CONGRESSIONAL BLACK CAUCUS LEGISLATIVE WEEKEND
ISSUE FORUM ON TEENAGE PREGNANCY PREVENTION
sponsored by Congresswoman Eva M. Clayton
Thursday, September 12, 1996
D.C. Convention Center
Washington, D.C.
2:30 pm. - 4:00 p.m.

Mary Vernon's Testimony
CDC

Representative Clayton, thank you for the opportunity to speak at this Congressional Black Caucus Legislative Forum on an issue that -- whether we want to admit it or not -- affects everyone in this room, and the nation in general. Adolescent sexual behavior, with resulting teen pregnancy, teen childbearing, and sexually transmitted diseases, including HIV infection among teens, remain a major dilemma in the United States.

I am not here today to release new data, but to share with you some good news and bad news. We have observed that reproductive maturity is occurring earlier than it did a century ago. In fact, the age of reproductive maturation has been decreasing three months every decade for the past 110 years. Researchers state that the average age of reproductive maturation for girls (first menstruation) is 12.5 years and for boys (nocturnal emissions) is 13.5 years. Given that the age of first menstruation has been going down and the age of marriage has been going up, the number of years during which unmarried adolescents can become pregnant has been increasing.

One reason for the high rates of teen pregnancies is the growing proportion of adolescents who are engaging in sexual intercourse at younger ages. CDC's Youth Risk Behavior Survey data in 1995 shows that nearly one-third of ninth grade girls and nearly half of ninth grade boys have already had sexual intercourse. About 49% of white high school students and 58% of Hispanic high school students have become sexually experienced, and 74% of black high school students have become sexually experienced. The good news is that during the 1990s, the proportion of high school students who had ever had sexual intercourse has not continued to increase as it did during the 1970s and 1980s. We should be aware that teens from all ethnic groups, socioeconomic backgrounds, and religious affiliations are engaging in sexual intercourse. As a mother of two teenagers, I am constantly aware that teens who are having sexual intercourse may be my neighbors, the children of my friends, my children's peers, and even my own teenagers, even though they tell me that having sex as a teenager is too risky.

Each year in the United States, approximately one million adolescents between the ages 15 to 19, -- almost 30,000 of them are under age 15 get pregnant. The pregnancy rate among 15-19 year olds increased sharply between 1985 and 1990, especially among the 15-17 year olds. We observed a rise of 9% among 15-19 year olds from 1985 to 1990, followed by a plateau from 1990 to 1991. The increase was even more pronounced for teens under age 15 in 1990. It is encouraging that in 1992 there was a decline in the pregnancy rates among 15 to 19-year-olds in 37 of 42 states that report pregnancy data, plus the District of Columbia.

We know that more than half of all adolescents who get pregnant continue their pregnancy to term and have a baby. Between 1980 and 1990, we observed a 13% increase in the birth rate for 15 to 19 year-olds who became pregnant. In 1990, one in seventeen 15 to 19 year olds became a mother, and one in 150 -- 13 to 14 year olds became a mother. Recent data indicate that while the adolescent live birth rates among 15 to 19 year olds increased between 1988 (53.0) and 1991 (62.1), they had decreased slightly between 1992 (60.7) to 1993 (59.6).

The proportion of adolescent pregnancies ending in an induced abortion remains high (about 30 -35% between 1980 and 1990), again with the highest rates occurring among the youngest adolescents. In 1990, about half of pregnancies among teens under age 15 resulted in an induced abortion. About 38% of pregnancies among 15 to 17 year olds, and about 36% among 18 to 19 year olds resulted in an abortion. It appears that the abortion rates among 15-19 year-olds plateaued from 1980 to 1989, and then actually decreased from 1990 (40%) to 1991 (37%). These data may suggest that teenagers who get pregnant didn't plan to get pregnant. In fact, about 95% of adolescent pregnancies are unintended. The good news is that 1992 data show a downward trend in the adolescent abortion rates in 31 of the 42 states for which data were available.

Another encouraging fact is that among sexually experienced adolescents, the pregnancy rate actually decreased by 9% over the decade from 1980 to 1990. Sexually experienced adolescent women were actually less likely to get pregnant in 1990 than in 1980. An important reason for this change was an increase in use of condoms by adolescents. According to the CDC Youth Risk Behavior Survey,

among currently sexually active students, the proportion who reported using a condom at last sexual intercourse increased from 46% in 1991 to 54% in 1995. Condom use appears to be more prevalent among black students. While 66% of sexually active black students reported condom use, only 53% of sexually active white students and 44% of sexually active Hispanic students reported condom use. Condom use among sexually active high school students has increased from 1991 to 1995.

In contrast, among sexually active students, 17% reported using a birth control pill at last sexual intercourse. One in five (21%) white students reported using the pill at last intercourse as compared to 1 in 10 black (10%) and Hispanic (11%) students. Among female students, condom use decreased with increasing grade (59% in grade 9 to 43% in grade 12), and birth control pill use increased with increasing grade (from 13% in grade 9 to 29% in grade 12).

Teen pregnancy clearly is a major public health and societal problem for all of us. But please realize that teen pregnancy is one of several related epidemics that result from the same sexual behaviors among largely the same population of teenagers. One in 8 teenagers contracts an STD each year and more than 80 percent of all STD cases occur among individuals under 29 years of age. Further, approximately one-fifth of all people with AIDS are in their twenties. Since the median incubation period between infection with HIV and onset of AIDS is ten years, many 20-29 year olds with AIDS likely were infected as teenagers. More than 300,000 Americans already have died of HIV-related illnesses. It is estimated that one half of all HIV

infections occur in young people under 25 years of age, and one quarter of all new HIV infections occur in young people between the ages of 13 and 21. The bad news is that AIDS is now the 6th leading cause of death among 15 to 24 year olds.

