.H.**

Mary E. Vernon, MD, MPH, currently serves as the Chief Medical Officer, Division of Adolescent and School Health, National Center for Chronic Disease Prevention and Health Promotion, at the Centers for Disease Control and Prevention (CDC) in Atlanta, Georgia. Prior to coming to the CDC, Dr. Vernon was an Assistant Professor of Pediatrics in the Department of Pediatrics at Duke University Medical Center (DUMC) and the Director of Adolescent Health Programs at the Lincoln Community Health Center in Durham, North Carolina. She also completed her Pediatric residency training and a Robert Wood Johnson General Academic Pediatric Fellowship at the DUMC. She received her Medical Degree from the Columbia College of Physicians and Surgeons in New York City and her Masters in Public Health from the Maternal and Child Health Division at the University of North Carolina in Chapel Hill, School of Public Health.

Dr. Vernon is presently the lead person in the Division of Adolescent and School Health for adolescent preventive and clinical health services. She is responsible for providing technical assistance to CDC funded organizations involved in school-based and school-linked health services. Through a grant with the American Medical Association, Dr. Vernon is providing assistance in the implementation of the Guidelines for Adolescent Preventive Services (GAPS) in the school setting, private practitioners offices, Health Maintenance Organizations, and community health centers. In addition, Dr. Vernon represents the CDC on several national committees involved with primary health care, health promotion and disease prevention, policy issues, and public health services programs that address children and adolescents.

Dr. Vernon has demonstrated a strong commitment to the health care of children and adolescents. Prior to coming to the CDC she was responsible for writing grants that secured more than \$1.5 million for the children and adolescents in North Carolina. Since her arrival at the CDC, her expertise in primary care has been valuable in developing new initiatives with grantees, such as the Columbia University School Health Policy Initiative and other national organizations, responsible for generating and supporting policy development for school health. She is interested in the development of collaborations between Federal, non-federal, and private agencies and organizations in the delivery of public health, primary care, and preventive health services to children and adolescents.

## GAIL WYATT BIO

Gail Elizabeth Wyatt's work as a psychologist and social activist has been strongly influenced by her life experiences, strong family ties, and a sense of pride in her cultural heritage. Wyatt followed a family tradition and attended an historically Black university, Fisk, in Nashville, Tennessee for her bachelor's and master's degrees. She received her doctorate from the educational psychology program at the University of California, Los Angeles. Wyatt became the first African-American woman to receive training as a sex therapist at UCLA's Neuropsychiatric Institute. She later became the first African-American woman to be licensed as a clinical psychologist in California. She was awarded her first grant to examine the sexual experiences of African-American and White women in Los Angeles County. This was one of the first community-based studies of women's abusive and consensual sexual experiences and factors that influence sexual decision making. Wyatt received the first Research Scientist Career Development Award (RSDA) given to an African-American woman to develop the methodology and training necessary to conduct such work. Over the following 10 years, a combination of NIMH and RSDA support provided Wyatt with the time and data needed to write about the methodology she developed to examine sexual behavior within a sociocultural framework. Her face-to-face interview, The Wyatt Sex History Questionnaire, is used extensively both nationally and internationally. The California Professional Society on the Abuse of Children honored Wyatt with its Distinguished Service Award in both 1987 and 1991. In 1992, Wyatt became the first member of an ethnic minority group to receive the NIMH Research Scientist Award. The Los Angeles Young Women's Christian Association also honored her research contributions with a Silver Achievement Award.

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12/94

**Biographical Sketch  
MARY EMMA LOUISE VERNON**

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Personal Data:

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Education:

1. South Carolina State College, Orangeburg, SC Bachelor of Science Degree, Magna Cum Laude, 1968-1972
2. Harvard University, Cambridge, Massachusetts: Health Careers Program, Pre-Med Courses, Summer 1970 and 1971
3. Columbia College of Physicians and Surgeons, New York City, New York: Medical Doctor, 1972-1976

Post Graduate Training:

1. Internship and Residency, Duke University Medical Center, 1972-1976  
Durham, NC.
2. Robert Wood Johnson General Academic Pediatric Fellowship, 1979-1981  
Duke University Medical Center, Durham, NC.
3. Masters in Public Health Degree (Maternal and Child Health), 1988-1990  
The UNC School of Public Health at the University of North Carolina at Chapel Hill, NC.

Previous Position:

1. Assistant Professor of Pediatrics, Department of Pediatrics, Duke University Medical Center, 1982 to present
2. Director of Adolescent Health Services and Teen-Link Project, Lincoln Community Health Center, 1981-1991
3. Associate Attending, Durham County General Hospital, 1982-1991

Present Position:

1. Chief Medical Officer, Centers for Disease Control and Prevention (CDC), June 1991-present
2. Project Officer, Division of Adolescent and School Health (DASH), National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP), Centers for Disease Control and Prevention (CDC), June 1991-present

STATEMENT OF DR. HENRY FOSTER

SENIOR ADVISOR TO THE PRESIDENT  
ON TEEN PREGNANCY AND YOUTH ISSUES

CONGRESSIONAL BLACK CAUCUS LEGISLATIVE WEEKEND

ISSUE FORUM:  
A CRY FOR HELP: THE VIOLENCE EPIDEMIC

SEPTEMBER 13, 1996

Thank you very much for your warm introduction. I am most appreciative to Congressman Stokes for convening these health workshops. Also, on a personal note, I thank him for the strong statement he delivered to the Senate Labor and Human Resources Committee in support of my Surgeon General nomination last year. And thank you, Fredette, for all of your logistical support of this meeting.

On January 29 of this year, President Clinton appointed me as his Senior Advisor on Teen Pregnancy and Youth Issues, and I also serve as a consultant to the Centers for Disease Control and HHS as a whole. Although separate workshops on violence and on women's issues are being held, and this categorical delineation is not inappropriate, I must emphasize that teen pregnancy is indeed a form of violence in more ways than one. Let me start with a hard fact.

For women who finish high school, reach the age of 20 and get married before their first child is born, their child has only an 8 percent chance of living in poverty. Conversely, for those females who don't do these three things before having their first child, the chance of the child living in poverty rises to 80 percent. Make no mistake -- poverty is a form of violence and holds a direct relationship to teen pregnancy.

The magnitude of teen pregnancy in this country is staggering. More than one million teen pregnancies, virtually all unplanned, will occur in this country this year. The United States leads all other Western nations by a two-fold margin. Our annual teen

pregnancy rate of 111 per 1,000 females aged 15-19 is more than double that of the next nearest Western nation, which is the United Kingdom at 46 births per 1,000. The Netherlands and Japan have just 10 pregnancies per 1,000. It is most important to appreciate that this is an American problem that cuts across all ethnic, economic and social conditions. This a problem affecting the whole nation.

There is yet another aspect to the violence of teen pregnancy: at least one-half of babies born to adolescent mothers are fathered by adults. More than 400 teen pregnancies each day are caused by men six or more years older than their female consort. And all too often the participation by the female is forced. This calls for national and local action focused directly on irresponsible and delinquent fathers.

Now let me share with you a few aspects of the program that has sent more than 50 inner city youth to college -- the "I Have A Future" program. The selection of a community-based intervention in a residential setting is its major unique aspect. First, this residential venue allows us to address idle time more adequately; (i.e., evenings, weekends, and summers) than do school-based programs. Second, community-based centers such as these are open to all adolescents, including students not in school. Third, the closer proximity to families provides a far better opportunity to involve parents and siblings.

It was most evident that it would be a mistake to go into these communities and tell these residents what was best for them. Instead we conducted 500 heads of household surveys. Our questions were in two major groups:

- (1) What do you envision as the greatest problems facing your children? and,
- (2) What do you think might be useful interventions to improve these conditions?

As suspected, these citizens want the same thing for their children that you would want for yours. They are concerned about the high rate of crime, teen pregnancy, violence, sexually transmitted diseases, lack of job opportunities and too much idle time for their youngsters. And, as for interventions, they thought family life/teen pregnancy education, conflict resolution, contraception availability, computer programs and recreational activities would all be of benefit.

The IHAF Program incorporates the following five objectives:

- (1) To improve knowledge and attitudes related to personal health, including awareness of human sexuality, the value of abstinence, the effects of drug and alcohol abuse and other behaviors that may place youth at risk;
- (2) To provide ready access to social services including contraceptive availability;

- (3) To increase socially appropriate behavior with particular focus on school achievement;
- (4) To engender a more positive self-concept and constructive attitude toward community, family life, and the future; and
- (5) To expand educational opportunities for health professional students.

In closing, a word about the National Campaign to Prevent Teen Pregnancy. As the President's Senior Advisor on Teen Pregnancy and Youth Issues, I serve as his liaison to the National Campaign. The Campaign is privately funded and is a non-partisan effort being led by a distinguished Board whose chair is former New Jersey governor Tom Kean. Four Task Forces have been established. They are: (1) Media; (2) State and Local Action; (3) Religion, Culture and Public Values and, (4) Effective Programs and Research.

The mission of the Campaign is "to prevent teen pregnancy by supporting values and stimulating actions that are consistent with a pregnancy-free adolescence." The national goal is to reduce the teen pregnancy rate by one-third by the year 2005.

I thank you very much for inviting me to share some of my ideas with you.

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## WHAT IS THE ADMINISTRATION DOING?

### QUESTION:

The President has called on communities and individuals to help reduce teen pregnancy. But what is the Clinton Administration doing to help communities address the problem?

### ANSWER:

- ▶ The Administration is working hard to address this complex social problem, through funding for community demonstration projects, public/private partnerships, and comprehensive research to find out which approaches work best.
- ▶ And it was the President's leadership that gave a jump start to the private sector's National Campaign to Prevent Teen Pregnancy.
- ▶ In addition, much of the Administration's social and economic agenda, ranging from education reform to welfare reform is designed to offer young people both disincentives and positive alternatives to early parenting and sexual activity.
- ▶ But, as the President mentioned in his State of the Union address, government can't do it alone. Community organizations, churches, schools, and citizens and the federal government must join together to fight this problem.

## NEW HHS PREGNANCY PREVENTION PROGRAM

### QUESTION:

What is the Department's FY 97 budget request of an additional \$30 million in teen pregnancy prevention funds going to be used for?

### ANSWER:

- ▶ I'm not responsible for oversight of HHS's programs, but I understand that the budget request will build on the Department's ongoing partnership with local communities. The Department is seeking to help and encourage those communities that have demonstrated a significant need as well as a significant commitment in this area. The new program will build on new research findings about what works.

### BACKGROUND:

- ▶ President Clinton is seeking \$30 million in his FY 1997 budget to help communities in their fight against teenage pregnancy.
- ▶ The **President's Teenage Pregnancy Prevention Initiative** will enable us to build on current Departmental activity in this area, to expand what we know about effective prevention strategies, and make sure these strategies are put to use in communities that have high teen pregnancy rates.
- ▶ The initiative will further the Department of Health and Human Service's on-going partnership with local communities, focusing especially on those that have a solid infrastructure to launch new strategies. The Initiative will help communities provide opportunities for young people to take responsibility, increase their competence, and make progress toward becoming contributing members of adult society.

- ▶ Based on the needs of individual communities, the Initiative will support a wide variety of approaches to preventing teenage pregnancy. These approaches include abstinence-based activities, school health, family planning, alcohol and drug use prevention and referral for treatment, academic tutoring, literacy training, drop-out prevention programs, career and college counseling, mentoring, job skills training, apprenticeships, part-time paid work, community service programs, and local media campaigns. The funding can be used to fill gaps in services, ensure coordination of services, and other similar activities.
- ▶ The President's Teenage Pregnancy Prevention Initiative will fund 25 projects at \$1 million each. Because evaluation and learning is a key component of this initiative, \$5 million will be set aside for rigorous evaluation, and federal training and technical assistance.
- ▶ These demonstration grants will provide resources to expand or strengthen promising strategies that address local community needs. Bringing together business, media, religious, and other groups, they will work to encourage individual and community responsibility and provide opportunities for youth in the effort to reduce teen pregnancy rates in this country.

**Characteristics of the ACF program:**

- Demonstration grants not to exceed \$1 million each.  
(Earlier materials stated 25 grants at \$1 million each.)
  - Target urban, suburban, and rural areas with high teen pregnancy rates and where collaborative efforts and/or interagency linkages are already in place or are beginning.
- I. Demonstration programs will be encouraged to involve many sectors of the community, including the business, media, education, religious, health and social service sectors.
  - II. Grantees may be any non-profit public or private entity or consortium of such entities. Potential grantees include, but are not limited to: municipal governments, public health departments, community-based organizations, public schools, universities, and hospitals.
  - III. Types of activities which may be funded:
    - abstinence-based activities
    - school health
    - family planning
    - academic tutoring
    - school drop-out prevention
    - alcohol and drug use prevention and referral for treatment
    - job skills training
    - peer counseling
    - mentoring
  - IV. Evaluation and learning are key components of this new initiative. \$5 million will be set aside for training, technical assistance and evaluation.
    - Each site will use a portion of the grant funds for a process evaluation. In addition, HHS will award a contract for an in-depth cross-site evaluation.
    - ACF will provide technical assistance including information about program model refinement, evaluation design and implementation, and how to access other federally funded resources available in the community.
  - V. This new initiative will be based on recently completed and reviewed research by Child Trends, Inc. This research identified promising approaches as those which:
    - Enhance current and future economic opportunity for teens
    - Combine education about abstinence with information about contraception
    - Address males as well as females

- Involve and inform families and communities
- Make contraceptive services accessible to teens
- Link a broad array of services for teens (e.g., education/training plus contraceptive services)
- Increase the length of time for interventions
- Start intervention at an early age
- Are comprehensive in nature
- Support families.

This research also identified limitations of many existing programs:

- Scope of intervention/program is too narrow;
  - Program goals do not relate to program inputs;
  - Program starts with adolescents rather than younger children
  - Approach lacks sensitivity to culture, age, or gender
  - Approach is not based on documented research findings.
- FTE numbers will not increase as a result of this program.

## HOW DOES THE NEW ACF PROGRAM COMPARE WITH OTHERS?

### QUESTION:

How is this new teen pregnancy program different from those that CDC, the Office of Population Affairs, and other HHS agencies already run?

### ANSWER:

- ▶ My understanding is that it is a complementary effort with other HHS programs.
- ▶ This new program differs in several significant ways:
  - 1) It is targeted to communities with high teen pregnancy rates that have already developed coalitions or infrastructure;
  - 2) The programs that are funded will be rigorously evaluated;
  - 3) It will emphasize the need to target both young men and young women.

### Existing programs within HHS

**CDC** (Community Coalition Partnership Programs for Prevention of Teen Pregnancy; \$4.7 million)

- Thirteen demonstration grants were awarded at an average of \$250,000 each. The CDC program emphasizes coalition building within communities with high rates of teen pregnancy; the **ACF** program seeks to capitalize on the existing infrastructure in communities (proven successful at implementing programs) and will serve urban, suburban, and rural communities.

**OPA** (Family Planning Program, Title X; \$60.0 million is spent on teen programs and/or services to teens)

- The Title X Family Planning Program provides funding support to more than 4000 family planning clinics nationwide and serves nearly 5 million persons annually. Approximately 30 percent of Title X clients are adolescents. Title X supported clinics offer a wide range of services, including reproductive health and family planning services, counseling, education, and outreach. While all of these services are available to adolescent clients, abstinence is always the primary focus when counseling adolescents about sexuality issues.

**OPA** (Adolescent Family Life Program; \$6.3 million)

- Since 1982, the AFL program has awarded nearly 200 grants supporting demonstration projects to prevent early sexual activity and pregnancy and to provide comprehensive services to pregnant and parenting adolescents, their children and families. Programs providing prevention services emphasize abstinence as the best way to prevent adolescent pregnancy and both programs providing prevention services and those providing care services encourage the involvement of parents. Other innovative features of prevention projects include.

## WHAT ELSE IS THE ADMINISTRATION DOING?

### QUESTION:

What are some other ways the Administration is working to prevent pregnancy among teenagers?

### ANSWER:

- ▶ President Clinton recognizes that providing youth with "something to say 'yes' to" is a critical component of preventing negative outcomes like teenage pregnancy.
- ▶ As an example of this kind of initiative, in October, 1995, The Clinton Administration launched the Community Schools Program -- \$9 million in grants to 48 programs to provide safe places where youth from high-risk communities can go after school and on weekends and engage in productive activities and experiences that will help them make a safe passage to adulthood.
- ▶ In just a few months of operation, Community Schools Programs across the country have launched a range of exciting and critical activities for youth. These activities include mentoring, access to health care, tutoring, drug and violence prevention, job skills, and connections to the job market among others.
- ▶ The Community Schools Program was authorized in the Crime Bill at \$37 million in FY 1995, increasing to \$201.5 million in FY 2000. It was funded in FY 1995 at \$25.9 million, and the President requested \$72.5 million for the program in FY 1996.
- ▶ Congress rescinded the FY 1995 appropriation to \$10 million, and in FY 1996, Congress zeroed out the program.
- ▶ In FY 1995, ACF funded 48 grantees for the first year of a five-year project period. These grantees were funded at levels substantially below the levels they had requested.
- ▶ Consistent with his commitment to promoting positive youth development, the President has requested \$13.6 million for Community Schools in his FY 1997 budget.