The statistics indicate that our young people are at-risk. Behind every statistics is a child or adolescent in trouble. We must work to make the PREVENTION OF ADOLESCENT PREGNANCY, AND OTHER RELATED HEALTH, SOCIAL, and ECONOMIC PROBLEMS a priority for adolescents throughout the United States. There are no simple answers to the challenges we face, but through continued dialogue and awareness, I know we can make a difference in the lives of many young people.

Thank you Representative Clayton and other members of the Black Caucus for your leadership.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Chief of Staff
Washington D.C. 20201

FACSIMILE

DATE July 15, 1996

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

Lyn Hogan

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

Kevin Thurm
Chief of Staff
DHHS

690-6133

RECIPIENT'S FAX NUMBER ( ) 456-7028

NUMBER OF PAGES TO SEND (INCLUDING COVER SHEET) 3

COMMENTS

Aug 7-4-6 pm - National Science Foundation
OEOB
Come through HHS

Aug. 12-13 Nashville - Infant Mortality
Inst of Medicine
Oprah Land Hotel

Aug. 13 At-Risk Kids
Nashville Schools

Aug 15 White House Fellows meeting

Aug 16 New London, CT
Teen Pgy Prevention

~~YMCA~~ APB - Nocksville, TN

Aug 29 - 31 - Alaska - Teen Pgy.

Sept 4
Pittsburgh -
Women's Health
APB

Sept. 6 -
Morehouse School of Medicine

Sept 10
Trenton NJ
Planned

Sept. 9
Robert Wood Johnson visit

Sept. 11
Willmgt, DE
APB

Sept 13
Arkansas Black Nurses

American Program Broadcasting Schedule — Lyn Hogan 456-7028

TRAVEL ITINERARY
HENRY W. FOSTER, JR., M.D.
JULY * AUGUST * SEPTEMBER

DEPARTURE DATE	RETURN DATE	LOCATION	ACTIVITY
Sun., July 7	Tues., July 9	Baltimore, MD/Dallas TX	Teen Preg. Presentation/Zeta Phi Beta-Black Female Issues
Sun., July 14	Tues., July 16	Washington, D.C.	Teen Leadership IOM Council
Wed., July 17	Fri., July 19	New York, NY	Pathfinder Board Meeting
Fri., July 26	Mon., July 29	Chicago, IL	Family Reunion/NMA Presentation
Wed., July 31	Sun., August 4	Atlanta, GA New York, NY	Olympics/Vacation To receive Crile Award
Thurs., August 15	Sat., August 17	New London, CT	Key Note Speech *
Thurs., August 23	Thurs. August 23	Knoxville, TN	YMCA/Keynote Speech APB

out July 9 - Aug. 4 Sept.
out during Rep + Dem convention

Oct. 29 - AIDS Conf.
Atlanta, GA

Oct. 30 - NY, NY
Keynote on Teen Pregnancy

Nov. 4 - Syracuse, NY

Nov. 8 - Tennessee -
Keynote Address

week of
Nov. 11 - Florida -
Ft. Lauderdale -

Nov. 21 - APB, Buffalo, NY

Nov. 22 - Syracuse, NY

Nov. 23 - NYC -
Einstein Medical
School

Dec. 4 - Chicago -
for HIV
Illinois Adolesc
Caucus -

Dec. 11 Las Vegas

TRAVEL ITINERARY
HENRY W. FOSTER, JR., M.D.
JULY * AUGUST * SEPTEMBER

DEPARTURE DATE	RETURN DATE	LOCATION	ACTIVITY
Tues., August 27	Thurs., August 29	Washington, D.C.	HHS Meeting *
Fri., August 30	Sun., September 1	Anchorage, AK	Keynote Community Coalition ?
Thurs., September 5	Sun., September 8	Tuskegee, AL	Morehouse/VA Hospital Presentation
Mon., September 9	Thurs., September 12	Wilmington, DE Washington, D.C. Trenton, N.J.	HHS Office activities * Keynote address Keynote address
Fri., September 13	Sat., September 14	Pine Bluff, AR	Black Nurses Associations
Mon., September 16	Wed., September 18	Tallahassee, FL	Health Start Presentation
Fri., September 20	Mon., September 23	Myrtle Beach, SC	South Carolina PN Association
Thurs., September 26	Fri., September 23	Jacksonville, FL	S. Florida Medical Foundation

Revised 6-25-96

APB

APB

more info

December

Las Vegas, NV

Community Coalition

Sept. 16 Tallahassee
17 Teen Preg. Reduction
18 Healthy Start

Sept. 19 Site visit to Robert Wood Johnson

Sept 23 - South Carolina

24 - South Carolina St. University

Sept. 28 - Florida, Domestic Violence
APB

Sept. 30 Keynote on Teen Preg.
Toledo, Health Dept

Oct. 4 Health Care In the Millenium
Lansing, MI

Oct. 10 - where?
National Black
Child Assoc.
APB

Oct 14-16
D.C.
Inst. of Medicine

Oct. 17 - Birmingham
AL

Oct. 21-22 -
DC
chairing a meeting

Oct. 24 Philadelphia
APB

Oct. 25 Welfare
Madison, WI

DATE: 9/10/69

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
200 INDEPENDENCE AVE., SW
WASHINGTON, D.C. 20201