## NATIONAL CAMPAIGN TO PREVENT PREGNANCY

### QUESTION:

Could you tell us about the National Campaign to Prevent Teen Pregnancy?

### ANSWER:

- ▶ The Campaign grew out of President Clinton's challenge issued in his 1995 State of the Union address that "parents and leaders all across the country ...join together in a national campaign against teen pregnancy to make a difference."
- ▶ In October 1995, a follow-up meeting was held at the White House with a group of private citizens to discuss what might be done, which led to the formation of the Campaign. In his 1996 State of the Union, the President mentioned the Campaign as one very positive response to the problem of teen pregnancy.
- ▶ It is a totally private and nonpartisan effort being led by a distinguished board. Work is conducted through four task forces and a small staff, and private sector funding is being sought to accomplish its objectives.
- ▶ The mission of the National Campaign is to prevent teen pregnancy by supporting values and stimulating actions that are consistent with a pregnancy-free adolescence. Its goal is to reduce the teen pregnancy rate by one-third by 2005.
- ▶ The campaign will, among other things, enlist the help of the media, and support and stimulate state and local action to reduce teen pregnancy. It will also foster a national discussion about how religion, culture, and public values influence both teen pregnancy and responses to it.
- ▶ The Campaign's founding board met for the first time in February. Former New Jersey Governor Tom Kean was elected as its founding chairman, and Isabel Sawhill from the Urban Institute as its President. Sarah Brown, formerly of the Institute on Medicine, was appointed Director of the National Campaign.

- ▶ The Executive Committee of the National Campaign to Prevent Teen Pregnancy met in July to discuss the Campaign's first-year projects and to review progress on setting up administrative and financial systems. The Committee also reviewed the plans from each of the four Task Forces that have been formed. The four Task Forces include:
  - Effective Programs and Research Task Force, chaired by Kristin Moore, Executive Director, Child Trends, Inc.;
  - State and Local Action Task Force, chaired by Barbara Huberman, Director of Training, Advocates for Youth;
  - Religion and Public Values Task Force, chaired by William Galston, Professor, School of Public Affairs, University of Maryland; and
  - Media Task Force, chaired by Jody Miller, Senior Vice President for Operations, Americast.

▶

## WHAT IS DR. FOSTER'S ROLE?

### QUESTION:

Dr. Foster, can you tell us what your role is in the Administration?

### ANSWER:

- ▶ I serve as Senior Advisor to the President on Teen Pregnancy and Youth Issues and act as a liaison to the private sector initiative, "The National Campaign to Prevent Teen Pregnancy."
- ▶ I serve as an unpaid expert on an intermittent basis, and will be reimbursed for travel and related expenses. I am located at DHHS, and will advise Dr. David Satcher, who is the director of the Centers for Disease Control and Prevention, as well as the President and Secretary Shalala.
- ▶ I do not have oversight or management responsibilities for teen pregnancy programs at DHHS.

## HOW WOULD YOU CURB TEEN PREGNANCY?

### QUESTION:

Despite massive spending by the federal government and other entities, little progress has been made in the area of teen pregnancy. What ideas do you have for curbing teen pregnancy?

### ANSWER:

- ▶ As the President said, "Teen pregnancy is one of the most serious social problems facing our country." The statistics are startling -- about 1,000,000 teenagers each year become pregnant -- although there has been some progress in the last few years.
- ▶ I have dedicated my career to reversing these trends and preventing the tragedy of teen pregnancy. Through my "I Have a Future" program, I have worked to teach young people to say "no" to sex and "yes" to their educations and their futures.
- ▶ I believe that each and every one of us -- parents, doctors, teachers, religious leaders, students, businesses, older siblings, and elected officials -- must be a part of the solution.
- ▶ All of us must work together to send clear and consistent messages to young people about sex. When young people ask about safe sex, we must tell them that abstinence is the only form of truly "safe" sex.
- ▶ We must teach young people to delay sexual activity and send this message to every child in America: Until you are emotionally and economically able to provide for a child, you should not have sex, and you should not have a child. This message is exactly the same for boys as it is for girls.
- ▶ But, it is not enough for us simply to ask our children to say "no" -- we must also give them something to say "yes" to. Yes to education. Yes to healthy activities. yes to a job. Yes to their family. And, yes to a productive future.

- ▶ The truth is, it is going to take true leadership at the local level. It is going to take parents talking to their kids, teachers reaching out to young people in need, communities finding positive activities for children to engage in, and the media sending the right message about delaying sexual activity and being responsible.
- ▶ It's going to take each and every one of us. But, with a little vision and a lot of hard work, I believe that we can turn this thing around and open up horizons for the young people of America.

## THE "I HAVE A FUTURE" PROGRAM

### QUESTION:

Dr. Foster, can you tell us about your program "I Have a Future"?

### ANSWER:

- ▶ I started the "I Have a Future" program to expand adolescent health programs beyond schools and help the young people in Nashville's public housing projects create futures filled with aspiration and opportunity.
- ▶ First and foremost, our focus is on abstinence, community, and self-esteem.
- ▶ Let me take a minute and run through the three parts of the program:
  - First, we equip adolescents with the basic information they need about health, human sexuality, and drug and alcohol use so they understand the benefits of abstinence and the consequences of early sexual activity.
  - Second, we provide a comprehensive array of adolescent health services, with a focus on abstinence and a very strong emphasis on parental and community involvement.
  - Third, and most important, we help young people enhance their life-options through activities that improve their job skills, self-reliance, values, and self-esteem.
- ▶ For example, the youth entrepreneurial component of our program helps teenagers learn more about themselves and about the world by empowering them to start businesses in their communities.
- ▶ This kind of skills-development and character-building is not only important for girls and young women -- but, as research is showing us, is critically important for boys and young men.
- ▶ We have to take the time to understand all the unique aspects of young people's lives: building up their self-esteem, telling them we believe in them, and not simply treating them as collections of problems.

- ▶ I founded the "I Have a Future" program because most teen pregnancy programs at the time were limited to advocating contraception. These programs did not have a significant impact on teen pregnancy because they only addressed the capacity to have a child without addressing the desire to have a child. "I Have a Future" was designed to empower teens to take control of their futures and delay childbearing to a more appropriate time.

## REDUCING TEEN PREGNANCY THROUGH ABSTINENCE

### QUESTION:

Do you think that teaching abstinence will reduce teen pregnancy rates?

### ANSWER:

- ▶ People always ask me what the "safest" kind of sex is, and I always answer, "There is only one truly safe kind of sex -- and that's no sex." In my opinion, abstinence education is our best method of preventing teen pregnancy.
- ▶ In my "I Have a Future" program, we taught young people to say "no" to early sex and "yes" to their futures, their jobs, and their educations.
- ▶ This approach is common sense; it treats young people as individuals -- not collections of problems.
- ▶ The longer we get teens to delay sexual activity, the more likely they are to stay in school. And, the longer they wait, the more likely they are to use contraceptives effectively, to avoid the danger of exposure to multiple sex partners, and the risk of sexually transmitted diseases, including the HIV virus.

## IS ABSTINENCE REALISTIC?

### QUESTION:

Isn't your stress on abstinence unrealistic and potentially deadly, given the fact that most young people are sexually active before age 18?

### ANSWER:

- ▶ No. Not only is it not unrealistic to focus on abstinence, it is immoral for us to sit back in silence. It is simply not acceptable -- emotionally, physically, and financially, for 14-year-olds and 15-year-olds to be having sex and having children.
- ▶ All of us must come together and send clear and consistent messages: If you are having sex-- stop. And if you haven't started, by all means, don't.
- ▶ We simply cannot give up on educating our children about healthy lives and productive futures. My emphasis on abstinence is the healthiest thing in the world. Abstinence is the surest way of preventing not only the transmission of HIV, but also pregnancy and sexually-transmitted diseases.
- ▶ That's the fact -- and I have found that young people respect facts and like it when adults talk honestly with them.
- ▶ There's another fact that I like to tell young people: Millions of their peers have chosen abstinence. We must not allow our young people to think that being sexually active at their age is appropriate behavior.
- ▶ At the same time, we cannot give up on those who are already sexually active. We must ensure that they understand the potential consequences of their actions. We must give them accurate information about sexuality and contraceptive methods.

## CAUSES OF TEEN PREGNANCY

### QUESTION:

What are the causes of the high teenage pregnancy rate in the U.S.?

### ANSWER:

- ▶ Tragically, each year about one million adolescent girls in the U.S. become pregnant. Too often, these young women are unmarried -- most often, their pregnancies are unintended.
- ▶ The statistics are staggering -- but the causes are complex, numerous, and in fact, not completely understood. Let's talk about what we do know:
  - The proportion of adolescents who are sexually active has been steadily increasing for the past two decades. Adolescents are initiating sexual activity at younger ages.
  - And while contraceptive use has increased, the proportion of adolescents who are sexually active has also increased -- and thus, so has the rate of pregnancies.
  - It is increasingly recognized that many adolescents become sexually active by force or coercion and that this has serious implications for their development and ability to protect themselves against pregnancy and STD infection.
  - There's also the role of our media and entertainment culture -- which often glorifies sexual behavior without helping teenagers understand the consequences of high-risk behavior.
  - Data show that adolescents from low-income families are more likely to initiate sexual activity at a young age, less likely to use contraceptives, and more likely to become pregnant than adolescents from higher-income families.

- ▶ As I said, these are complex and diverse factors -- and that's why we all need to help lead a comprehensive effort to attack this problem from every possible angle. Nothing less than the lives of our young people -- and the future of our country -- is at stake.

## WHAT MAKES AN EFFECTIVE PREVENTION PROGRAM?

### QUESTION:

Dr. Foster, what, in your opinion, are some of the key elements of an effective teen pregnancy prevention program?

### ANSWER:

- ▶ Four broad factors have been identified that consistently predict early parenthood: poverty, early school failure, early behavior problems, and family problems or dysfunction.
- ▶ We need programs that address these factors, most of which begin early in a child's life. An ideal program would be long-term and comprehensive, and would involve both the child and his or her parents.
- ▶ However, many teen pregnancy prevention programs, although very well-intended, are frequently too little, too late. We need much more research about what works, and why.
- ▶ However, there are some general strategies that appear to affect teen pregnancy:
  - Strong one-on-one support from a responsible adult;
  - Involvement of family and community members so as to enhance the likelihood of choosing culturally appropriate and locally relevant interventions;
  - Abstinence education and the teaching of refusal skills;
  - Attention to basic health and sexuality education;
  - Attention to the importance of peer influences;
  - Culturally- and age-specific strategies;
  - Attention to education achievement and the world of work.

## WHEN/WHERE DOES TEEN SEXUAL ACTIVITY OCCUR?

### QUESTION:

There is a statistic that says 70 percent of all teenage pregnancies occur between 3 and 5 in the afternoon. What is the source of this statistic and what does this mean to you in terms of your effort to remedy the problem of teenage pregnancy?

### ANSWER:

- ▶ To the best of my knowledge, this statistic has not been specifically cited in the research literature.
- ▶ What we can say is that the absence of parental supervision may be providing teenagers the opportunity to become sexually active. D.P. Hogan and E. M. Kitagawa found in a 1979 sample of adolescent girls that 76 percent were more likely to be sexually active if parental supervision of dating was lax rather than strict.
- ▶ This doesn't change our responsibility to our children. All of us need to take more responsibility for providing our children with adult supervision and healthy after school activities like athletics, art, music, and a job.

## DO CONTRACEPTIVES LED TO TEEN SEXUAL ACTIVITY?

### QUESTION:

Doesn't making contraceptives readily available encourage teen sexual activity?

### ANSWER:

- ▶ There has been a great deal of research on the causes of early sexual activity. There is certainly no indication that the existence of reproductive health and contraceptive services for adolescents encourages them to become sexually active.
- ▶ In fact, research does show that adolescents start having sex an average of 9 to 12 months before seeking clinic services.
- ▶ I wish all teens would postpone sexual activity, but unfortunately, that is not realistic. As long as they engage in these behaviors, we must do something to allow them to protect themselves against pregnancy and sexually transmitted diseases.

## THE ROLE OF ADULT MALES IN TEEN PREGNANCY

### QUESTION:

There has been some discussion lately on the role of adult men in teen pregnancy. Can you comment on this?

### ANSWER:

- ▶ Results from an Alan Guttmacher Institute (AGI) study, released last year, show that, in general, the younger the adolescent mother, the greater the age difference between her and the infant's father.
  - More than one-half of adolescent mothers have a partner three or more years older.
  - About 20 percent of adolescent mothers have a partner six or more years older.
- ▶ There are a number of important implications to these findings:
  - These age differences raise serious concerns about coercion and abuse. Programs and protocols need to be developed, especially for young adolescent girls, to deal with these problems and issues.
  - Adolescent pregnancy is not just limited to adolescents; adult men bear responsibility in many cases.
  - Because so many fathers of infants born to adolescent mothers are no longer adolescents themselves and are beyond school age, expansion of outreach efforts in male involvement and pregnancy prevention assumes great importance.
  - These findings underscore the importance of sexuality education for our youth -- including a focus on abstinence which incorporates instruction in resistance skills.

## TRENDS -- TEEN BIRTH RATES AND CONTRACEPTIVE USE

### QUESTION:

What are the current trends in teen birth rates and contraceptive use?

### ANSWER:

- ▶ After a long period of sustained decline, birth rates for adolescents began to increase in 1986. Between 1986 and 1991, the birth rate for adolescent girls age 15-19 increased by more than 25 percent.
- ▶ The most recent data (60.7 and 59.6 births per 1,000 girls age 15-19 in 1992 and 1993, respectively) indicate a slight decrease, but the rates are still substantially higher than those observed during the 1980's.
- ▶ Data from a number of sources indicate that contraceptive use among adolescents has increased somewhat. For example, the proportion of adolescent girls age 15-19 using a contraceptive method at first intercourse increased from 53 percent to 71 percent during the periods 1980-1982 to 1988-1990.
- ▶ Similarly, the proportion of sexually active high school students reporting condom use at last intercourse increased from 46 percent to 53 percent between 1991 and 1993. Oral contraceptive use increased from 15 percent to 18 percent during the same time period.
- ▶ It is important to note that one reason for the overall increase in the adolescent birth rate is the substantial increase in adolescent sexual activity. During the 1980s, the proportion of adolescent girls sexually active by age 18 increased from 51 percent to 56 percent. The proportion of adolescent boys sexually active by age 18 increased from 63 percent to 73 percent. Increased contraceptive use was not sufficient to cancel out the effect of the larger proportion of adolescents at risk of pregnancy.

## JAMA ARTICLE ON TEEN PREGNANCY DATA

### QUESTION:

A recent article in the *Journal of the American Medical Association (JAMA)* - April 3, 1996), written by a CDC researcher, describes the increase in teen pregnancy rates during the 1980s. However, more recent data, published by CDC in the Sept. 22, 1995 edition of the *Mortality and Morbidity Weekly Report (MMWR)* shows both teen pregnancy and birth rates declining for the years 1991 and 1992. Why the discrepancy?

### ANSWER:

There is no discrepancy. Each article clearly describes the years for which data are reported. The *JAMA* article only reports data for the period 1980-1990, whereas the *MMWR* covers the years 1991-1992 only. The *JAMA* article correctly reports the increase in teen pregnancy rates during the 1980s; pregnancy rates among 15-19 year-olds remained fairly stable from 1980-1985, but increased by 9% from 1985-1990. This article does not address the period after 1990. The *MMWR* reports that pregnancy rates for 15-19 year-olds decreased significantly in 31 of 42 states for the years 1991-1992 (a 2% - 15% decrease per State).

# Pregnancy, Abortion, and Birth Rates Among US Adolescents—1980, 1985, and 1990

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**Objective.**—To analyze pregnancy, abortion, and birth rates among US adolescent girls in 1980, 1985, and 1990.

**Design.**—Retrospective analysis of trends in data on pregnancies, abortions, and births.

**Population.**—US adolescent girls aged 13 to 19 years.

**Main Outcome Measures.**—Pregnancy, abortion, and birth rates (with and without adjustment for sexual experience) among teenaged girls aged 15 to 19 years and girls under 15 years.

**Results.**—Although pregnancy rates among all teenaged girls 15 to 19 years old remained fairly stable from 1980 to 1985, they increased by 9% during the last half of the decade, totaling 95.9 pregnancies per 1000 teenaged girls 15 to 19 years old by 1990. Because rates of sexual experience increased even faster, pregnancy rates among sexually experienced teens aged 15 to 19 actually declined between 1980 and 1990 by approximately 8%. Abortion rates among these teens remained stable during the 1980s, with 35.8 and 36.0 abortions per 1000 in 1980 and 1990, respectively. As with overall pregnancy rates, abortion rates among these sexually experienced teenaged girls declined during the 1980s. Between 1980 and 1985, birth rates among teenaged girls aged 15 to 19 years declined by 4%, but they increased by 18% during the latter half of the decade, totaling 59.9 births per 1000 in 1990. Among these sexually experienced teenagers, birth rates also declined between 1980 and 1985 and then increased over the next 5 years. In 1990, pregnancies and abortions among girls younger than 15 years accounted for only 3% of all adolescent pregnancies and abortions. However, the number of births among these younger adolescents increased by 15% over the decade. In that age group, trends in pregnancy, abortion, and birth rates over the decade were similar to those for older teens. However, during the late 1980s, the abortion rate declined and the pregnancy rate remained stable, resulting in a 26% increase in the birth rate.

**Conclusions.**—Despite efforts to reduce adolescent pregnancy in the United States, pregnancy and birth rates for that group continue to be the highest among developed countries. Considering that 95% of adolescent pregnancies are unintended, increased efforts to prevent these pregnancies are warranted.

(JAMA. 1996;275:989-994)

DESPITE EFFORTS to reduce adolescent pregnancy in the United States, pregnancy and birth rates among US adolescents were higher than those in most other developed countries in 1990.<sup>1,2</sup> Both the public health impact and the societal and individual costs of adolescent pregnancy are well known.<sup>4</sup> The financial costs of early adolescent childbearing are high, and the human costs to young mothers and their children are substantial.<sup>6,6</sup> Adolescent mothers are less likely to complete their education and are more likely to have limited career and economic opportunities, to rely on welfare, and to have failed marriages and future unintended pregnancies.<sup>4,7,8</sup> They also are less likely than older women to have the skills needed for parenting and have a higher incidence of pregnancy-related complications, such as hypertension, anemia, and cephalopelvic disproportion.<sup>9</sup> Infants born to adolescent mothers, particularly girls younger than 15 years, have a higher risk of negative health outcomes, such as prematurity, low birth weight, and death.<sup>10</sup>

For editorial comment see p 1030.

This article updates an earlier report that presented data through 1983 for 15- to 19-year-olds<sup>11</sup> and presents pregnancy, abortion, and birth rates for girls younger than 15 years. We examined national trends in pregnancy, abortion, and birth rates for girls younger than 15 years and for teens aged 15 to 19 years (divided into subgroups of those aged 15 to 17 and 18 to 19 years) separately because of differences among these groups in physical, social, and psychological development.

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Calif; Dr Velebil is with the Institute for the Care of Mother and Child, Prague, Czech Republic; Dr Wingo is with the American Cancer Society, Atlanta, Ga; and Ms Wilson is with the Division of Health Interview Statistics, National Center for Health Statistics.

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Table 1.—Number and Percentage of Abortions in Selected States and Births Among US Girls Aged 10 to 14 Years, by Single Years of Age, 1988\*

| Age, y | Abortions, No. (%) | Births, No. (%) |
|--------|--------------------|-----------------|
| 10     | 14 (0.6)           | 15 (0.1)        |
| 11     | 27 (1.1)           | 36 (0.3)        |
| 12     | 102 (4.3)          | 223 (2.1)       |
| 13     | 483 (20.4)         | 1804 (17.0)     |
| 14     | 1737 (73.5)        | 8510 (80.4)     |
| Total  | 2363 (100.0)       | 10 588 (100.0)  |

\*Abortion data are from the National Center for Health Statistics (NCHS) and are reported from 14 states: Colorado, Indiana, Kansas, Maine, Missouri, Montana, New York, Oregon, Rhode Island, South Carolina, Tennessee, Utah, Vermont, and Virginia. Birth data are also from the NCHS. The data are for 1988 because that is the last year for which states reported exact ages of girls obtaining abortions to the NCHS. Percentages do not total 100.0 because of rounding.

Pregnancies, abortions, and births among girls younger than 15 years cluster around the ages of 13 and 14 years. However, researchers have used a wide variety of denominators in calculating pregnancy, abortion, and birth rates for these girls.<sup>12-17</sup> One study used the entire population of girls 10 to 14 years old as the denominator and reported a pregnancy rate of 3.3 per 1000,<sup>14</sup> whereas another study for that same year used only girls aged 14 years as the denominator and reported a pregnancy rate of 17.5 per 1000.<sup>17</sup> The lack of a standard denominator seriously limits our ability to compare pregnancy, abortion, and birth trends from different sources and times. Thus, we propose standardizing the ages included in the denominator for calculating rates for girls younger than 15 years.

Finally, when examining trends in pregnancy, abortion, and birth rates among adolescents, we take into account the changes in rates of sexual experience because they affect this population at risk for pregnancy and childbearing.

## METHODS

### Pregnancies, Abortions, and Births

In our study, pregnancies were calculated as the sum of live births and legal induced abortions among adolescent girls 19 years' old or younger. Because of inadequate reporting, estimates of spontaneous abortions and stillbirths were not included. Abortions were calculated as the national estimate of induced abortions among adolescents 19 years old or younger. Births refer to the number of live births among adolescents aged 10 to 19 years.

### Data Sources

The number of induced abortions among adolescents was based on data compiled annually by the Centers for Disease Control and Prevention (CDC) as part of their ongoing abortion surveillance system of the 50 states, New York City, and the District of Colum-

Table 2.—Percentage of Adolescent Girls Who Had Ever Had Sexual Intercourse, by Race and Age Group, United States, 1982, 1988, and 1990\*

| Race  | Age Group, y | Sexually Experienced Adolescent Girls, % (95% Confidence Interval) |                  |                  |
|-------|--------------|--------------------------------------------------------------------|------------------|------------------|
|       |              | 1982                                                               | 1988             | 1990             |
| All†  | <15          | 8.5 (7.2-9.8)                                                      | 8.4 (6.8-10.0)   | 8.4 (6.8-10.0)   |
|       | 15-19        | 46.9 (42.8-51.0)                                                   | 52.9 (49.5-56.3) | 54.9 (50.4-59.5) |
|       | 15-17        | 32.2 (27.6-36.8)                                                   | 38.3 (33.5-43.0) | 41.0 (34.9-47.0) |
|       | 18-19        | 64.1 (58.1-70.0)                                                   | 73.9 (68.9-78.8) | 74.4 (68.7-80.2) |
| White | 15-19        | 44.9 (40.4-49.5)                                                   | 52.1 (48.2-56.0) | 53.0 (47.6-58.5) |
|       | 15-17        | 30.1 (25.0-35.2)                                                   | 35.8 (30.0-41.6) | 38.8 (31.4-46.2) |
|       | 18-19        | 61.5 (54.7-68.3)                                                   | 74.3 (69.0-79.6) | 73.6 (67.4-79.8) |
| Black | 15-19        | 59.0 (53.2-64.7)                                                   | 60.2 (54.2-66.1) | 69.6 (61.3-77.7) |
|       | 15-17        | 44.1 (35.4-52.7)                                                   | 50.4 (41.8-59.0) | 56.5 (46.7-66.2) |
|       | 18-19        | 79.5 (72.7-86.3)                                                   | 75.7 (66.0-85.4) | 83.2 (74.3-92.1) |

\*The data are from the National Surveys of Family Growth (NSFG) for 1982 and 1988 and from the NSFG Telephone Reinterview for 1990 except for girls under 15 years, for whom we used the 1988 NSFG.  
†Includes races other than white or black.

bia.<sup>18-20</sup> In 1969, the CDC began abortion surveillance to document the number and characteristics of women obtaining legal induced abortions and to assist efforts to identify and reduce preventable causes of morbidity and mortality associated with abortions. Abortion data in this report were based on data provided by state health agencies to the CDC. The total number of legal induced abortions was available from all reporting areas for each study year. However, not all of these areas collected information on the age of the women who obtained abortions (no abortion data by age were available for 10 states for 1980, 13 states for 1985, and 10 states for 1990).<sup>18-20</sup>

To obtain estimates for states with missing age-specific abortion data in any study year, we made assumptions about the data based on a standard comparison. The standard was either the neighboring state with the closest population and fertility characteristics or, if the characteristics of the neighboring states were dissimilar, the aggregate of data for all states that reported corresponding age-specific data. Additional details on our methods for estimating age-specific abortion data are available from the corresponding author (A.M.S.) upon written request.

In those areas that reported age, we assumed that women with unknown ages followed the age distribution of women with known ages for that state (ages usually are unknown in fewer than 5% of all abortions).

The number of states with incomplete reported data on abortions according to race and ethnicity was too large to make reasonable national estimates of abortion for these categories. Therefore, we do not present pregnancy data by race or Hispanic ethnicity.

We obtained information on the number of births by the age and race of the mother from the National Center for Health Statistics (unpublished data, 1980,

1985, and 1990). Data were available for births by age and ethnicity for 1990; however, data for births among Hispanic adolescents were available for only a limited number of states for 1980 and 1985.

### Rates

For teenaged girls aged 15 to 19 years, all rates were calculated per 1000 teens in the specific age group (15 through 19, 15 through 17, and 18 through 19 years). For girls younger than 15 years, to determine the appropriate ages to include in the denominator for rate calculations we examined the percentages of girls 10 to 14 years old who gave birth or had a legal induced abortion for each single year of age. To estimate the national single-year-of-age distribution of abortions in that group, we used data on 297 300 abortions performed in the 14 states that reported exact age in 1988,<sup>21</sup> the most recent year for which exact age data were available (Table 1). Because 97% of births and 94% of abortions among girls younger than 15 years occurred at age 13 or 14 years, we determined these ages to be the most appropriate for the denominator. Therefore, all rates calculated for girls younger than 15 years of age in this report are per 1000 girls 13 and 14 years old.

All rates are based on unrounded numbers.

### Population Estimates

We based estimates of the total population of US adolescent girls aged 13 and 14, 15 to 19, 15 to 17, and 18 to 19 years on census data for 1980 and 1990 and intercensal estimates for 1985 reported by the Bureau of the Census.<sup>22</sup>

### Estimates of Sexual Experience

We derived estimates of sexual experience from data collected in the National Survey of Family Growth (NSFG) for 1982 and 1988 and the 1990 NSFG Telephone Reinterview (Table 2). The

NSFG, a national household probability survey, collected data on 1888 teenaged girls aged 15 through 19 years in 1982, 1252 in 1988, and 743 in 1990; and data on 7969 women aged 15 through 44 years in 1982, 8500 in 1988, and 5686 in 1990. Respondents were chosen to be representative of US women of reproductive age. The 1980 sexual experience estimates were based on 1982 NSFG data, and the 1985 estimates were computed by straight-line interpolation between the 1982 and 1988 NSFG estimates. For teenagers 15 to 19 years old, the 1990 NSFG Telephone Reinterview data were used directly for computing the 1990 estimate.

The 1982 NSFG estimates of sexual experience for teenagers 15 to 19 years old were based on the percentage of teenaged girls who were 15 to 19 years old on the date of interview and who reported having had sexual intercourse by that date. In the 1988 and 1990 NSFGs, estimates of sexual experience were obtained by calculating the percentage of women who were 15 to 19 years old at the midpoint of the interviewing period and reported having had sexual intercourse by that date.

Because girls younger than 15 years were not surveyed in the NSFG, we estimated sexual experience rates for these girls by single year on the basis of recall data on age at first intercourse for sexually experienced respondents who were 15 to 19 years old in the NSFG study year. For girls younger than 15 years, the 1990 estimate was based on 1988 NSFG data because there were too few respondents in this age group in the 1990 telephone reinterviews to compute reliable estimates of age at first intercourse. Sexual experience estimates by race were calculated for 15- to 19-year-olds but not for girls younger than 15 years, because the number of girls in specific racial subgroups was too small to compute reliable estimates.

To estimate pregnancy, abortion, and birth rates for sexually experienced adolescents, we adjusted the denominator to include only those in a particular age group who reported ever having had sexual intercourse. To estimate pregnancy, abortion, and birth rates for sexually experienced girls younger than 15 years, we adjusted the denominator by using a weighted average of sexual experience rates for girls 13 and 14 years of age.

## RESULTS

### Pregnancies

Pregnancy rates among 15- to 19-year-old teenagers remained fairly stable from 1980 to 1985 but increased by 9% during the last half of the decade, reaching 95.9

Table 3.—Pregnancy Rates and Number of Pregnancies Among All Adolescent Girls and Sexually Experienced Adolescent Girls, by Age Group, United States, 1980, 1985, and 1990\*

| Group of Adolescent Girls | Age Group, y | Pregnancy Rate |       |       |
|---------------------------|--------------|----------------|-------|-------|
|                           |              | 1980           | 1985  | 1990  |
| All                       | <15          | 6.3            | 6.9   | 7.1   |
|                           | 15-19        | 88.8           | 87.7  | 95.9  |
|                           | 15-17        | 57.5           | 57.0  | 62.8  |
|                           | 18-19        | 133.1          | 131.9 | 138.3 |
| Sexually experienced      | <15          | 74.2           | 82.1  | 84.8  |
|                           | 15-19        | 189.3          | 175.8 | 174.8 |
|                           | 15-17        | 178.6          | 161.7 | 153.2 |
|                           | 18-19        | 207.7          | 191.3 | 185.9 |

|  |       | No. of Pregnancies |         |         |
|--|-------|--------------------|---------|---------|
|  |       | 1980               | 1985    | 1990    |
|  | <15   | 22 852             | 24 609  | 22 928  |
|  | 15-19 | 924 769            | 804 868 | 835 230 |

\*Rates are per 1000 teenaged girls except rates for girls under 15 years, which are per 1000 girls 13 and 14 years old. All rates are based on unrounded numbers.

Table 4.—Abortion Rates and Number of Abortions Among All Adolescent Girls and Sexually Experienced Adolescent Girls, by Age Group, United States, 1980, 1985, and 1990\*

| Group of Adolescent Girls | Age Group, y | Abortion Rate |      |      |
|---------------------------|--------------|---------------|------|------|
|                           |              | 1980          | 1985 | 1990 |
| All                       | <15          | 3.5           | 4.1  | 3.5  |
|                           | 15-19        | 35.8          | 36.8 | 36.0 |
|                           | 15-17        | 25.0          | 26.0 | 25.3 |
|                           | 18-19        | 51.0          | 52.3 | 49.7 |
| Sexually experienced      | <15          | 41.2          | 48.0 | 41.7 |
|                           | 15-19        | 76.3          | 73.7 | 65.5 |
|                           | 15-17        | 77.7          | 73.7 | 61.7 |
|                           | 18-19        | 79.6          | 75.9 | 66.8 |

|  |       | No. of Abortions |         |         |
|--|-------|------------------|---------|---------|
|  |       | 1980             | 1985    | 1990    |
|  | <15   | 12 683           | 14 389  | 11 271  |
|  | 15-19 | 372 608          | 337 383 | 313 404 |

\*Rates are per 1000 teenaged girls except rates for girls under 15 years, which are per 1000 girls 13 and 14 years old. All rates are based on unrounded numbers.

pregnancies per 1000 teenaged girls 15 to 19 years old by 1990 (Table 3). Between 1985 and 1990, pregnancy rates increased both among teens 15 to 17 years old and those 18 to 19 years old. In all study years, the pregnancy rate for 18- to 19-year-old teens was more than twice the rate for younger teens. With the increase in the pregnancy rate, there was an overall decline in the actual number of pregnancies among these teenagers, primarily due to the decline in the population of adolescent girls 15 to 19 years old from 1980 to 1990 (10.4 million in 1980, 9.2 million in 1985, and 8.7 million in 1990).

In 1990, pregnancies among girls younger than 15 years accounted for approximately 3% of all adolescent pregnancies.<sup>9,10</sup> In 1990, the pregnancy rate was 7.1 per 1000 girls 13 and 14 years old (Table 3). From 1980 to 1990, the pregnancy rate in that group increased by 13% (10% between 1980 and 1985 and 3% between 1985 and 1990).

In general, rates of sexual experience for 15- to 19-year-olds increased between 1982 and 1990 (Table 2). However, differences in these rates should be interpreted with caution because of the generally small sample sizes.

In contrast to overall rates, pregnancy rates among sexually experienced teens aged 15 to 19 declined between 1980 and 1990 by approximately 8%, mostly during the period 1980 to 1985 (Table 3). The decline among 15- to 17-year-olds (178.6 to 153.2) was greater than among teens aged 18 to 19 years (207.7 to 185.9).

The percentage of 13- and 14-year-old girls who reported being sexually experienced did not change significantly between 1980 and 1990. In 1990, the pregnancy rate for girls younger than 15 years was 84.8 per 1000 compared with 74.2 per 1000 in 1980 (Table 3).