PHONE: (202) 690-7627 FAX: (202) 690-7380

OFFICE OF THE ASSISTANT SECRETARY FOR LEGISLATION
ROOM 416-G HUMPHREY BUILDING

TO : Lyn Hogan

OFFICE : DPC

PHONE NO : 456-5567

FAX NO : 456-7028

TOTAL PAGES (INCLUDING COVER): _____

FROM:

[ ] RICHARD J. TARPLIN
[✓] HELEN MATHIS
[ ] KEVIN BURKE
[ ] SANDI EUBANKS BROWN
[ ] ROSE CLEMENT LUSI
[ ] STEPHANIE WILSON
[ ] HAZEL FARMER

REMARKS:

attached is a statement that Dr. Foster would like to do Friday at the news form for Rep. Stokes.

Teen Pregnancy: A Form of Violence

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 of support he delivered to the Senate Labor and Human Resources Committee in support of my Surgeon General nomination last year. And thank you Verdett 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. Although separate workshops on violence and women's issues are being held, and this categorical delineation is not inappropriate, I must emphasize that teen pregnancy is indeed a from 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 its life in poverty. Conversely, for those females who don't do these three things before having their first child, the chance of the child living its life 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 teenage 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 106 per 1,000 females aged 19 and below 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 cross-cuts all ethnic, economic and social classes. This a problem affecting the whole nation.

There is yet another violent aspect of teen pregnancy; at least one-half of babies born to adolescent mothers are fathered by adults. Men six or more years older than their female consort cause more that 400 teen pregnancies everyday. And all too often the participation by the female is forced. This calls for comprehensive strategies 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 with a residential venue is its major unique aspect. First, this residential venue allows us to more adequately address idle time; 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 basically 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, availability of contraception, computer programs, recreational activities, and health services 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; i.e., violence;

(2) To provide ready access to health and 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. This 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.

As the President's Senior Advisor, I serve as his emissary and conduit to the National Campaign and consultant to the Centers for Disease Control and HHS as a whole. My interaction with the Campaign Board is of an ad hoc nature since the effort is non-partisan.

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

FAX COVER SHEET

TO: Lynn Hogan ATT.

FAX #: 202-456-7028 # OF PAGES: 3 (includes cover sheet)

DATE: Aug. 20, 1996

RE/SUBJECT: Request for Dr. Henry Foster

FROM: Kathy Klatt

The Junior League of Atlanta, Inc.
3154 Northside Parkway, NW
Atlanta, Georgia 30327
404-261-7799
FAX # : 404-814-0856

COMMENTS/MESSAGE:

IF YOU HAVE ANY DIFFICULTY RECEIVING THIS FAX,
PLEASE CALL LEAGUE HEADQUARTERS AT 404-261-7799

BUILDING A
BETTER COMMUNITY

August 20, 1996

Lynn Hogan
Domestic Policy Council
The White House
Washington, D.C.
Fax: 202-456-7028

Dear Ms. Hogan:

I am writing to ask your assistance in arranging for Dr. Henry Foster to come to Atlanta on December 3, 1996. We would like Dr. Foster to participate in a panel discussion on "Teen Pregnancy Prevention." This would be a panel for The Junior League of Atlanta membership (world's largest Junior League) with the objective of providing an educational opportunity for dialogue and interaction on this issue.

We have made a multi-year commitment to research, educate and identify programs and projects for our involvement in this vital issue. It is our goal to be in the forefront of community leadership as an influential advocate and catalyst for change.

We would be delighted to pay Dr. Foster's airfare and hotel expenses.

Since President Clinton has initiated a campaign to address this problem, it would be wonderful if someone of national stature could contribute to our local effort.

Thank you for your consideration.

Sincerely,

Kathleen P. Klatt

Contact Person: Kathleen Klatt
770-391-0243
Fax: 404-715-4733

cc: Betsy Meyers
White House Women's Initiatives and Outreach
Fax: 202-456-7311

BUILDING A
BETTER COMMUNITY

THE JUNIOR LEAGUE OF ATLANTA, INC.

Celebrating Over 80 Years of Service to the Community

1996-1997 FACT SHEET

Mission Statement
The Junior League of Atlanta, Inc. is an organization of women committed to promoting voluntarism, developing the potential of women, and to improving the community through the effective action and leadership of trained volunteers. Its purpose is exclusively educational and charitable.

Vision Statement
We have a shared vision of the organization, which is to be a catalyst for community change by empowering women who are passionately focused on the health, education, and welfare of women and children.

Value Statement
The Junior League of Atlanta, Inc. accomplishes its mission through the actions of women who share the same organizational values. They are:

- Dedication to Voluntarism
- Membership Camaraderie
- Diversity
- Personal Development and Fulfillment
- Mentoring for Community Leadership
- Giving of Ourselves

Reaching Out Statement
The Junior League of Atlanta, Inc. reaches out to women of all races, religions, and national origins who demonstrate an interest in and commitment to voluntarism.

History
Founded in 1916 with 45 members, The Junior League of Atlanta, Inc. today has 5,000 members, making it the largest of the 292 Leagues in the world, all of which are affiliated through The Association of Junior Leagues International, Inc.