### Abortions

Rates of abortions among all teenagers 15 to 19 years old remained stable

Table 5.—Birth Rates and Number of Births Among All Adolescent Girls and Sexually Experienced Adolescent Girls, by Race/Ethnicity and Age Group, United States, 1980, 1985, and 1990\*

| Race/Ethnicity                        | Age Group, y | No. of Births |         |         |
|---------------------------------------|--------------|---------------|---------|---------|
|                                       |              | 1980          | 1985    | 1990    |
| All adolescent girls                  |              |               |         |         |
| All races†                            |              |               |         |         |
|                                       | <15          | 2.8           | 2.9     | 3.6     |
|                                       | 15-19        | 53.0          | 51.0    | 59.9    |
|                                       | 15-17        | 32.5          | 31.0    | 37.5    |
|                                       | 18-19        | 82.1          | 79.6    | 88.6    |
| White                                 |              |               |         |         |
|                                       | <15          | 1.4           | 1.4     | 1.9     |
|                                       | 15-19        | 45.4          | 43.3    | 50.9    |
|                                       | 15-17        | 25.5          | 24.4    | 29.5    |
|                                       | 18-19        | 73.2          | 70.4    | 78.0    |
| Black                                 |              |               |         |         |
|                                       | <15          | 10.4          | 10.7    | 12.7    |
|                                       | 15-19        | 97.9          | 95.4    | 112.8   |
|                                       | 15-17        | 72.5          | 69.4    | 82.3    |
|                                       | 18-19        | 134.9         | 132.4   | 153.0   |
| Hispanic‡                             |              |               |         |         |
|                                       | <15          | ...           | ...     | 6.2     |
|                                       | 15-19        | ...           | ...     | 99.9    |
|                                       | 15-17        | ...           | ...     | 65.7    |
|                                       | 18-19        | ...           | ...     | 147.2   |
| Sexually experienced adolescent girls |              |               |         |         |
| All races†                            |              |               |         |         |
|                                       | <15          | 33.0          | 34.1    | 43.1    |
|                                       | 15-19        | 113.0         | 102.1   | 109.1   |
|                                       | 15-17        | 100.9         | 88.1    | 91.5    |
|                                       | 18-19        | 128.1         | 115.4   | 119.1   |
| White                                 |              |               |         |         |
|                                       | 15-19        | 101.0         | 89.2    | 95.9    |
|                                       | 15-17        | 84.4          | 74.0    | 76.0    |
|                                       | 18-19        | 119.1         | 103.8   | 105.9   |
| Black                                 |              |               |         |         |
|                                       | 15-19        | 166.0         | 160.3   | 162.1   |
|                                       | 15-17        | 164.5         | 146.9   | 145.8   |
|                                       | 18-19        | 169.7         | 170.6   | 183.9   |
| Births                                |              |               |         |         |
|                                       |              | 1980          | 1985    | 1990    |
| Sexually experienced adolescents      | <15          | 10 169        | 10 220  | 11 657  |
|                                       | 15-19        | 552 161       | 467 485 | 521 826 |

\*Rates are per 1000 teenaged girls except rates for girls under 15 years, which are per 1000 girls 13 and 14 years old. All rates are based on unrounded numbers.

†Includes races other than white or black.

‡Data are available for Hispanic births for all states and the District of Columbia for all adolescent girls only for 1990. Hispanics can be of any race.

during the 1980s, with 35.8 abortions per 1000 teenaged girls 15 to 19 years old in 1980 and 36.0 abortions in 1990 (Table 4). Like pregnancy rates, abortion rates among teens 18 to 19 years old were about twice the rates among teens 15 to 17 years old. Between 1980 and 1990, the overall number of abortions among these teenagers declined by 16%.

In 1990 the abortion rate among girls younger than 15 years was 3.5 per 1000 girls 13 and 14 years old (Table 4). Abortion rates among these girls increased by only 1% over the decade (before rounding) because a sharp increase of 16% from 1980 to 1985 was reversed by a decline from 1985 to 1990.

Whereas abortion rates among all teenagers aged 15 to 19 years remained stable, abortion rates among these sexually experienced teenagers declined during the 1980s. The greatest decline was among the 15- to 17-year-olds. In contrast, the abortion rate for sexually ex-

perienced girls younger than 15 years was approximately the same at the beginning and end of the decade (Table 4).

#### Births

Birth rates among teenagers 15 to 19 years old declined by 4% between 1980 and 1985, but they increased by 18% between 1985 and 1990, reaching 59.9 births per 1000 teenaged girls 15 to 19 years old in 1990 (Table 5). Although the greatest percentage increase in birth rates occurred between 1985 and 1990 among teens 15 to 17 years old, the birth rates for teens aged 18 to 19 years old were consistently more than twice as high as those among younger adolescents. Between 1980 and 1990, the population of teenage girls 15 to 19 years old declined by 16%, but the actual number of births among 15- to 19-year-olds declined by only 5%.

Between 1980 and 1985, birth rates among white and black teenagers 15 to 19 years old declined slightly; however,

rates for both groups increased substantially during the latter part of the decade. Similar patterns were noted for white and black teenagers 15 to 17 years old and 18 to 19 years old. For each of the study years, for teens in that age group, birth rates for black teens were approximately two times those for white teens. For 1990, the only year with complete data for Hispanics, birth rates for Hispanic teenagers were lower than those for blacks and higher than those for whites in each age group.

In 1990, the birth rate for girls younger than 15 years was 3.6 per 1000 girls 13 and 14 years old (Table 5). In contrast to the minimal change in abortion rates, birth rates in that group increased substantially—by 30% from 1980 to 1990—with most of this increase occurring in the latter half of the decade. For each of the study years, for girls younger than 15 years, birth rates for black girls were approximately seven times those for white girls (Table 5).

Among sexually experienced teenagers 15 to 19 years old, birth rates declined between 1980 and 1985 and then increased over the next 5 years, totaling 109.1 births per 1000 teenaged girls 15 to 19 years old in 1990.

Among sexually experienced white and black teenagers aged 15 to 19 years, there was an overall decline in birth rates between 1980 and 1990. In these groups, a large decline was observed between 1980 and 1985, followed by an increase between 1985 and 1990.

As with the pregnancy rate for sexually experienced girls younger than 15 years, the birth rate in this group increased (from 33.0 per 1000 girls 13 and 14 years old in 1980 to 43.1 per 1000 in 1990) (Table 5).

#### COMMENT

Between 1980 and 1990, pregnancy and birth rates among teenagers 15 to 19 years old increased by about 8% and 13%, respectively, whereas abortion rates remained fairly stable. In contrast to the trends for all teenaged girls 15 to 19 years old, pregnancy and abortion rates for sexually experienced teens 15 to 19 years old declined by about 8% and 14%, respectively, between 1980 and 1990. Birth rates for sexually experienced teenagers aged 15 to 19 years declined only slightly because the decline in abortions was proportionately larger than the decline in the number of pregnancies.

Between 1980 and 1990, pregnancy and birth rate trends for girls younger than 15 years were similar to those for older adolescents; pregnancy and birth rates increased (by 13% and 30%, respectively), and there was a slight in-

crease in the abortion rate (1%). However, during the second half of the decade, the abortion rate among girls younger than 15 years declined by 13% while the pregnancy rate remained nearly stable, resulting in a large increase in the birth rate (26%) during the decade in which the US Public Health Service had set a national goal to eliminate births among girls aged 14 years or younger by 1990.<sup>22</sup>

To focus on the magnitude of the problem of teenaged pregnancy for those at risk, we examined pregnancy, abortion, and birth rates exclusively among those adolescents who reported ever having had sexual intercourse. Examining pregnancy rates among sexually experienced adolescents should provide more accurate analyses for measuring the efficacy of family planning programs that target subgroups of adolescents at high risk for pregnancy.<sup>11</sup> The importance of examining trends both for adolescents who report being sexually experienced and for all adolescents is illustrated both by this report and by an earlier CDC study on teen pregnancy.<sup>11</sup> Both studies present contrasting pregnancy trends for all teenagers and for sexually experienced teenagers 15 to 19 years old. In the earlier study, we reported that between 1974 and 1980 the pregnancy rate among all teens increased by 8.2%, whereas the pregnancy rate among sexually experienced teens declined by 5.7%. Data from a larger sample would provide a more precise estimate of sexual experience. Ideally, estimates of the population of teens at the greatest risk for pregnancy would include only those who are currently sexually active; however, this information is not available for each of the study years.

The decline in pregnancy rates among sexually experienced teenagers 15 to 19 years old may be associated with the increased use of contraceptives by teenagers during the 1980s. The proportion of teens using contraception at first premarital intercourse increased from 53% during the period 1980 through 1982 to 71% during the period 1983 through 1988.<sup>24</sup> Most of the increase in use at first premarital intercourse was due to an increase in condom use from 28% to 55%. During the latter part of the decade, the birth rate among sexually experienced teens increased as abortion rates declined. Furthermore, the increasing proportion of sexually experienced teens suggests that efforts at primary prevention (encouraging sexual abstinence) have not been as effective on a population basis as needed<sup>25,26</sup>; however, recent reports suggest that the increase in rates of sexual experience that occurred during the 1980s slowed during the early 1990s.<sup>27</sup>

Consideration of sexual experience is even more critical for girls under 15 years. Only a small fraction of these young girls are sexually experienced, and their sexual activity tends to be sporadic and infrequent.<sup>1</sup> However, among sexually experienced girls younger than 15 years, more than 8% (84.8 per 1000) became pregnant in 1990, and about half of those had a live birth.

We used the population of girls 13 and 14 years of age as the denominator for this analysis rather than the more commonly used 5-year group including girls 10 to 14 years old because the factors we examined, such as when the girls gave birth and when they had abortions, indicated that the girls most at risk of pregnancy overwhelmingly were those aged 13 and 14 years and were not distributed evenly across the 5-year age group of 10 to 14 years. This narrower age denominator is more appropriate because it allows for the computation of rates that reflect more accurately the population at risk.

A teenaged girl's state of psychosocial development is an important determinant of her behavior in choosing to be abstinent or sexually active and in deciding to use or not use contraception to prevent pregnancy.<sup>28,29</sup> Because adolescents often deny (even to themselves) that they are sexually active when in fact they are, contraceptive compliance is a special concern for this age group.<sup>30</sup> Younger adolescents are less likely to use contraception at first intercourse than older adolescents, and they are less likely to use a contraceptive method consistently thereafter.<sup>1,30,31</sup> Only 39% of adolescent girls who had sexual intercourse before their 15th birthday reported using contraception at first intercourse, compared with 54% of teens who waited to have intercourse until they were at least 17 years of age.<sup>32</sup>

The estimated numbers and rates of abortions, and hence of pregnancies, in our analyses are conservative for several reasons. First, the number of legal abortions reported to the CDC is probably lower than the number actually performed. Estimates provided by public health agencies often are lower by about 12% to 15% than those obtained by direct surveys of abortion providers,<sup>18,33</sup> but those obtained by direct surveys do not supply data by age, race, or ethnicity. Second, we did not include estimates of the number of spontaneous abortions or stillbirths when computing pregnancy rates. There is no reason to believe that the proportion of pregnancies resulting in fetal loss varies from year to year or by age among teenagers. Finally, these data show pregnancy outcomes by age at resolution; thus, for example, those

teens who had become pregnant at the age of 19 years and had an induced abortion or birth at 20 years would have been excluded from this analysis.

National trends in adolescent pregnancy cannot be accurately assessed without complete information on abortion, as approximately 40% of all pregnancies among adolescents end in abortions. Accurate monitoring of pregnancy trends requires complete reporting of age, race, and Hispanic ethnicity from every state. We recommend, therefore, that states collect complete abortion data that include information on age, race, and Hispanic ethnicity.

To reduce teen pregnancies, two basic types of approaches are needed: interventions to delay the initiation of sexual activity among adolescents and interventions to prevent pregnancy among adolescents who are sexually active. Most evaluations of sex education programs suggest a positive effect on delaying sexual initiation.<sup>25</sup> There is evidence that appropriate family planning interventions for sexually active adolescents may increase contraceptive use among both youths who attend school and those who do not.<sup>25</sup>

Despite similar rates of sexual experience, rates of adolescent pregnancies and births are higher in the United States than in other developed countries, and an estimated 95% of pregnancies among adolescents are unintended.<sup>1,34</sup> Possible explanations include the continued controversy regarding sex education, the lack of access to contraceptives, and the reluctance of the media to present sexual behavior in a responsible manner.<sup>35</sup> National health objectives for the year 2000 include reducing the pregnancy rate for adolescent girls aged 17 years or younger to no more than 50 pregnancies per 1000.<sup>36</sup> Even without including fetal losses, the 1990 rate for teens 15 to 17 years old is about 26% higher than this goal. Considering the increase in pregnancy rates from 1985 to 1990 among teenagers 15 to 17 years old, substantially more efforts are needed to achieve this goal. Unfortunately, the data from the 1980s suggest that the public health goals for the year 2000 are unlikely to be achieved.

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# Pregnancy in Adolescence

In this issue of THE JOURNAL, Spitz et al<sup>1</sup> examine childbearing rates for US teenagers in the decade of the 1980s. The authors wisely divide these data into 5-year periods. To have done otherwise would have been misleading, for these rates prove to have been mercurial: stable from 1980 to 1985, markedly increased for 1985 to 1990. An analysis of more recent data shows rates declining in 1991 to 1992.<sup>2</sup> Accordingly, before attributing meaning to these data, one must take a longer view. In the 1970s, birth rates among adolescents declined sharply, probably owing to the legalization and availability of abortion; for reasons that are not clear, these rates then leveled off until 1988, when they rose to a new peak for 10- to 17-year-olds.<sup>3(p334)</sup>

See also p 989.

Using as the denominator the numbers of sexually active adolescent girls rather than all those in a given age cohort is an important aspect of the report. Although it is intuitively obvious, not all studies make this distinction, which results in an underestimate of the dependent variable. Unfortunately, another more subtle refinement of risk is not reported because of the difficulty in determining timing and frequency of intercourse. This is a particularly important issue for young adolescents whose sexual activity is sporadic.<sup>4</sup>

Biological factors also affect outcome rates. For example, younger girls within the first 2 years following menarche have lower fertility owing to their lower numbers of ovulatory cycles in comparison to older adolescents. Younger adolescents also have higher rates of spontaneous abortion and stillbirth, neither of which is addressed in this report.

A particularly interesting finding is the decline in legal abortions among sexually active adolescent girls over the course of the 1980s. This finding may be interpreted in a number of ways. Since marriage rates are not given, this decrease may represent an increase in adolescents' choosing to deliver their babies because of marriage. Changing attitudes toward out-of-wedlock parenthood and decreasing access to, or availability of, physicians who provide abortions are alternate explanations. There is actually evidence of an enormous increase in births to unmarried adolescents, from less than 15% of all births in this age group in 1960 to nearly 65% by 1988.<sup>5(p331)</sup> The complex reasons for this include changing societal attitudes toward out-of-wedlock births and improved support in schools for pregnant teenagers, as well as the increasing difficulty for adolescent fathers to find jobs and support families. The availability of abortion services clearly decreased over the course of the 1980s. It is estimated that 83% of counties had no providers of abortion services.<sup>6</sup>

Ethnic differences in attitudes toward marriage and abortion have been reported, and so racial differences in pregnancy, abortion, and birth rates are to be expected. Indeed, birth rates for blacks were twice those of white adolescents in the study by Spitz et al.<sup>1</sup> It is unfortunate that data for Hispanic adolescents were not available until the end of the decade.

A parallel trend in the rates of sexually transmitted diseases (STDs) among adolescents during the 1980s suggests that sexually active teenagers were not using effective birth control methods, including condoms. Here too, however, there were ethnic, gender, and age differences. For example, the rates of syphilis among 15- to 19-year-olds doubled from 1985 to 1990, with the greatest increase seen in women and African Americans. This recent rise in STD rates has been attributed to an increase in exchange of sex for drugs and in "survival" sex among the increasing numbers of homeless youth.

Multiple factors are responsible for the high rates of pregnancy and childbearing among adolescents. Comparisons with other developed countries with equally high rates of adolescent sexual activity but lower rates of pregnancy and STDs than ours<sup>6</sup> suggest some of these. Failure to provide age-appropriate education, both in home and in school, limited access to effective birth control methods and to systems of care that monitor and support sexual decision making, presentation of sex irresponsibly in the media, and poverty have all been cited as possible societal explanations. Personal factors such as poor self-image, depression, and substance abuse also contribute to vulnerability to adolescent pregnancy.

The solutions to the problem of adolescent pregnancy remain elusive. Research on effective pregnancy prevention has yielded inconsistent results. Accordingly, we continue to rely on common sense. Clearly, just as the problem is multifactorial, the solution must involve many levels: family, schools, religious and community organizations, government, the media, and physicians. And the ultimate solution will most likely involve changes in societal values regarding sexual activity and in the priority we give to adolescents' problems.

Three potential levels of intervention are needed. The first is the need to postpone initiation of sexual experimentation until psychosocial maturity guides protective behaviors. This is not as difficult a goal as it may appear, as its foundation is laid within those early childhood experiences of both boys and girls that can enhance self-esteem, promote intrafamilial communication, and model nonexploitive interactions and respect between the sexes. While family and community are key at this level, the primary care provider can play a role through anticipatory guidance beginning in the first decade of life. The second level includes preparation for first (and subsequent) intercourse by counseling about appropriate methods that protect against both pregnancy and STDs. Open communication within the family to enhance a young woman's self-esteem and self-confidence in communicating with a sexual partner is critical,<sup>7</sup> as is accurate information provided by physicians. The third level involves improved access to protective methods. Measures that reduce the obstacles to teenagers' receiving reproductive care, such as establishing school-based clinics, providing universal health insurance, and improving training of providers in adolescent health, are necessary to achieve this goal.

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## UNPLANNED PREGNANCY RATES: U.S. VS. OTHER NATIONS

### QUESTION:

Why are our rates of unintended pregnancy so high compared to other Western nations? What can we do about this?

### ANSWER:

- ▶ Adolescent pregnancy rates are considerably higher in the United States than in other developed nations--and this is despite the fact that rates of sexual activity are similar.
- ▶ It does appear that contraceptive use, at least among Western European adolescents, is higher than among U.S. adolescents. However, because we are dealing with different cultural and social systems, as well as different health care systems, it is difficult to specify the exact reasons.
- ▶ It is apparent that we should be studying the Western European experience more closely and applying or adapting their successful strategies where appropriate; lower rates of adolescent pregnancy than those occurring in the U.S. are clearly possible.

### BACKGROUND:

- ▶ The annual teen pregnancy rate in the United States is 111 per 1,000 females aged 15-19. The rates for other countries are computed using live births and abortions only and do not include miscarriages. To make the U.S. rate comparable, it would be 96 per 1,000 aged 15-19 in 1992. In 1988, it was 97. The rates reported for the United Kingdom of 46 births per 1,000 females aged 15-19 and for the Netherlands and Japan of 10 pregnancies per 1,000 are for 1988.
- ▶ In any case, the U.S. rate is still more than double the next nearest Western country. The U.S. rate (including miscarriages) is 111 per 1,000 females aged 15-19.

## TEENS AND UNINTENDED PREGNANCY

### QUESTION:

I find it difficult to believe that such a large percentage of teen pregnancy is unintended. What evidence is there to support this assertion?

### ANSWER:

- ▶ The most recent data we have on unintended pregnancy comes from a report issued by the Institute of Medicine in 1995, The Best Intentions.
- ▶ The IoM report found that 82 percent of adolescent pregnancies are unintended, compared with an incidence of 57 percent for women overall. That so many adolescent pregnancies are unintended is not surprising, given that the young woman is probably unmarried, has not completed her education, and is not able to adequately support her child.

### BACKGROUND:

- ▶ Estimates of unintended pregnancy are derived from the National Survey of Family Growth (NSFG), a nationally representative survey of women aged 15-44, which has been conducted periodically since the early 1970s by the National Center for Health Statistics. Unintended pregnancy is defined, by the NSFG, as a pregnancy which, at the time of conception, was either mistimed (desired at a later time) or unwanted (not desired at any time).

## TEEN PREGNANCY AND THE WELFARE LAW

### QUESTION:

How does the new welfare reform law address teen pregnancy?

### ANSWER:

- ▶ Unmarried minor parents will be required to live with an adult or in an adult-supervised setting and participate in educational and training activities. States would be responsible for assisting minor parents in locating an adult-supervised living arrangement.
- ▶ The Secretary of HHS shall establish and implement a strategy to (1) prevent non-marital teen pregnancies and (2) assure that at least 25% of communities have teen pregnancy prevention programs. The Department will report to Congress annually in respect to the progress in these areas.
- ▶ Starting in FY 1998, \$50 million a year (out of the Treasury funds not otherwise appropriated) will be added to the appropriations of the Maternal and Child Health Block Grant. The funds would be allocated to states using the same formula used for the bulk of the block grant funds. Funds would enable states to provide abstinence education with the option of targeting the funds to high risk groups (i.e. groups most likely to bear children out-of-wedlock). Abstinence Education is defined in part as an educational and motivational program which has as its exclusive purpose, teaching the social, psychological and health gains to be realized by abstaining from sexual activity.
- ▶ No later than January 1, 1997, the Attorney General shall establish and implement a program that provides research, education and training on the prevention and prosecution of statutory rape.

## ROBIN HOOD FOUNDATION REPORT

### QUESTION:

What does the report on the costs of teen pregnancy by the Robin Hood Foundation tell us?

### ANSWER:

- ▶ The report, entitled "Kids Having Kids: A Robin Hood Foundation Special Report on the Costs of Adolescent Childbearing," documented the many consequences of teenagers having children. These include:
  - ▶ Reproducing the Cycle of Poverty -- The girls born to adolescent moms are up to 83 percent more likely to become teenage moms themselves, thus reproducing the cycle of poverty and disadvantage for yet another generation.
  - ▶ Trouble in School -- Children born to teenage mothers are 50 percent more likely to repeat a grade and perform significantly worse on cognitive development tests. They are also far more likely to drop out of high school than are the children born to women from the same socio-economic background who wait until the age of 20 or 21 to have children.
  - ▶ Increase Child Abuse and Neglect -- Children born to teenage mothers are twice as likely to be abused or neglected.
  - ▶ Behind Bars -- The teen sons of adolescent mothers are up to 2.7 times more likely to land in prison than their counterparts in the comparison group. By extension, adolescent childbearing in and of itself costs taxpayers roughly \$1 billion each year to build and maintain prisons for the sons of young mothers.
  - ▶ Foster Children -- Of the estimated 472,000 foster children in the United States, over 23,000 are the children of adolescent mothers, which in turn results in a taxpayer burden of approximately \$900 million.

- ▶ Consequences on teen mothers:
  - 70 percent of the mothers drop out of school.
  - They are twice as likely to be dependent on welfare.
- ▶ A unique component of the study is its examination of the costs and consequences of teen pregnancy on society:
  - ▶ Teen childbearing costs U.S. taxpayers almost \$7 billion every year.
  - ▶ The cost to society in lost national productivity and avoidable expenditure of social service resources is as much as \$29 billion each year.

## SEX EDUCATION

**QUESTION:**

At what grade level do you think children should begin health/sex education?

**ANSWER:**

- ▶ Health and sex education need to begin -- and do begin -- at home. Parents are always the first teachers, whether or not they realize it at the time.
- ▶ It is up to parents and schools to ensure that all children have good, accurate, age-appropriate information on all aspects of health throughout the school years.
- ▶ It makes sense to teach children, even very young children, about washing their hands before eating, about proper diet, and the connection between today's choices and tomorrow's health.
- ▶ At the same time, we must never forget that how we teach health education and what we teach about human sexuality are fundamentally local decisions: dictated and implemented by the local community -- not by Washington.

## SCHOOL-BASED CLINICS

**QUESTION:**

Do you support school-based clinics? What role should parents play in these settings? Should they distribute birth control on site?

**ANSWER:**

- ▶ I believe school-based clinics play an important role in providing health services to children who might not otherwise receive them.
- ▶ The most critical factor in determining whether a school-based clinic is the appropriate answer for a particular community is whether the school board, and by extension, the parents, of the students, support such an approach.
- ▶ Although most school-based clinics do not provide contraceptives on site, the question as to whether they should or should not is best answered by the school authorities, their communities, and the parents of the children -- not by Washington.

## PARTIAL BIRTH ABORTIONS

### QUESTION:

What is your position on H.R. 1833, the Partial Birth Abortion Act, which would prohibit doctors from performing a certain type of abortion? As a physician, what do you think?

### ANSWER:

- ▶ The President has stated his position. I don't have anything to add to that.

### BACKGROUND:

- ▶ On April 10, 1996, the President vetoed H.R. 1833.
- ▶ The President and I believe that the decision to have an abortion should be between a woman, her conscience, her doctor, and her God. We believe that legal abortions should be safe and rare. We oppose late term abortions except where they are necessary to protect the life of the mother or where there is a threat to her health, consistent with the law.
- ▶ In fact, this procedure is very rare, and is used only in very tragic cases in which the fetus has little or no chance at life. The issue for me is women's health -- and the fact that outlawing this procedure only means that more women will have to risk their own lives.
- ▶ The President has stated very clearly that he does not support use of this procedure on an elective basis, as rare as that may be. He would allow its use only when necessary to save the life of the mother or to avert a very serious threat to her health -- including her ability to have children in the future. He has repeatedly told Congress he wants four simple words added to the bill: "serious adverse health consequences."

## **BACKGROUND INFORMATION**

### **TABLE OF CONTENTS**

1. Teen Pregnancy and the Welfare Reform Law
2. HHS Programs Relating to Teen Pregnancy
3. National Campaign to Prevent Teen Pregnancy newsletter
4. Summary of the Robin Hood Foundation Report
5. New York Times Article on Statutory Rape/Early Marriage

"(iii) the excess (if any) of amounts described in subsection (i)(2)(C)(ii) over the amounts described in subsection (i)(2)(C)(i) (relating to nonbusiness rents and royalties), and

"(iv) 50 percent of the net loss from the carrying on of trades or businesses, computed separately with respect to—

"(I) trades or businesses (other than farming) conducted as sole proprietorships,

"(II) trades or businesses of farming conducted as sole proprietorships, and

"(III) other trades or businesses.

For purposes of clause (iv), there shall not be taken into account items which are attributable to a trade or business which consists of the performance of services by the taxpayer as an employee."

**(c) EFFECTIVE DATES.—**

(1) **IN GENERAL.**—Except as provided in paragraph (2), the amendments made by this section shall apply to taxable years beginning after December 31, 1995.

(2) **ADVANCE PAYMENT INDIVIDUALS.**—In the case of any individual who on or before June 26, 1996, has in effect an earned income eligibility certificate for the individual's taxable year beginning in 1996, the amendments made by this section shall apply to taxable years beginning after December 31, 1996.

**SEC. 911. FRAUD UNDER MEANS-TESTED WELFARE AND PUBLIC ASSISTANCE PROGRAMS.**

(a) **IN GENERAL.**—If an individual's benefits under a Federal, State, or local law relating to a means-tested welfare or a public assistance program are reduced because of an act of fraud by the individual under the law or program, the individual may not, for the duration of the reduction, receive an increased benefit under any other means-tested welfare or public assistance program for which Federal funds are appropriated as a result of a decrease in the income of the individual (determined under the applicable program) attributable to such reduction.

(b) **WELFARE OR PUBLIC ASSISTANCE PROGRAMS FOR WHICH FEDERAL FUNDS ARE APPROPRIATED.**—For purposes of subsection (a), the term "means-tested welfare or public assistance program for which Federal funds are appropriated" includes the food stamp program under the Food Stamp Act of 1977 (7 U.S.C. 2011 et seq.), any program of public or assisted housing under title I of the United States Housing Act of 1937 (42 U.S.C. 1437 et seq.), and any State program funded under part A of title IV of the Social Security Act (42 U.S.C. 601 et seq.).

**SEC. 912. ABSTINENCE EDUCATION.**

Title V of the Social Security Act (42 U.S.C. 701 et seq.) is amended by adding at the end the following section:

**"SEPARATE PROGRAM FOR ABSTINENCE EDUCATION**

"SEC. 510. (a) For the purpose described in subsection (b), the Secretary shall, for fiscal year 1998 and each subsequent fiscal year,

allot to each State which has transmitted an application for the fiscal year under section 505(a) an amount equal to the product of—

"(1) the amount appropriated in subsection (d) for the fiscal year; and

"(2) the percentage determined for the State under section 502(c)(1)(B)(ii).

"(b)(1) The purpose of an allotment under subsection (a) to a State is to enable the State to provide abstinence education, and at the option of the State, where appropriate, mentoring, counseling, and adult supervision to promote abstinence from sexual activity, with a focus on those groups which are most likely to bear children out-of-wedlock.

"(2) For purposes of this section, the term 'abstinence education' means an educational or motivational program which—

"(A) has as its exclusive purpose, teaching the social, psychological, and health gains to be realized by abstaining from sexual activity;

"(B) teaches abstinence from sexual activity outside marriage as the expected standard for all school age children;

"(C) teaches that abstinence from sexual activity is the only certain way to avoid out-of-wedlock pregnancy, sexually transmitted diseases, and other associated health problems;

"(D) teaches that a mutually faithful monogamous relationship in context of marriage is the expected standard of human sexual activity;

"(E) teaches that sexual activity outside of the context of marriage is likely to have harmful psychological and physical effects;

"(F) teaches that bearing children out-of-wedlock is likely to have harmful consequences for the child, the child's parents, and society;

"(G) teaches young people how to reject sexual advances and how alcohol and drug use increases vulnerability to sexual advances; and

"(H) teaches the importance of attaining self-sufficiency before engaging in sexual activity.

"(c)(1) Sections 503, 507, and 508 apply to allotments under subsection (a) to the same extent and in the same manner as such sections apply to allotments under section 502(c).

"(2) Sections 505 and 506 apply to allotments under subsection (a) to the extent determined by the Secretary to be appropriate.

"(d) For the purpose of allotments under subsection (a), there is appropriated, out of any money in the Treasury not otherwise appropriated, an additional \$50,000,000 for each of the fiscal years 1998 through 2002. The appropriation under the preceding sentence for a fiscal year is made on October 1 of the fiscal year."

**SEC. 913. CHANGE IN REFERENCE.**

Effective January 1, 1997, the third sentence of section 1902(a) and section 1908(e)(1) of the Social Security Act (42 U.S.C. 1396a(a), 1396g-1(e)(1)) are each amended by striking "The First Church of Christ, Scientist, Boston, Massachusetts" and inserting

## Teen Provisions in the Welfare Law

- ▶ Unmarried minor parents will be required to live with an adult or in an adult-supervised setting and participate in educational and training activities. States would be responsible for assisting minor parents in locating an adult-supervised living arrangement.
- ▶ The Secretary of HHS shall establish and implement a strategy to (1) prevent non-marital teen pregnancies and (2) assure that at least 25% of communities have teen pregnancy prevention programs. The Department will report to Congress annually in respect to the progress in these areas.
- ▶ Starting in FY 1998, \$50 million a year (out of the Treasury funds not otherwise appropriated) will be added to the appropriations of the Maternal and Child Health Block Grant. The funds would be allocated to states using the same formula used for the bulk of the block grant funds. Funds would enable states to provide abstinence education with the option of targeting the funds to high risk groups (i.e. groups most likely to bear children out-of-wedlock). Abstinence Education is defined in part as an educational and motivational program which has as its exclusive purpose, teaching the social, psychological and health gains to be realized by abstaining from sexual activity.
- ▶ No later than January 1, 1997, the Attorney General shall establish and implement a program that provides research, education and training on the prevention and prosecution of statutory rape.

# HHS FACT SHEET

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

August 27, 1996

Contact: HHS Press Office  
(202) 690-6343

## PREVENTING TEENAGE PREGNANCY

**Overview:** Each year, approximately one million pregnancies occur among American teenagers. Last year, President Clinton challenged "parents and leaders all across this country to join together in a national campaign against teen pregnancy to make a difference." A group of prominent Americans responded to that challenge, forming the National Campaign to Reduce Teen Pregnancy. As the President's new Senior Advisor on Teen Pregnancy and Youth Issues, Dr. Henry Foster serves as liaison to the National Campaign.

The Administration's strategy to prevent teen pregnancy combines opportunity and responsibility -- and starts with a strong message from the top. It supports state, local government and community efforts and works in partnership with young people, parents, schools, civic leaders, businesses, nonprofit organizations, and state and local governments. It encourages abstinence and personal responsibility by young people. It provides financial support to enhance access to health and family planning services. And it invests in research and evaluation to determine what approaches work.

As part of this strategy, President Clinton's FY 1997 budget requests \$30 million for HHS to launch a new Teen Pregnancy Prevention Initiative, to support community prevention efforts in cities with high teen pregnancy rates.

The Administration's strategy also is reflected in all of HHS' activities. Most recently, for example, HHS:

- Awarded 15 grants totalling \$4.3 million to innovative and comprehensive demonstration programs to prevent early teen sexual activity and reduce teen pregnancies. These programs emphasize and encourage abstinence.
- Launched the CDC Teen Pregnancy Prevention Program by awarding 13 grants totalling \$6.5 million over two years to community-wide coalitions. The grants will help support local efforts to reduce teen pregnancy.

## RECENT TRENDS

After rising steadily from 1986 to 1991, teen birth rates are down nationwide and teen pregnancy rates have declined in a majority of states:

- From the mid 1980s through 1991, pregnancy and birth rates among teens rose steadily. From 1986 to 1991, the pregnancy rate for 15-19 year-olds increased by 10 percent; the birth rate was up by 24 percent.
- However, from 1991 to 1992, pregnancy rates for teens aged 15-19 declined in 30 of 41 reporting states.
- Also, the birth rate for teens 15-19 declined 5 percent from 1991 to 1994. The birth rate for teens 15-17 declined 2 percent from 1991 to 1992, remained stable in 1993 and declined 1 percent from 1993 to 1994.