The 1996-1997 Community Partners
The Junior League of Atlanta, Inc. will provide over 100,000 volunteer hours and will give much needed financial assistance to the following community agencies and programs:

Adaptive Learning Center
Adult Literacy One on One
American Red Cross
Atlanta Alliance on Developmental Disabilities (AADD)
Atlanta Botanical Garden
Atlanta Children's Shelter
Atlanta Community Food Bank
Atlanta History Center
Atlanta Opera
Atlanta Preservation Center
Atlanta Speech School
Atlanta Union Mission
Capitol Area Mosaic (CAM)
Center for Positive Aging
Center for Puppetry Arts
Council on Battered Women
Crawford Center for Therapeutic Horsemanship
Egleston Children's Hospital
Exodus, Inc.
Fulton County Juvenile Court
Genesis Shelter, Inc.
Georgia Campaign Against Adolescent Pregnancy (GCAPP)
Georgia Council on Child Abuse
Georgia Mental Health Institute (GMHI)
Georgia Shakespeare Festival
Grady Health Systems
Habitat for Humanity - Atlanta
High Museum of Art
Historic Oakland Foundation
Hospice Atlanta, Inc.
Immunize Georgia's Little Guys
Jerusalem House
MARR, Inc.
My Turn Now
Northside Shepherd's Center
Prevent Blindness Georgia
Rainbows, Inc.
Ronald McDonald House
Scottish Rite Children's Medical Center
Summerhill Project
Teen Outreach Program (TOP)
Wesley Woods Center
Young Audiences
Zoo Atlanta

Financial Overview
All monies raised through the fundraising efforts of The Junior League of Atlanta, Inc. are used to train and educate its membership for effective community service as well as to financially aid projects and programs of its 45 community partners where League volunteers serve. The operating expenses of The Junior League of Atlanta, Inc. are supported solely by dues collected from its membership.

For More Information, Contact:
Lisa Anne Gaston, Public Relations Chairman, (404) 261-7799

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Washington, D.C. 20201

FACSIMILE

DATE AUG 9 1996

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

Lynn Hogan

456-5567

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

Mary Beth Donahue
Deputy Chief of Staff
DHHS

690-6133

RECIPIENT'S FAX NUMBER ( ) 456-7028

NUMBER OF PAGES TO SEND (INCLUDING COVER SHEET): 3

COMMENTS:

Lynn:

For your information!

Position Description for Dr. Henry Foster, Jr.

Dual Title:

- Senior Advisor to the President on Teen Pregnancy and Youth Issues
- Expert to the Director, Centers for Disease Control and Prevention

1. Serve as an advisor to the Director of the Centers for Disease Control and Prevention, the Secretary of Health and Human Services, the President, and their respective staffs on matters pertaining to teen pregnancy and related adolescent health issues.

2. Evaluate past and current teen pregnancy prevention programs (public and private) and, based on findings, work with CDC, HHS and White House staff on a national teenage pregnancy prevention initiative.

3. Serve as a liaison between the Administration and outside leaders and groups who focus their activities on teen pregnancy prevention.

4. Bring national attention to the enormous magnitude of the problem of teen pregnancy in the United States.

5. Raise public awareness of successful local and state efforts and raise public awareness of federal efforts and resources that are available to assist communities in addressing these problems in their communities.

6. Assist the Administration in galvanizing groups and individuals at the local level to create and implement initiatives to substantially reduce the teen pregnancy rate in the United States.

7. Serve as a representative of the Administration on teen pregnancy issues by speaking publically and participating in both national and local meetings of organizations concerned with teen pregnancy and youth issues.

8. Make appearances and give interviews to the media to publicize the teen pregnancy issue, feasible interventions starting with abstinence and challenge people (particularly at the local level) to become more involved.

9. Meet with individuals and groups in less public settings to motivate them to action on behalf of the President, the Secretary, and the CDC director.

10. Participate in teen pregnancy meetings with White House, HHS and CDC staff.

To: Dan Porterfield
Marybeth Donohue

cc: Carol Rasco
Jeremy Ben-Ami
Elizabeth Drye

From: Lyn Hogan

Date: 7/12/96

Re: Implementing Dr. Foster's Schedule

Following is a breakdown of what I view as Dr. Foster's key activities, the actions needed to implement these activities, and my **suggestions** as to who should be responsible for which activity. When we talk Monday morning, I'd appreciate your feedback on the list below.

Thanks!

Key activities should include:

Speeches
Congressional testimony
Site visits
Media Interviews
Meetings With White House, HHS, CDC Officials
Liaison to local communities addressing teen pregnancy issues
- Advice on initiating a program
- Reporting progress of specific strategies and affects on the community

Actions to Implement and Delineation of Responsibilities:

Scheduling site visits and/or speeches ✓
HHS/CDC – Terry

Scheduling Dr. Foster's travel, filing for reimbursement
Dr. Foster

Preparing briefing memos, talking points and/or speeches
DPC/Lyn Hogan

Staffing Dr. Foster at events
HHS/??