A more complete listing of HHS teen pregnancy programs follows:

- The Adolescent Family Life Program, created in 1981, has awarded nearly \$106 million to support demonstration projects that provide abstinence-focused educational services to prevent early unintended pregnancies and also develop and implement new approaches in the delivery of medical, social, and educational services to pregnant and parenting adolescents, their infants, and their families.
- Community Coalition Partnership Programs for the Prevention of Teen Pregnancy is a new demonstration program that will provide \$6.5 million over two years to enable 13 communities to develop plans for implementing and evaluating community-wide interventions that are innovative, comprehensive, and sustainable.
- Healthy Schools, Healthy Communities established 27 new school-based health centers in 20 states and the District of Columbia to serve the health and education needs of children and youth at high risk for poor health, teenage pregnancy, and other problems.
- "Beginning Too Soon: Adolescent Sexual Behavior, Pregnancy, and Parenthood" is a two-volume comprehensive review by HHS of the most recent literature on teen sexual behavior, pregnancy and parenthood and the effectiveness of teen pregnancy prevention programs.
- Reproductive Health and Family Planning Services (under Title X of the Public Health Service Act) are provided to nearly 5 million persons each year, nearly one third of whom are under 20 years of age. Abstinence counseling and education are an important part of the Title X service protocol for adolescent clients.

- **Health Care and Promotion** under Medicaid provides Medicaid-eligible adolescents under age 21 with access to a comprehensive range of preventive, primary, and specialty services within its Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program. In conjunction with the Maternal and Child Health Bureau, new guidelines are being disseminated to state Medicaid and Maternal and Child Health programs. These guidelines, from the Bright Futures project, stress the importance of family and community support for positive health and social behaviors, including adolescent pregnancy prevention.
- **Federal/State Partnerships**, including the Maternal and Child Health Services Block Grant and the Social Services Block Grant (authorized by Titles V and XX of the Social Security Act, respectively), include support for adolescent pregnancy prevention programs, state adolescent health coordinators, state prenatal care hotlines, family planning, school health, and other prevention services. The Community Services Block Grant enables local community agencies to provide low-income populations, including youth at risk, with job counseling, summer youth employment, GED instruction, crisis hotlines, information and referral to health care, and other services. The Preventive Health and Health Service Block Grant (under Title XIX of the Public Health Service Act) provides resources to 49 States for services to the general population, including health education, risk reduction and public health nursing.
- **Youth Programs** including Runaway and Homeless Youth Programs, the High Risk Youth Program, Community Schools, National Youth Sports, and Youth Violence Prevention Programs, address a wide range of risk factors.
- **Healthy Start** has demonstration projects in 22 communities nationwide to reduce infant mortality in the highest-risk areas and to improve the health and well-being of women, infants, and their families. Among a broad array of services provided, thousands of teenagers participate in prevention programs exclusively designed for adolescents that encourage healthy lifestyles, youth empowerment, sexual responsibility, conflict resolution, goal setting, and the enhancement of self-esteem.
- **Empowerment Zones and Enterprise Communities** in 105 rural and urban areas across the country have been awarded grants to stimulate economic and human development and to coordinate and expand support services. As they implement their strategic plans, some sites are including a focus on teenage pregnancy prevention and youth development.
- **Health education in schools** supports the efforts of every state and territorial education agency to implement school health programs to prevent the spread of HIV and sexually transmitted diseases (STDs). Assistance is also provided to 13 states to build an infrastructure for school health programs. Efforts are targeted at preventing early sexual activity, STDs, HIV, drug and alcohol abuse, tobacco use, and injuries.

- Community and migrant health centers, including family and neighborhood health centers, operate in 1600 sites and provide primary and specialized health and related services to medically underserved adolescents. Some centers include special hours or clinics for adolescent patients.
- Indian Health Service provides a full range of medical services for American Indians and Alaska Natives. IHS has a special emphasis on youth substance abuse, child abuse and women's health care, and supports projects targeted at preventing teenage pregnancy.
- Drug treatment and prevention programs include services to prevent first-time and repeat births among teenagers. Sixty-five residential substance abuse treatment programs for pregnant and postpartum women, as well as women with dependent children, receive support to provide family planning, education, and counseling services. In addition, 13 grant demonstration projects offer interventions and outreach to female adolescents ages 12-20 who are at risk for alcohol, tobacco, and other drug use; physical and sexual abuse; and pregnancy. And, a two-year public information campaign is reaching out to adolescent girls ages 9-14, and to their families and social networks, to educate them about the risks and consequences of drug, alcohol, and tobacco use.
- Resources centers and clearinghouses at both the state and national level provide information and technical assistance to state and community-based health, social service, and youth-serving agencies. Toll-free hotlines also provide guidance on family and youth services, STDs, AIDS, and other issues.
- Research, surveillance, demonstrations, and evaluations are conducted on an ongoing basis to gather and provide information and technical assistance on the magnitude, causes, and prevention of teenage pregnancy and on programs and approaches that work.

#### **WELFARE REFORM: REACHING THE NEXT GENERATION**

Because estimates indicate that over half the mothers who receive Aid to Families with Dependent Children were teenagers when they had their first child, preventing teenage pregnancy has been a critical part of the Clinton Administration's approach to welfare reform. "The Personal Responsibility and Work Opportunity Reconciliation Act of 1996," which the President signed into law on August 22, 1996, contains several measures to reduce teenage pregnancy and prevent welfare dependency. The new law will send teenagers the message that staying in school, postponing sexual activity, and preparing to work are the right things to do. As President Clinton has said, "Nobody should get pregnant or father a child who isn't prepared to raise the child, love the child, and take responsibility for the child's future."

- **Teen Pregnancy Prevention.** Under the new law, starting in FY 1998, \$50 million a year in mandatory funds will be added to the appropriations of the Maternal and Child Health (MCH) Block Grant for abstinence education. In addition, the Secretary of HHS will establish and implement a strategy to (1) prevent non-marital teen births, and (2) assure that at least 25 percent of communities have teen pregnancy prevention programs. No later than January 1, 1997, the Attorney General will establish a program that studies the linkage between statutory rape and teen pregnancy, and that educates law enforcement officials on the prevention and prosecution of statutory rape.
- **Live at home and stay in school requirements.** Under the new welfare reform law, unmarried minor parents will be required to live with a responsible adult or in an adult-supervised setting and participate in educational and training activities in order to receive assistance. States will be responsible for locating or assisting in locating adult-supervised settings for teens.
- **Strengthened Child Support Enforcement.** The new welfare reform law includes the child support enforcement measures President Clinton proposed in 1994 -- the most sweeping crackdown on non-paying parents in history. The measures include: streamlined efforts to name the father in every case; employer reporting in new hires to catch non-paying parents who move from job to job; uniform interstate child support laws; computerized state-wide collections to speed up payments; and tough new penalties, like drivers' license revocation, for parents who fail to pay. These measures could increase child support collections by \$24 billion and reduce federal welfare costs by \$4 billion over 10 years.

###

# THE NATIONAL CAMPAIGN TO PREVENT TEEN PREGNANCY

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# CAMPAIGN UPDATE

June/July, 1996

This brief progress report is designed to bring you up to date on recent developments in launching the National Campaign to Prevent Teen Pregnancy.

## Membership of Leadership Task Forces In Place and First Meetings Scheduled:

The Campaign has appointed members of its four Task Forces and initial meetings of each group have been held or scheduled. Rosters of all four groups appear at the end of this update. Members are appointed for staggered terms to allow new individuals to be added each year. As mentioned in the April/May Update, these groups are the heart of the Campaign as much of our substantive work will be conducted under their leadership. The Task Force on Effective Programs and Research, chaired by Kristin Moore, Executive Director of Child Trends, Inc., held its first meeting in June. Among other things, the group agreed to develop a paper on "what works" in community programming and will conduct new analyses of the 1995 National Survey of Family Growth. The State and Local Action Task Force, chaired by Barbara Huberman, Director of Training at Advocates for Youth, met July 26 and developed early plans for a variety of ways the Campaign can assist states and communities in their own teen pregnancy prevention work.

The Religion and Public Values Task Force, chaired by William Galston, Professor of Public Affairs at the University of Maryland, and the Media Task Force, chaired by Jody Miller, Senior Vice President of Operations of Americast, are scheduled to meet in September. As a part of both meetings, a summary of public opinion on a variety of teen pregnancy issues will be presented by Princeton Survey Research Associates, Inc. The Media group, which will meet at the headquarters of People Magazine (whose president, Ann Moore, is on that task force) will also review several sets of focus group data related to teen pregnancy prevention.

## Executive Committee Meeting:

The Executive Committee met in July to discuss the Campaign's first-year projects and to review our progress in setting up administrative and financial systems. Using a detailed work plan developed by the Campaign Director and President, the Committee reviewed preliminary plans from each of the four task forces and also voted formally to add a few new members to each.

### **Robin Hood Foundation Report, *Kids Having Kids*, Released:**

On June 13, 1996, the Robin Hood Foundation formally released its comprehensive report on teen pregnancy, *Kids Having Kids*, which highlights the social and economic costs of adolescent pregnancy in the United States. At the White House event coinciding with the release, President Clinton praised the report and commented on the start up of the National Campaign several times, stating "I think we should all make a personal commitment to support them [The National Campaign to Prevent Teen Pregnancy], each of us in our own communities. They are going to be doing what all of us should be doing. They'll learn what works, spread the word, and work to replicate it throughout the country." Persons interested in obtaining a copy of the Robin Hood *Kids Having Kids* report should contact: Yvette McKenzie, The Robin Hood Foundation, 111 Broadway, New York, NY 10006, phone: (212) 227-6601.

### **Campaign Activities:**

In addition to the activities already noted, we have given presentations about the Campaign to numerous groups representing a wide variety of perspectives, including a consortium of leaders from the mountain states convened by the Colorado Department of Health, the Child Welfare League of America, and U.S. Agency for International Development. The Campaign President and Director have also met with several organizations to discuss possible Campaign activities. For example, the media activities being planned were discussed with Board member Judy McGrath, President of MTV and MTV's Director of Research. Meetings have also been held with the Executive Vice President of Corporate Affairs of Black Entertainment Television (BET); the Executive Director of the Campaign For Our Children; the President of the Video/Action Fund; the head of The American Assembly; and the President of the Planned Parenthood Federation of America.

Specific projects under development include convening an international conference on teen pregnancy prevention that would promote a cross-cultural exchange of promising models and ideas. We are also working with the Family Impact Seminar to develop a series of round tables (to include published summaries) on emerging issues in teen pregnancy, such as the role of sexual abuse in early teen sexual activity and pregnancy; new ideas about how to involve boys and men in pregnancy prevention; and facing up to the conflicts sometimes encountered between those who advocate for preventing teen pregnancy and those whose focus is on providing services to teens who are already pregnant or parenting.

We are also responding to many requests from organizations around the country for presentations about teen pregnancy and the National Campaign. In some instances, we try to use a speaking engagement as an opportunity to conduct a "site visit" of sorts to state and local programs or coalitions in order to gain a better understanding of grass-roots realities. The information gathered during site visits serve as learning tools in developing the Campaign's activities. For example, the President and Director of the Campaign are planning a week-long trip to Oregon and California in September during which time they will meet with the leaders of

several community coalitions as well as with teenagers participating in the programs. Other site visits in the fall are tentatively scheduled for Richmond, Chicago, New York City and Little Rock, Arkansas.

### Staff appointed:

We are pleased to announce the following appointments: Beverly Jackson has assumed the role of Director of Communications and Development for the Campaign. She has had extensive experience in communications and media with the Smithsonian Institution, Children's Hospital National Medical Center, and the American Psychological Association. She will be in charge of developing and implementing a strategic communications plan for the Campaign to increase the public's understanding of teen pregnancy and the Campaign's mission and programs; managing the media and public relations programs for the Campaign; and providing support for our fund-raising work. Catherine Bailey began in July as a staff assistant to provide general support to our very busy office. We are still recruiting for a director of state and local affairs and a research director as well.

### Important Resources in the Field:

From time to time, the Campaign Update will inform you of important resources in the field of teen pregnancy prevention. In this issue we want to alert you to four fact sheets that summarize useful data on this topic.

- *Adolescent Pregnancy Fact Sheet*  
Contact: Jan Chapin, Division of Women's Health Issues, The American College of Obstetricians and Gynecologists, 409 12th Street, SW, Washington, DC 20024-2188, phone: (202) 638-5577
- *Executive Summary: Adolescent Pregnancy and Childbearing in the U.S.*  
Contact: Amadie Hart, Population Resource Center, 1725 K Street, NW, Suite 1102, Washington, DC 20006, phone: (202) 467-5030.
- *Facts at a Glance*  
Contact: Child Trends, Inc., 4301 Connecticut Avenue, NW, Suite 100, Washington, DC 20008, phone (202) 362-5580.
- *The Facts: Adolescent Sexual Behavior, Pregnancy and Parenthood*  
Contact: Advocates for Youth, 1025 Vermont Avenue, NW, Suite 200, Washington, DC 20005, phone (202) 347-5700

### Staying in touch:

We welcome your inquiries, materials and suggestions. Our **new** main number is (202) 857-8655; fax (202) 331-7735; and our address is shown on the letterhead. Stay in touch, and please feel free to circulate widely the **new Campaign brochure** enclosed with this update.

The National Campaign to Prevent Teen Pregnancy, founded in February 1996, is a nonprofit, nonpartisan initiative supported entirely by private donations.

***Need:*** Teen pregnancy goes hand in hand with high risk for all involved, particularly the mother and the child, and imposes large costs on taxpayers as a result. If every child in America were born to parents ready and able to nurture and support that child, the next generation would have a far brighter future.

***Mission and Goal:*** The mission of the campaign is to prevent teen pregnancy by supporting values and stimulating actions that are consistent with a pregnancy-free adolescence. The campaign's goal is to reduce the teen pregnancy rate by one-third by the year 2005.

***Strategy:*** The Campaign's strategy has five major prongs: take a strong stand against teen pregnancy; enlist the help of the media; support and stimulate state and local action; lead a national discussion about the role of religion, culture, and public values in an effort to build common ground; make sure that everyone's efforts are based on knowledge about what works.

For more information contact the Campaign directly  
Telephone: (202) 857-8655. Fax: (202) 331-7735

# THE NATIONAL CAMPAIGN TO PREVENT TEEN PREGNANCY

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NOTE: Task Force Chairs serve as ex officio members of all other task forces.

## **Robin Hood Foundation Summary**

### **Kids Having Kids Excerpts from “Highlight of Study Findings”**

Researchers began by examining the gross differences in outcomes between adolescent mothers and women who delay childbearing until the age of 20 or 21 (also referred to as older or later childbearers). They then applied statistical controls to apportion this overall difference into as many as three categories: background factors, factors closely linked to adolescent childbearing (e.g. motivation, self-esteem, peer-group influence) and finally adolescent childbearing itself.

#### **Consequences for Children of Adolescent Mothers**

Compared to children of later childbearers, children of adolescent mothers are more likely to:

- be low-birth weight babies;
- have childhood health problems and receive less health care;
- grow up in homes without fathers and with less emotional support and cognitive stimulation;
- run away from home;
- be physically abused, abandoned or neglected;
- do poorly in school and drop-out of high school;
- have a child before age 18;
- have lower long-term earnings potential; and
- if they are male, be in prison as teenagers.

#### **Consequences for Adolescent Mothers**

- Compared to later childbearers, adolescent childbearing accounts for adolescent mothers being less likely to complete high school, more likely to have larger families, and more likely to spend time as a single parent during the first 13 years of childhood.
- Only 3 of ten adolescent mothers earn a high school diploma by age 30, compared with nearly 76 percent in the comparison group of women who delay childbearing until age 20 or 21. Further analysis found that adolescent childbearing alone accounts for more than 40 percent of this difference.
- The reasons for the differences in employment and earnings between adolescent mothers and later childbearers are complex.
  - Early childbearing is NOT the cause of low employment levels and earnings of adolescent mothers. (These result from factors other than decisions regarding when to bear children.)
  - Adolescent mothers earn only slightly less during the first twelve years of

parenthood than they would be expected to earn if they delayed childbearing until age 20 or 21. In contrast, over their young adult lives (ages 19 to 30), they work and earn somewhat more than do their later childbearing counterparts.

- Larger family sizes, together with weakened chances of stable marriage, lead to about 50 percent higher rates of welfare dependence among adolescent parents.

### **Consequences for the Fathers**

- The consequences of adolescent childbearing on both younger and older fathers are not as sharp as the effects on mothers and their children.
- Adolescent childbearing and closely linked factors account for adolescent dads finishing one semester less school than the comparison group of older fathers. In many cases, the semester may be the pivotal one that determines whether a high school senior will graduate or drop out.
- Over the 18 years following the birth of their first children, the dads of children born to adolescent mothers earn about \$3,000 (in 1996 dollars) less per year compared to the male partners of delayed childbearers.
- Fathers who do not marry the adolescent mothers of their children have incomes sufficient for society to expect them to contribute support at a level that would offset as much as 40 to 50 percent of the welfare costs to the adolescent mothers and their families.

### **Costs of Adolescent Childbearing for the Nation**

The report notes that costs to society estimates are probably lower bound estimates. Researchers estimate the cost of adolescent childbearing when the mother is 17 years of age or younger -- which represents 45 percent of first-time teen mothers. Further, the analyses do not take into account -- because the research data was unavailable -- all potentially relevant costs to society in terms lost productivity and wasted resources.