Media preparation/media calls
HHS/Press--Dan Porterfield and/or Lisa Gilmore

Contact for Dr. Foster's Liaison Functions/Reporting Etc.
DPC/Lyn Hogan

Dr. Foster meetings with The White House, HHS and CDC
Dr. Foster / HHS coordinate these meetings if requested

Bi-monthly progress/scheduling meetings
DPC/HHS--Lyn Hogan and Marybeth Donohue

Monthly progress report to Carol Rasco and Secretary Shalala
DPC/HHS--Lyn Hogan and Marybeth Donohue

Need his schedule Aug, Sept, Oct,

Implementation Plan

Need schedule through October –

Key activities should include:

Speeches
Congressional testimony
Site visits
Media Interviews
Meetings With White House, HHS, CDC Officials
Liaison to local communities addressing teen pregnancy issues
- Advice on initiating a program
- Reporting progress of specific strategies and affects on the community

Actions to Implement and Delineation of Responsibilities:

Scheduling site visits and/or speeches, Dr. Foster's travel, filing for reimbursement

HHS/CDC: Half-time person at the Centers For Disease Control is currently responsible for these activities.

me

Preparing briefing memos, talking points and/or speeches

DPC/Lyn Hogan: These materials will not always be needed, but when they are, I will produce them with a final sign-off from both of you and HHS.

Staffing Dr. Foster at events

DPC/HHS: We will decide on a per-event basis whether or not Dr. Foster needs to be staffed and who will staff him. There is no available personnel or funding for personnel to staff Dr. Foster, so we will have to split these responsibilities with HHS as needed.

Media preparation/media calls

HHS: Dan Porterfield, Lisa Gilmore, and Marybeth Donohue currently coordinate press requests with Lorrie McHugh. This process has been in place and works quite well, so there is no reason to change it.

me

Contact for Dr. Foster's Liaison Functions/Reporting Etc.

DPC, Lyn Hogan: During Dr. Foster's site visits and though his travels, he learns about and gathers information on community-based teen pregnancy prevention initiatives around the country. I'll serve as a clearing house for that information so we are always up to date on what Dr. Foster is learning. National Campaign – information –

Dr. Foster meetings with The White House, HHS and CDC

Dr. Foster: To date, Dr. Foster either sets up meetings as needed or receives meeting requests through us or HHS. We'll continue operating this way.

Bi-monthly progress/scheduling meetings

DPC/HHS--Lyn Hogan and Marybeth Donohue: There has been no coordinated progress reports with Dr. Foster. Marybeth and I will schedule a bi-monthly phone conference with Dr. Foster and I will follow-up with a brief memo to both of you after each phone conference.

M E M O R A N D U M

To: Carol Rasco
Jeremy Ben-Ami

cc: Dan Porterfield, HHS
MaryBeth Donahue, HHS
Lisa Gilmore, HHS

From: Lyn Hogan
Elizabeth Drye, DPC

Date: July 15, 1996

Re: Dr. Foster Implementation Plan

As you requested, I have worked with HHS to develop what we think is a realistic implementation plan for Dr. Foster's activities as Senior Advisor to the President on Teen Pregnancy and Expert Advisor to Secretary Shalala and CDC Director David Satcher.

Generally, I discussed with MaryBeth Donahue, Dan Porterfield and Lisa Gilmore (all at HHS) which activities Dr. Foster can carry out for us and when. Between now and the end of August, Dr. Foster has several non-Administration speaking engagements scheduled, and is then on vacation for two weeks of the summer. We are also assuming you do not want Dr. Foster speaking during either of the August conventions.

That said, it makes sense to set up site visits and speeches for Dr. Foster during September through November. We can easily set up events for Dr. Foster in conjunction with other non-Administration events he already has scheduled. MaryBeth Donahue will work from the Foster memo to put together a realistic schedule for Dr. Foster for September though November.

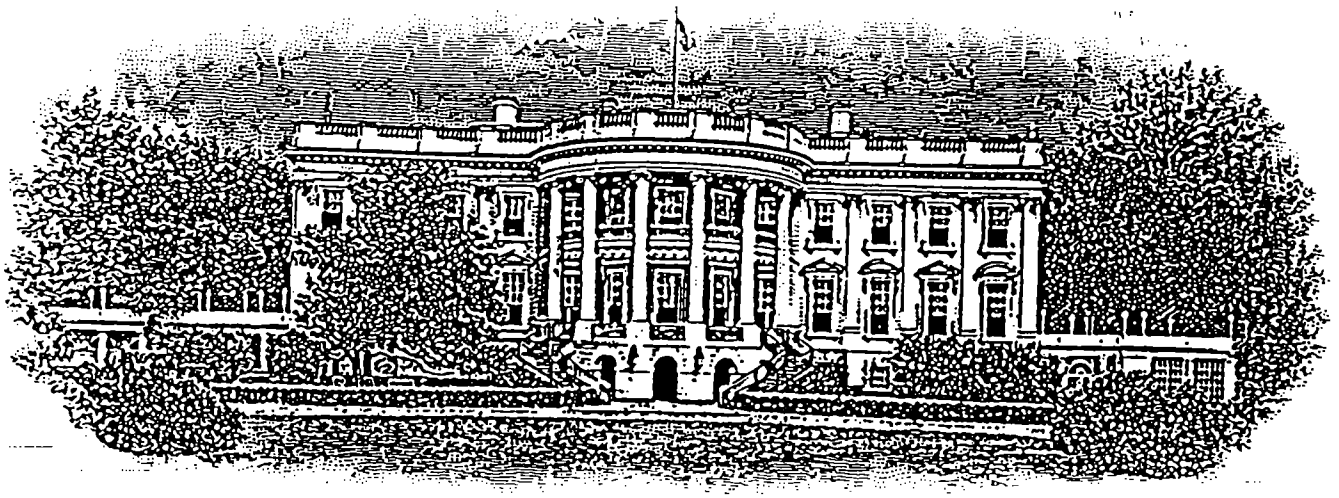
Nuts and Bolts Implementation

The next question is, given the limited resources we have to work with, how best can we get this plan off the ground? I took the key activities discussed in the 6/28/96 Foster memo and broke them into the actions and responsibilities. I then went over these in a conference call with MaryBeth, Dan, and Lisa and received some excellent feedback.

Following is the draft implementation plan we developed, much of which is already being done by HHS. Once we receive your approval, we'll share it with Dr. Foster and get under way.

Dan Portinfield

The White House



DOMESTIC POLICY

FACSIMILE TRANSMISSION COVER SHEET

TO: Mary Beth Donohue

FAX NUMBER:

TELEPHONE NUMBER:

FROM: Lyn Hogan

TELEPHONE NUMBER:

PAGES (INCLUDING COVER): 7

COMMENTS:

THE WHITE HOUSE

WASHINGTON

June 28, 1996

MEMORANDUM FOR CAROL RASCO

FROM: Kevin Thurm, HHS
Jeremy Ben-Ami

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 Alleghany 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.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Chief of Staff
Washington D.C. 20201

FACSIMILE

DATE July 15, 1996

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

Lyn Hogan

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

Kevin Thurm
Chief of Staff
DHHS

690-6133

RECIPIENT'S FAX NUMBER ( ) 456-7028

NUMBER OF PAGES TO SEND (INCLUDING COVER SHEET) 3

COMMENTS

~~SECRETARY'S CALENDAR~~

SEPTEMBER 1996

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
1 [HOLD/TRAVEL]	LABOR DAY 2 [HOLD/TRAVEL]	3	4 [SENATE/HOUSE RETURN] Pittsburg, PA	5 ←	Dubuque,
8	9 DC ?	10 Princeton, NJ	11 Wilmington, DE	12	PM Pine B
15	16 Tallahasee, FL ?	17	18 P.M. [redacted]	19	[redacted] (Myrtle Beac
22	23 (Myrtle Beach, SC)	24	25	26 (Jacksonville, FL)	
29	30 [redacted]				

A/O JULY 15, 1996

SATURDAY	
6	7
AL)	
13	14
bluff, AR ?	
20	21
k, SC)	Dallas TX
27	28
	Nashville, TN

SECRETARY'S CALENDAR

OCTOBER 1996

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDA
		1	2	3	
6	7	8	9	10	
13	COLUMBUS DAY 14	15	16	17	
20	21	22	23	24	
27	28	29	30	31	

Lansing,

Columbia,

Phil, PA

A/O

TURDAY

4	5
MI	
11	12
MO	
18	19
	(redacted)
25	26
	A[redacted]Rec'd
	C[redacted]mtg

To: Dan Porterfield
Marybeth Donohue

cc: Carol Rasco
Jeremy Ben-Ami
Elizabeth Drye

From: Lyn Hogan

Date: 7/12/96

Re: Implementing Dr. Foster's Schedule

Following is a breakdown of what I view as Dr. Foster's key activities, the actions needed to implement these activities, and my **suggestions** as to who should be responsible for which activity. When we talk Monday morning, I'd appreciate your feedback on the list below.

Thanks!

Key activities should include:

Speeches
Congressional testimony
Site visits
Media Interviews
Meetings With White House, HHS, CDC Officials
Liaison to local communities addressing teen pregnancy issues
- Advice on initiating a program
- Reporting progress of specific strategies and affects on the community

Actions to Implement and Delineation of Responsibilities:

Scheduling site visits and/or speeches
HHS/CDC

Scheduling Dr. Foster's travel, filing for reimbursement
Dr. Foster

Preparing briefing memos, talking points and/or speeches
DPC/Lyn Hogan

Staffing Dr. Foster at events
HHS/??

Media preparation/media calls
HHS/Press--Dan Porterfield and/or Lisa Gilmore

Contact for Dr. Foster's Liaison Functions/Reporting Etc.
DPC/Lyn Hogan

Dr. Foster meetings with The White House, HHS and CDC
Dr. Foster

Bi-monthly progress/scheduling meetings
DPC/HHS--Lyn Hogan and Marybeth Donohue

Monthly progress report to Carol Rasco and Secretary Shalala
DPC/HHS--Lyn Hogan and Marybeth Donohue

Foster — Plan

Problems

Dr. Foster –
no body of people to staff
him –

CDC person – scheduling
Terry Conan –
shown –
bringing in new person

Planning + Evaluation
staff ?

NO open press for Dr. Foster
keep a local message
On our #, teen preg. event –
he needs staffing

— * Conservative US extremist

Staffing —
Regional VIS, ts —
need no staffing —
set up "as needed bases"

* Laurie McQue — tell him what to say
top Comm. people
White House Media Affair —
Dr. Foster treated like Sec. and everyone else
media inquires - Come to Meyseth
She passes them onto Nelissen
and Laurie for their judgent -

Need to give Dr. Foster
feedback on what he says
need to say message -

DATE: 9/6/96

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
200 INDEPENDENCE AVE., SW
WASHINGTON, D.C. 20201

PHONE: (202) 690-7627 FAX: (202) 690-7380

OFFICE OF THE ASSISTANT SECRETARY FOR LEGISLATION
ROOM 416-G HUMPHREY BUILDING

TO : Lynn Hogan

OFFICE : DPC

PHONE NO : _____

FAX NO : _____

TOTAL PAGES
(INCLUDING COVER): _____

FROM:

[ ] RICHARD J. TARPLIN
[X] HELEN MATHIS
[ ] KEVIN BURKE
[ ] SANDI EUBANKS BROWN
[ ] ROSE CLEMENT LUST
[ ] STEPHANIE WILSON
[ ] HAZEL FARMER

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

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 in 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.