Researchers estimate the cost is \$6.9 billion annually. This includes:

- Welfare and food stamps combined cost \$2.2 billion;
- Increased medical-care expenses cost \$1.5 billion;
- Constructing and maintaining prisons to house the increase number of criminals caused by adolescent childbearing costs about \$1 billion;
- The increased costs of foster care are slightly less than \$.9 billion; and
- The loss of tax revenue is \$1.3 billion.

The cost to taxpayers of adolescent childbearing together with the other disadvantages faced by adolescent mothers is between \$13 billion and nearly \$19 billion per year -- This is the amount the taxpayers would save if a policy successfully delayed adolescent childbearing and successfully

addressed these other disadvantages.

Society is forced to use its energy and resources to mitigate the problems caused by teen childbearing and is unable to expend those resources for more productive purposes. The researchers calculated that this created a social cost to the nation of just under \$9 billion per year (utilizing the tightest controls for various background factors) or \$21 billion per year (controlling for a moderate range of background factors).

N.Y. Times; 9-9-96

## Marriage Advised in Some Youth Pregnancies

By B. DRUMMOND AYRES Jr.

LOS ANGELES, Sept. 8 — To the overburdened case workers of the Orange County Social Services Agency, it seemed an innovative solution to the nation's growing problem of underage girls who are made pregnant by adult men.

The case workers began recommending marriage, not in every instance but whenever they concluded that the girl and the man were willing to wed and raise their child together, and determined that sex had been consensual and that the girl needed the man's financial support.

In the case workers' view, supported by the local juvenile court, such marriages, while unusual and seldom authorized elsewhere in the nation, were nevertheless preferable to the usual but often unsatisfactory agency solutions of welfare payments, foster homes, adoption and, sometimes, charges of sexual abuse or statutory rape against men when girls are under 18.

At least 15 such couples have become married in about the last year.

But six weeks ago, when word got out that the agency had allowed a pregnant 13-year-old from Anaheim to marry her 20-year-old boyfriend, heated debate broke out between the county social welfare and law-enforcement authorities about whether the new policy promotes family values or condones what in most states is statutory rape.

Social Services Agency workers argue that marriage is just one of many approaches to solving a problem of great complexity, one freighted and shaded not just with age and questions of felony law but also with moral, religious, family and cultural issues. They point out that the policy has so far resulted in only a scattering of marriages out of about 25,000 under-age-pregnancy cases handled

annually by the county.

"We do this in those few cases in which it seems the best thing for the girl and the child," said Larry M. Leaman, the agency's director, "in cases where we have a man who is standing by the teen-age mother, wanting to do the right thing, ready for a family, willing to support it and where the girl's parents, if they are around, also favor marriage."

He added: "We know the odds of success are still steep, especially when a 13-year-old and a 20-year-old are involved. But marriage in such cases, if the criteria are right, is better than the man being pushed aside and, all too typically, the mother and child ending up in the welfare system and the family scattered."

Yet many police officers, court of-

ty prosecutors, "and when an adult has sex with a minor child, it's against the law. If the girl will testify, we think we should go to court. Legally, it's pretty straightforward. It's a quagmire otherwise, but we're not going to condone it."

Such prosecutions have been steadily rising in recent years as more and more states and localities become concerned about studies indicating that most babies born to teen-age girls are fathered by men who are at least 20 years old.

In California, Gov. Pete Wilson has begun a campaign to prosecute such men. Florida and Georgia have just passed tough statutory rape laws. And Delaware and Massachusetts are considering such steps.

"We don't want to blanket-judge every case," Mr. Wilson said in a statement, "but arranged marriages of convenience should not be an out for avoiding prosecution for statutory rape. We should vigorously prosecute statutory rape and child abuse and end the social pathology that has led to the runaway teen pregnancies that lead to a lifetime of welfare dependency and a dead-end road to a future."

He has also called for a review of the Orange County marriage policy, and one has been promised by the county's Juvenile Justice Commission, an advisory agency that monitors the treatment of juveniles.

Yet policy decisions are made by the county juvenile court, almost always based on the recommendations of welfare officials. And in the 15 cases of teen-adult marriages, judges gave approval based on welfare agency recommendations.

"This is a tough one," said Cindy Stokke, the commission's chairwoman. "Given the factors the social workers must weigh — things like law versus family — it's a real Catch-22 situation."

### Should a pregnant girl, 13, wed her boyfriend, 20? Are rape charges better?

ficials and family counselors, as well as some top state officials, argue that a better solution is prosecuting men for child abuse or statutory rape. They say an unyielding line must be drawn on the nation's rising number of teen-age pregnancies.

But the cases are tough to prosecute when sex has been consensual because obtaining prosecution testimony from the girl is difficult. Still, opponents of such marriages argue for prosecution.

"We're not out to solve social problems but to enforce the law," said Charles Middleton, an Orange Coun-

Cont'd from previous page

ty prosecutor.

Managed care proponents stress that doctors receive their monthly fee for each patient no matter how few times they see that patient. And Toni Chagnon, president of Genesis Health Plan, which has 6,400 of Westchester's welfare clients, points out that her plan, which is solely for Medicaid-eligible patients, pays doctors monthly fees that are comparable to those paid by H.M.O.'s dealing with private paying patients.

Moreover, the two H.M.O.'s that pay doctors for every visit rather than a monthly cap also pay rates competitive with commercial insurance plans. The Oxford health plan pays a doctor \$54 for an initial visit; Independent Health Plan pays \$51.

Linda Samuels, a deputy commissioner for social services in Westchester, said that some critics complain that the program "is more generous than the average person gets in their health plan."

"But that is the way Medicaid has been for many years in New York State," she said.

Despite the gains made by managed care, most private doctors continue to spurn welfare clients. Dr. Tallon, of the United Hospital Fund, said there was a suspicion that economic and racial discrimination might play a role. "Some doctors

don't want poor people in the waiting room," he said.

Independent Health, one of the health plans used by Westchester's welfare families, acknowledges that it has made acceptance of Medicaid clients voluntary for its participating physicians.

"No one is a winner if you force physicians to see welfare recipients when they don't want to," said Barbara Pike, Independent's assistant director of marketing.

While doctors may get paid more than they did with Medicaid, the heart of the county's cost-saving strategy has been to use managed care organizations to reduce emergency room visits. The H.M.O.'s have negotiated steep discounts with hospitals for nonessential emergency room visits and they telephone patients who make such visits to remind them to call their primary doctor first.

Dr. Karen Costley, medical director of Ossining Open Door, a clinic that is part of the Health Source managed care network, said the county's plan still did not provide a sufficient deterrent for patients to forgo the emergency room.

"The E.R.'s feeling is that medically, legally, a patient is presented to our door, we have to care for them," she said. "And then there's

the managed-care plan which says we're not going to pay to see a patient that we paid primary care physicians to manage. So it becomes a battle between the managed care plan and the E.R., and the patient usually gets what they want."

Still, patients accustomed to showing up in an emergency room and waiting have had to adapt to a system built on appointments, and that has not always worked out so well. Dr. Costley says Open Door's "no-show rate" is 20 percent.

"Our patient population has other life priorities that just doesn't allow them to keep their appointments," Dr. Costley said. "There's a lot going on sometimes and we don't always get calls canceling."

For many welfare recipients the changeover to managed care has been no more upsetting than switching membership cards. A welfare client like Milagros Lebron, 52, of Yonkers, chose her plan, Health Source, because the doctor she has seen for her high blood pressure, Dr. Sayegh, is part of that network and so is her neighborhood pharmacy. Ms. Briceno, a Peruvian immigrant, chose Community Choice Health Plan so she could stay with her doctor, Syed Shariff.

"He's a very good doctor," said Ms. Briceno. "When I take the baby, he checks her real good, like the urine, and he gives her a lead test."

THE WHITE HOUSE

WASHINGTON

June 28, 1996

MEMORANDUM FOR CAROL RASCO

FROM: Kevin Thurm, HHS  
Jeremy Ben-Ami

*KT*  
*JB*

SUBJECT: Outreach Plan for Dr. Foster

Since Dr. Foster assumed his position as Senior Advisor to the President on Teen Pregnancy and as Expert Advisor to Secretary Shalala and CDC Director David Satcher, he has been active with local and national groups on this issue, particularly as the President's liaison to the National Campaign to Reduce Teen Pregnancy. He has also maintained an active part-time public schedule, which has included speeches, congressional testimony, site visits, and media interviews. To compliment these activities, in coordination with him, we would like to focus more on an outreach program.

We define the outreach activities in two areas: speeches and site visits. Dr. Foster's schedule will continue to include appropriate meetings with the White House, HHS and CDC officials on teen pregnancy and youth policy in which he fulfills his advisory and consultant functions. In addition, following the summary is a proposed outline of his activities over the next several months.

1. Public Speaking Role

Dr. Foster serves an important role in carrying the President's message on teen pregnancy prevention. By being publicly active, he is able to demonstrate the President's commitment to teen pregnancy prevention, while educating people about the Administration's approach to this issue.

In coordination with the White House Office of Public Liaison, HHS and teen pregnancy groups, we have instituted a system to help Dr. Foster pro-actively seek major opportunities to speak to national audiences and large groups and to prioritize invitations for his time.

2. Outreach to State and Local Communities

Dr. Foster also serves as a liaison to local communities addressing teen pregnancy issues. These communities are at various stages in organizing their efforts: some want advice about how to initiate a program, while others want to let us know about their progress on a specific strategy and its positive effects on the community. To enrich Dr. Foster's understanding of these programs, we are arranging for him to regularly visit communities or programs that the Administration has funded. For each site visit, we have asked Dr. Foster to visit and tour a local program that is part of a community-wide network, have a working meeting with its organizers, and pursue speaking or media

opportunities.

Specific grant programs from which we would choose our sites include those funded by CDC's Community Coalition Partnership Programs for Prevention of Teen Pregnancy and OPA's Adolescent Family Life Grants.

- **Community Coalition Partnership Programs for Prevention of Teen Pregnancy:** This program was launched by this Administration under CDC in September of 1995. At that time, we awarded 13 grants totaling \$6.5 million over two years to community coalitions to work with youth in preventing unwanted pregnancies. They aim to enable communities to develop plans for implementing and evaluating community-wide interventions that are innovative, comprehensive and sustainable.

NOTE: In informal conversations, CDC said that site visits by Dr. Foster would be very helpful in generating local media about these community efforts. The majority of partnerships funded include good programs, but in many cases there is a low level of awareness in the region about these programs and the services they provide. CDC said that radio coverage, for example, would be helpful in reaching out to community members.

- **Adolescent Family Life Grants:** In September of 1995, HHS's Adolescent Family Life Program awarded 15 grants totaling \$4.2 million dollars for comprehensive demonstration programs aimed at preventing early teenage sexual activity and reducing teenage pregnancies. These programs feature innovative ways to emphasize abstinence as the best way to prevent adolescent pregnancy and to encourage the involvement of parents in these discussions with their children. The program is administered by the Office of Population Affairs under Title XX. (Note: Many of these programs actually target secondary pregnancy prevention for parenting teens.)
- Other programs we have learned about that seem to be successful community-wide grassroots interventions that we would like Dr. Foster to visit.

### 3. Media

Similar to the process instituted to assist Dr. Foster in prioritizing requests for public appearances, we have developed a system for evaluating, with Dr. Foster's input, media requests. Over time, we seek to have a mix of national coverage with regional and local press. In particular, we anticipate that Dr. Foster will highlight community-based programs during his site visits.

Attached is a draft schedule of suggested travel for Dr. Foster that builds on both of these priority activities.

## **SUGGESTED ACTIVITIES FOR DR. HENRY FOSTER**

Following is a list of sites and initiatives funded by HHS which might be appropriate for a visit by Dr. Foster between now and the end of the year.

NOTE: This does not include previously scheduled engagements, and only attempts to outline suggestions for activities on behalf of the Administration in compliance with legal limitations on time allocated for such activities. We expect the Office of Public Liaison to request Dr. Foster as a speaker for additional conferences as well.

Emory University; Atlanta, GA: The AFL program is currently funding The Emory University School of Medicine to expand Postponing Sexual Involvement (PSI), a three-tier educational series developed by Marion Howard, to reach over 9,000 young men and women and their parents. The series emphasizes the need for age-appropriate abstinence messages which are continually reinforced from elementary school through high school. PSI is well known program model and many other communities have tried to replicate it. Dr. Foster could visit a school where the curriculum is used.

Lula Belle Stewart Center; Detroit, MI: (AFL grant) This center, also currently funded by the AFL program, provides prevention and care services for the low-income population in the urban Detroit/Wayne County area. Prevention efforts aim to increase both the knowledge base about pregnancy and disease prevention and communication between parents, adolescent, and pre-adolescent youth. The program focuses on primary and repeat pregnancies.

NOTE: There are other programs in the area that Dr. Foster could reach out to that are not currently federally funded.

Truman Medical Center, Kansas City, MO (AFL Grant): Kansas City's Teen Mentors of Mothers (MOMS) program at the Truman Medical Center provides support and assistance in accessing community services for pregnant and parenting adolescents through culturally-matched mentors. Mentors meet weekly with teens to aid in problem-solving about managing the difficulties of early childbearing. Support groups are also organized specifically for male partners, younger siblings and grandparents. This program focuses on repeat pregnancies. It is a care program providing services to pregnant and parenting teenagers.

Working with Adolescents in Time (WAIT); Kansas City, MO (CDC): The Maternal and Child Health (MCH) Coalition of Greater Kansas City is the lead organization for this grant, and for an existing teen pregnancy prevention community coalition called Adolescent Pregnancy Prevention Committee. The Coalition has already been highly successful in a number of community collaborative efforts, including immunizations. Areas selected for implementation of the grant are in Wyandotte County, Kansas and Jackson County, Missouri where the teen birth rates are 50% above national average. The area also encompasses the empowerment zone in MO and KS. It is a high crime and poverty area that has a high concentration of African American adolescents--whose birthrate is said to be over double that of their white counterparts.

University of Arkansas/Arkansas Dept. of Education (AFL Grant): The Sex Can Wait program educates students about pregnancy prevention in the 16 districts in rural Arkansas, where in some counties the rate of teen pregnancy is among the highest of any identifiable group in the world. The program's approach includes outreach to minority populations, parental education to promote family communication about sexuality, contraception, STD's and HIV/AIDS, and male involvement to promote male responsibility in pregnancy and parenting.

Family Planning Council of Southeastern Pennsylvania, Inc.; Philadelphia, PA (CDC): Family Planning Council is a private-non profit organization serving the five-county Philadelphia area. As the Title X family planning grantee for Philadelphia, the Council directs a network of health agencies that provide comprehensive family planning services to over 102,000 low-income individuals. The Council started the Health Resource Center Program (HRC) in 1991. Its goal is to reduce rates of unintended pregnancy, STD and HIV by establishing school-based, drop-in centers where students receive education, counseling, and condoms with referrals for health services and contraceptive care. It is now operating in 11 Philadelphia schools, and works with health care providers, a health-related telephone hotline, the Public Schools System and the Department of Public Health to implement it.

Five of the 11 schools with HRCs are located in neighborhoods with extremely high teen birth rates; these neighborhoods are the focus of the grant. The neighborhoods are in North Central Philadelphia, and are culturally diverse high crime and poverty areas. They also include two Empowerment Zones. The Council proposes to expand the existing partnership by creating local coalitions convened by each HRC, which will include teens, faculty from the high school and feeder middle schools, parents and service agencies. They have developed a plan to prevent teen pregnancy and specific goals for implementation.

Mercy Hospital; Pittsburgh, PA (AFL Grant): Mercy Hospital is coordinating a continuum of services to meet the physical, emotional, psychological and educational needs of pregnant and parenting teens, while expanding school-based prevention education programs. The program offers services to prevent first and repeat pregnancies.

Family Health Council Adolescent Resource Network; Pittsburgh, PA (CDC): FHC is a private non-profit that provides services including family planning, prenatal and obstetrical care, nutrition, pediatrics, state licensed adoption and community sexuality related education. It has a major initiative in Allegheny County to prevent teen pregnancy (Adolescent Resource Network), and another to reduce women's risk of HIV/AIDS infection. FHC has also received two other grants from CDC through the PA Department of Health that are based on coalition building: one focuses on STDs among teens and the other supports the creation of a network of providers and community based organizations to do breast and cervical cancer screening and education.

FHC plans an effective teenage urban primary pregnancy prevention program for teens for implementation over a 2-year period aiming for a 10% decrease in teen pregnancy by the year 2000. It is working with community partners, including: Blue Cross, Children's Hospital, and Magee-Women's Hospital.

City of Milwaukee Health Department; Milwaukee, WI (CDC): Although there are many teen pregnancy prevention programs in Milwaukee, rates have remained high because efforts have been fragmented. The CDC grant money is being used to continue and expand efforts already started by the Milwaukee Metropolitan Adolescent Pregnancy Prevention Consortium, which is serving as the lead agency for a consortium of over 70 provider agencies, parents and teens, school and elected officials, and the religious community.