- 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 Gutmacher 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).

UNPLANNED PREGNANCY RATES

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.

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 fare 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."

DATE: _____

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
200 INDEPENDENCE AVE., SW
WASHINGTON, D.C. 20201

66481 -

PHONE: (202) 690-7627 FAX: (202) 690-7380

Richard < 816-471-0577 Clyde McAver
Full Employmt Counc.)

OFFICE OF THE ASSISTANT SECRETARY FOR LEGISLATION
ROOM 416-G HUMPHREY BUILDING

TO : Lynne Hogan

OFFICE : DPC

PHONE NO : 456-5567

FAX NO : 456-7028

TOTAL PAGES (INCLUDING COVER): _____

FROM:

[ ] RICHARD J. TARPLIN
[X] HELEN MATHIS
[ ] KEVIN BURKE
[ ] SANDI EUBANKS BROWN
[ ] ROSE CLEMENT LUSI
[ ] STEPHANIE WILSON
[ ] HAZEL FARMER

REMARKS:

CBC Info on Issue Forums on Teenage Pregnancy Prevention -- that Dr. Foster has been invited to speak at.

Melanne Verveer

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

1) Eva Clayton: Wrap-up speaker wants to talk about Nat'l Campaign This 2:30 - 4 Convention Center

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

2) A Cry For Help The Urban Epidemic Friday 5th Speaker 9-1230 Stokes

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, consquences 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

- New law, only abstinence
- Statutory rape vs marriage make sure its adequately addressed
- check partial birth

1ST DISTRICT, NORTH CAROLINA

COMMITTEES:
AGRICULTURE
SUBCOMMITTEES:
RISK MANAGEMENT AND SPECIALTY CROPS
RESOURCE CONSERVATION, RESEARCH AND FORESTRY

SMALL BUSINESS
SUBCOMMITTEE:
PROCUREMENT, EXPORTS, AND BUSINESS OPPORTUNITIES

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

WASHINGTON OFFICE:
222 CANNON BUILDING
WASHINGTON, DC 20515
(202) 225-3101

DISTRICT OFFICES:
134 N. MAIN STREET
WILLIAMSTON, NC 27892
(919) 257-4800

400 WEST 5TH STREET
GREENVILLE, NC 27834
(919) 758-8800
1-800-774-8572

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 aganed 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
VA/HUD/INDEPENDENT AGENCIES
MEMBER
LABOR/HHS/EDUCATION

Congress of the United States

House of Representatives

Washington, DC 20515-3511

2365 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515-3511
(202) 225-7032

DISTRICT OFFICE:
3645 WARRENSVILLE CENTER RD.
SUITE 204
SHAKER HEIGHTS, OH 44122
(216) 522-4900

August 29, 1996

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

LS/fdw

DRAFT WORKING DOCUMENT

NOT FOR DISTRIBUTION, OR REPRODUCTION, OR CIRCULATION

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

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 fare 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 pf 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:

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.

- In addition, much of the Administration's social and economic agenda, ranging from education reform to empowerment zones to crime prevention programs, is designed to offer young people positive alternatives to early parenting and sexual activity.

- The President also supports welfare reform legislation that requires teens who are already parents to live at home, identify their child's father, finish high school, and prepare for work. But, as the President mentioned in his State of the Union address, government can't do it alone. Community organizations, churches, schools, and citizens must join together to help the federal government fight this problem.

TEEN PREGNANCY AND WELFARE REFORM

QUESTION:

Many Republicans support cutting off aid to teen mothers under welfare reform. Why isn't a ban on cash aid to teen moms the way to go?

ANSWER:

- Denying assistance to teen mothers just doesn't make sense. It won't do anything to move them towards self-sufficiency, and it would force small children to pay the price for their parents' past mistakes.

- Our approach to welfare reform would take strong action to address the problem of teen pregnancy, but would not give up on teenage parents and their children. We would require teen mothers to live at home with their parents, identify their child's father, finish high school, and work in order to become good role models and providers for their children.

NGA WELFARE PROPOSAL AND TEEN PREGNANCY

QUESTION:

Some people claim that the NGA proposal would fail to reduce out-of-wedlock and teen births, because it would continue to give assistance to teen mothers. How do you respond to that?

ANSWER:

- We believe that denying assistance to teen mothers just doesn't make sense. Our approach to welfare reform, like the governors' approach, would take strong action to address the problem of teen pregnancy, but would not give up on teenage parents and their children. We would require teen mothers to live at home with their parents, identify their child's father, finish high school, and work in order to become good role models and providers for their children.

- The governors' proposal also makes the family cap optional for states -- unlike the Conference bill, which mandated a family cap that state legislatures would have to vote out of. We believe that states should have more flexibility, not less under welfare reform, and that they shouldn't be constrained by such mandates.

- However, the governors' proposal contains an "illegitimacy ratio," which would give states a financial incentive to reduce their abortion rate. While the Administration believes that we must reduce out-of-wedlock childbearing, we do not support the use of an "illegitimacy ratio." Welfare reform should not become entangled in the politics of abortion.

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. One half of adolescent girls and two-thirds of adolescent boys are sexually active at age 17.

- 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:

- When attention first began to focus on the fathers of infants born to adolescent mothers, it was assumed that they were also adolescents.