Another program to note:

**Urban League of Milwaukee Male Adolescent Responsibility Project:** This is a primary prevention program targeted at middle school male students. It aims to instill a sense of pride in their heritage and hope for their future.

Inwood House Project, Bronx or Brooklyn, NY: This project, currently funded by the AFL program, will expand a current program called TEEN CHOICE to operate in three urban junior high schools with high teen pregnancy rates in Brooklyn and the Bronx. TEEN CHOICE works with abstinent students to postpone sexual involvement, and teaches sexually active students how to protect themselves from pregnancy and disease. Parents are involved with the program, which promotes improved communication between parents and children on sexuality issues.

Illinois Caucus for Adolescent Health, Chicago, IL (CDC): The Illinois Caucus is a non-profit organization focusing on policy advocacy and public education to improve the health of adolescents, particularly teen parents and those at high risk for pregnancy. It is a state-wide membership group with foundation funding, that is using the CDC grant to work with three communities to develop coalitions to prevent teen pregnancy. Communities served are Westtown (62% Latino), Humboldt Park (50% African American, 50% Latino) and Near Westside (67% African American). The Caucus has a significant community base and is staffed by community residents. The Coalition implementing the grant is made up of 7 community-based groups: Erie Teen Health Center, Vida Sida, Youth Services Project, Chicago Commons, Mile Square Health Center, West Side Future and Chicago Boys and Girls Clubs Horner Center. The Coalition is specifically working to establish or improve: a case management system for young people who have not become pregnant or caused a pregnancy, parent/child communication programs, male responsibility programs, integration of pregnancy prevention and HIV/STDs prevention, and peer education programs.

**The Springfield Urban League, Inc. Adolescent Responsibility Program:** This is a comprehensive primary prevention program for 90 adolescent males and females aged 7-17 that aims to foster responsible behavior and development of intrapersonal skills and self-esteem. The program draws support from volunteer "positive role models" who teach the classes, serve as chaperons, tutors, etc. The program has the following components:

- Education, mentoring and tutoring which includes 38 sessions held weekly for two hours each.
- Parenting support group for parents of program participants.
- A community awareness campaign directed at adults and teens.

Trustees of Health and Hospitals of the City of Boston: This is the "hub" organization in Boston, where the Adolescent Pregnancy Prevention and Intervention Network was formed as a new initiative. It is a public/private effort by the Boston Department of Health and Hospitals, the Boston Public Schools and the Alliance for Young Families to pool resources among the many teen pregnancy prevention programs in Boston, targeting 5 neighborhoods where teen birth rates are highest. (Alliance for Young Families is a non-profit consortium of human service and health care agencies in MA that works to prevent teen pregnancy, promote adolescent health and meet the service needs of pregnant and parenting teens and their children. One of its four programs is the Boston Initiative for Teen Pregnancy Prevention which coordinates a broad-based 300 member citywide coalition promoting postponement of early childbearing through responsible decision-making.)

Examples of specific sites in the Boston area that Dr. Foster could visit include:

**The Urban League of Eastern Massachusetts' Youth Education and Development Program; Roxbury, MA:** This is primarily a school-based program that started 8 years ago, working with African American and Latino males (8-15) in the Roxbury, Dorchester, Jamaica Plain and Mattapan areas. The program serves boys who come from single parent families with incomes at or below the poverty level, and aims to provide a vision for participating boys for their futures as students, workers, and parents by developing confidence, academic and employability skills, values and a sense of responsibility. The Director of this program participated in a meeting with the President and Dr. Foster this year.

**Geiger-Gibson Community Health Center; Dorchester, MA:** Teen Pregnancy Prevention and Healthy Start Programs has historically served pregnant and parenting teens, but has added a focus on prevention of primary and secondary pregnancies through case management services. With an emphasis on education, the program aims to teach girls and boys to set goals and avoid anything like young motherhood or fatherhood, violence or drugs that might get in the way.

There are additional programs around the country that we could recommend that are not funded by these programs; for example:

Girls Incorporated of Metro Denver. The national Girls Incorporated Preventing Adolescent Pregnancy is one of the programs included in *The Best Intentions*, compiled by the Institute of Medicine. The Denver chapter has adapted the program, which includes four age appropriate curricula addressing the needs of girls 9 to 18, covering: developing parent-daughter communication, assertiveness skills and the ability to say "no," awareness of contraception and disease protection, and career and education planning. The program was started in 1989, serves Hispanic (53%); African American (16%) and White (16%). In addition to their own facility, Girls Inc of Metro Denver sponsors teen pregnancy prevention programs in middle and elementary schools in Denver. It works with other community organizations, such as Girl Scouts, Boys and Girls Clubs, and a community health center.



DATE: 9-9-96

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REMARKS:

New Teen Pregnancy Prevention Q&A.

Old ones to be update will follow.

## TEEN PREGNANCY AND WELFARE REFORM

### QUESTION:

How does the new welfare reform law address teen pregnancy?

### ANSWER:

- ▶ Unmarried minor parents will be required to live with an adult or in an adult-supervised setting and participate in educational and training activities. States would be responsible for assisting minor parents in locating an adult-supervised living arrangement.
- ▶ The Secretary of HHS shall establish and implement a strategy to (1) prevent non-marital teen pregnancies and (2) assure that at least 25% of communities have teen pregnancy prevention programs. The Department will report to Congress annually in respect to the progress in these areas.
- ▶ Starting in FY 1998, \$50 million a year (out of the Treasury funds not otherwise appropriated) will be added to the appropriations of the Maternal and Child Health Block Grant. The funds would be allocated to states using the same formula used for the bulk of the block grant funds. Funds would enable states to provide abstinence education with the option of targeting the funds to high risk groups (i.e. groups most likely to bear children out-of-wedlock). Abstinence Education is defined in part as an educational and motivational program which has as its exclusive purpose, teaching the social, psychological and health gains to be realized by abstaining from sexual activity.
- ▶ No later than January 1, 1997, the Attorney General shall establish and implement a program that provides research, education and training on the prevention and prosecution of statutory rape.

## ROBIN HOOD FOUNDATION REPORT

### QUESTION:

What does the report on the costs of teen pregnancy by the Robin Hood Foundation tell us?

### ANSWER:

- ▶ The report, entitled "Kids Having Kids: A Robin Hood Foundation Special Report on the Costs of Adolescent Childbearing," documented the many consequences of teenagers having children. These include:
  - ▶ Reproducing the Cycle of Poverty -- The girls born to adolescent moms are up to 83 percent more likely to become teenage moms themselves, thus reproducing the cycle of poverty and disadvantage for yet another generation.
  - ▶ Trouble in School -- Children born to teenage mothers are 50 percent more likely to repeat a grade and perform significantly worse on cognitive development tests. They are also far more likely to drop out of high school than are the children born to women from the same socio-economic background who wait until the age of 20 or 21 to have children.
  - ▶ Increase Child Abuse and Neglect -- Children born to teenage mothers are twice as likely to be abused or neglected.
  - ▶ Behind Bars The teen sons of adolescent mothers are up to 2.7 times more likely to land in prison than their counterparts in the comparison group. By extension, adolescent childbearing in and of itself costs taxpayers roughly \$1 billion each year to build and maintain prisons for the sons of young mothers.
  - ▶ Foster Children -- Of the estimated 472,000 foster children in the United States, over 23,000 are the children of adolescent mothers, which in turn results in a taxpayer burden of approximately \$900 million.

- ▶ Consequences on teen mothers:
  - 70 percent of the mothers drop out of school.
  - They are twice as likely to be dependent on welfare.
- ▶ A unique component of the study is its examination of the costs and consequences of teen pregnancy on society:
  - ▶ Teen childbearing costs U.S. taxpayers almost \$7 billion every year.
  - ▶ The cost to society in lost national productivity and avoidable expenditure of social service resources is as much as \$29 billion each year.

## UPDATE: NATIONAL CAMPAIGN TO PREVENT TEEN PREGNANCY

### QUESTION:

Can you give an update on the activities of the "National Campaign to Prevent Teen Pregnancy?"

### ANSWER:

- ▶ As you know I serve as Senior Advisor to the President on Teen Pregnancy and Youth Issues and act as a liaison to the private sector initiative, "The National Campaign to Prevent Teen Pregnancy."
- ▶ The Executive Committee of the National Campaign to Prevent Teen Pregnancy met in July to discuss the Campaign's first-year projects and to review progress on setting up administrative and financial systems. The Committee also reviewed the plans from each of the four Task Forces that have been formed. The four Task Forces include:
  - Effective Programs and Research Task Force, chaired by Kristin Moore, Executive Director, Child Trends, Inc.;
  - State and Local Action Task Force, chaired by Barbara Huberman, Director of Training, Advocates for Youth;
  - Religion and Public Values Task Force, chaired by William Galston, Professor, School of Public Affairs, University of Maryland; and
  - Media Task Force, chaired by Jody Miller, Senior Vice President for Operations, Americast.

- ▶ The substantive work of the Campaign will be conducted under the leadership of these Task Forces. Members of each task force have been appointed and initial meetings are taking place. The Effective Programs and Research Task Force held its first meeting in June and agreed to develop a paper on "what works" in community programming and will conduct new analyses of the 1995 National Survey of Family Growth. The State and Local Action Task Force met in July and developed early plans for a variety of ways to assist states and communities with their own teen pregnancy prevention work. The Religion and Public Values Task Force and the Media Task Force will meet in September.
- ▶ The Campaign has also continued to make presentations on its work to a wide variety of interested groups. Other specific projects under development include: convening an international conference on teen pregnancy prevention that would promote a cross-cultural exchange of promising models and ideas; and working together with the Family Impact Seminar the Campaign is developing a series of round tables on emerging issues in teen pregnancy.

## NEW HHS PROGRAM

### QUESTION:

Does HHS have any new teen pregnancy prevention programs under consideration?

### ANSWER:

- ▶ The Administration on Children and Families is requesting \$50 million in FY 1998 for a comprehensive, community-based youth development demonstration initiative. While we believe ACF is an appropriate office for administering these funds, we envision this as a cross-Department initiative which can be developed and implemented through the Governing Council on Children and Youth.
- ▶ Funds under this program can be used for program planning and coordination of services across the community; for supplementing existing service programs; for filling gaps in services and for program evaluation and improvement.
- ▶ Allowable activities under this program include academic and educational support efforts, supervised recreation programs, health education and prevention efforts, work force preparation and entrepreneurship activities, and cultural activities. Activities must also support parents in their efforts to guide their youth toward adulthood. Priority will be given to funding programs in areas of significant poverty and juvenile delinquency and high incidence of teen parenting.
- ▶ Use of funds for training and technical assistance, research, demonstration, and evaluation is limited to 15% of the total appropriation. Communities will define appropriate outcome goals and they will be measured against these goals.

### BACKGROUND:



DATE: 7/6/76

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REMARKS:

Dr. Foster's Statement  
& Q & A which have been update & new ones  
are in the beginning.

We need comments by 12:00 noon 9/10/96

**Statement of**  
**Dr. Henry Foster**  
**at**  
**the Congressional Black Caucus Legislative Weekend**  
**Issue Forum: Teen Pregnancy Prevention**

**September 12, 1996**

Thank you, Representative Clayton. I am pleased to be here at the 26th Annual Legislative Conference of the Congressional Black Caucus, and to have the opportunity to speak about an issue that has so much impact on our communities and our country -- teen pregnancy prevention.

For almost four decades, as a teacher, as a university leader, as a practicing obstetrician/gynecologist, I have dedicated my life to bringing healthy lives into this world -- and to helping people reach their full potential.

And I bring this commitment and enthusiasm to my role as the President's Senior Advisor for Teen Pregnancy and Youth Issues and liaison to the National Campaign to Prevent Teen Pregnancy -- a recently-formed nonprofit nonpartisan initiative supported entirely by private donations and led by a diverse group of prominent Americans.

In this role, I've enjoyed a number of great opportunities:

The opportunity to learn more about the Clinton Administration's comprehensive strategy to prevent teen pregnancy -- which includes demonstration grants to communities, state-of-the-art research, and a strong prevention message from the top.

The opportunity to see first-hand innovative prevention strategies being developed at the grass-roots level, many of which have federal support. This includes the outstanding and innovative collaborations supported by the CDC's Community Coalition Partnership Grants.

And perhaps most uplifting, the opportunity to join the President in challenging all caring adults to listen to our young people, help them form positive goals, and give them the support to achieve them.

And make no mistake, that part includes helping our young people remain abstinent and postpone pregnancy until they are ready to care for both themselves and their children.

Why is teen pregnancy such a big problem?

Early sex and early pregnancy so often compounds problems already evident in the lives of these teenagers -- exposure to poverty, violence, drug use, HIV/AIDS, and so many other negative outcomes.

Because children born to teen parents are more likely to be poor,

... are twice as likely to be abused or neglected ...

... more likely to have serious health problems, ...

... are 50 percent more likely to repeat a grade, and are far more likely to drop out of school, ...

... and are 83 percent more likely to become teen mothers themselves if they are daughters, and are up to 2.7 times more likely to land in prison if they are sons.

And because there is nothing more in the national self-interest than the protection and nurturing of children and our future leaders.

That's why I launched the "I Have a Future" program in Nashville, Tennessee back in 1986 -- and there's a lot we can learn from this effort to promote abstinence and reduce teen pregnancy.

The fact is, too many children today believe that their only hope is having babies.

We've got to replace that with a dream of hope and unlimited achievement.

That's the philosophy behind the "I Have a Future" program.

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## WHAT IS THE ADMINISTRATION DOING?

### QUESTION:

The President has called on communities and individuals to help reduce teen pregnancy. But what is the Clinton Administration doing to help communities address the problem?

### ANSWER:

- ▶ The Administration is working hard to address this complex social problem, through funding for community demonstration projects, public/private partnerships, and comprehensive research to find out which approaches work best.
- ▶ And it was the President's leadership that gave a jump start to the private sector's National Campaign to Prevent Teen Pregnancy.
- ▶ In addition, much of the Administration's social and economic agenda, ranging from education reform to welfare reform is designed to offer young people both disincentives and positive alternatives to early parenting and sexual activity.
- ▶ But, as the President mentioned in his State of the Union address, government can't do it alone. Community organizations, churches, schools, and citizens and the federal government must join together to fight this problem.

- ▶ Based on the needs of individual communities, the Initiative will support a wide variety of approaches to preventing teenage pregnancy. These approaches include abstinence-based activities, school health, family planning, alcohol and drug use prevention and referral for treatment, academic tutoring, literacy training, drop-out prevention programs, career and college counseling, mentoring, job skills training, apprenticeships, part-time paid work, community service programs, and local media campaigns. The funding can be used to fill gaps in services, ensure coordination of services, and other similar activities.
- ▶ The President's Teenage Pregnancy Prevention Initiative will fund 25 projects at \$1 million each. Because evaluation and learning is a key component of this Initiative, \$5 million will be set aside for rigorous evaluation, and federal training and technical assistance.
- ▶ These demonstration grants will provide resources to expand or strengthen promising strategies that address local community needs. Bringing together business, media, religious, and other groups, they will work to encourage individual and community responsibility and provide opportunities for youth in the effort to reduce teen pregnancy rates in this country.

**Characteristics of the ACF program:**

- Demonstration grants not to exceed \$1 million each.  
(Earlier materials stated 25 grants at \$1 million each.)
  - Target urban, suburban, and rural areas with high teen pregnancy rates and where collaborative efforts and/or interagency linkages are already in place or are beginning.
- I. Demonstration programs will be encouraged to involve many sectors of the community, including the business, media, education, religious, health and social service sectors.
  - II. Grantees may be any non-profit public or private entity or consortium of such entities. Potential grantees include, but are not limited to: municipal governments, public health departments, community-based organizations, public schools, universities, and hospitals.
  - III. Types of activities which may be funded:
    - abstinence-based activities
    - school health
    - family planning
    - academic tutoring
    - school drop-out prevention
    - alcohol and drug use prevention and referral for treatment
    - job skills training
    - peer counseling
    - mentoring
  - IV. Evaluation and learning are key components of this new initiative. \$5 million will be set aside for training, technical assistance and evaluation.
    - Each site will use a portion of the grant funds for a process evaluation. In addition, HHS will award a contract for an in-depth cross-site evaluation.
    - ACF will provide technical assistance including information about program model refinement, evaluation design and implementation, and how to access other federally funded resources available in the community.
  - V. This new initiative will be based on recently completed and reviewed research by Child Trends, Inc. This research identified promising approaches as those which:

- Enhance current and future economic opportunity for teens
- Combine education about abstinence with information about contraception
- Address males as well as females
- Involve and inform families and communities
- Make contraceptive services accessible to teens
- Link a broad array of services for teens (e.g., education/training plus contraceptive services)
- Increase the length of time for interventions
- Start intervention at an early age
- Are comprehensive in nature
- Support families.

This research also identified limitations of many existing programs:

- Scope of intervention/program is too narrow;
  - Program goals do not relate to program inputs;
  - Program starts with adolescents rather than younger children
  - Approach lacks sensitivity to culture, age, or gender
  - Approach is not based on documented research findings.
- FTE numbers will not increase as a result of this program.