- The Alan Guttmacher Institute (AGI) released a study last year on the role that adult males play in teen pregnancy. It found that at least one-half of babies born to teenage girls were fathered by adults.

- Results from the AGI study show that, in general, the younger the mother, the greater the age difference between her and the infant's father; adolescent mothers are more likely than older mothers to have a partner at least several years older. 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 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.

- These findings also point to the fact that teenage pregnancy is not just limited to teenagers, but that in fact adult males bear responsibility in many cases.

- They underscore the importance of sexuality education for our youth--including a focus on abstinence which incorporates instruction in resistance skills.

- 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.

TRENDS -- TEEN BIRTH RATES AND CHILDBEARING

QUESTION:

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

ANSWER:

- From 1990 through 1993, the proportion of high school students who reported being sexually experienced remained stable, while an increasing percentage of sexually active students used condoms, thereby reducing their risk for unintended pregnancy and sexually transmitted diseases, including HIV infection.

- Birth Rate:

  After a sustained decline, the birth rate for teens aged 15-17 increased 27 percent between 1986 and 1991 (from 30.6 to 38.7 per 1000 females age 15 to 17). More recent data show a 2 percent decline in the birthrate between 1991 and 1992, overall levels are still substantially higher than in 1986.

- Contraceptive Use

  The percentage of those currently sexually active students who reported condom use at last sexual intercourse increased significantly, from 46 percent in 1991 to 53 percent in 1993. Oral contraceptive use at last sexual intercourse increased from 14.6 percent in 1990 to 18.4 percent in 1993.

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 -- 1,000,000 teenagers each year become pregnant.

- 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.

- We must be clear about what teen pregnancy is -- and what it is not. Teen Pregnancy is not a problem of the inner city. It is not a women's problem, nor a problem confined to certain religious or ethnic groups. And, most important, it is not -- nor will it ever be -- someone else's problem.

- It is our problem. 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 until marriage 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.

- Moreover, we need to send a broader message about responsible behavior. While we must encourage young people to delay sexual activity -- we must also insist that they use contraceptives consistently, responsibly, and correctly if they begin.

- I know that there is a lot of controversy about school based sex education and condom distribution. These issues, like most issues related to teen pregnancy, are local issues, to be decided by families, communities, and local school boards.

- 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.

CAUSES OF TEEN PREGNANCY

QUESTION:

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

ANSWER:

- Tragically, each year more than one million adolescent girls in the U.S. become pregnant. Too often, these young women are unmarried -- too 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.

  • Yes, contraceptive use among adolescents has increased, but the proportion of adolescents that are sexually active has also increased -- and thus, so has the rate of pregnancies.

  • Contraceptive use is positively associated with age. More younger adolescents are becoming sexually active and they are less likely to use contraceptives.

And, even though more adolescents are using contraceptives, their use is far from perfect.

▶ Social factors also play a role:

• 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.

• Too many adolescents who live in poverty don't see positive alternatives. They view their life options as restricted and see little reason for delaying sexual activity and parenthood in favor or pursuing educational and career goals.

• Risk-taking behaviors--drug use, alcohol use, early sexual activity-- tend to occur together and these behaviors are increasing among adolescents.

• Messages about sex are pervasive in the media. Advertising, television programs, movies, videos, and music all tend to portray sex without responsibility or consequences.

• 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.

▶ 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.

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 age-appropriate sexuality information about access to contraceptive methods. And, we must teach them that the correct and consistent use of latex condoms is effective at preventing pregnancy and sexually-transmitted diseases.

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.

WHAT MAKES EFFECTIVE PREVENTION PROGRAM?

QUESTION:

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

ANSWER:

- Unfortunately, it is not possible to identify many adolescent pregnancy prevention programs that have actually documented substantial success in preventing pregnancy or parenthood. Most of the interventions that have been rigorously evaluated have been found to have only small or no effects.

- 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.

- Most teen pregnancy prevention programs, although very well-intended, are frequently too little, too late.

- 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;

  - Attention to the importance of peer influences;

  - Different groups and ages need different interventions;

  - Attention to education achievement and the world of work.

NATIONAL CAMPAIGN TO PREVENT PREGNANCY

QUESTION:

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

ANSWER:

- The Campaign was stimulated by 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, 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 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 "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 in 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. In some cases, that means access to birth control -- with 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.

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?

ANSWER:

- 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.

- The Supreme Court has ruled that "Roe forbids a state from interfering with a woman's choice to undergo an abortion procedure if continuing her pregnancy would constitute a threat to her health."

- Therefore, the Administration cannot support H.R. 1833 because it fails to provide for consideration of the need to preserve the life and health of the mother, consistent with the Supreme Court's decision in Roe v. Wade.

BACKGROUND:

In a February 28 letter to Representative Henry Hyde, the President indicated he would be prepared to support H.R. 1833 if it was amended to state that the prohibition of this procedure does not apply to situations in which the selection of the procedure, in the judgment of the attending physician, is necessary to preserve the life of the woman or avert serious adverse health consequences to the woman.

NEW HHS PREGNANCY PREVENTION PROGRAM

QUESTION:

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

ANSWER:

- To build on the Department's ongoing partnership with local communities, this new initiative will give help to those communities with high teen pregnancy rates.

- 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.

- These new demonstrations will be conducted through the Administration for Families and Children (ACF). It will use the ACF program as its base, but will tie together the multiple programs sponsored by all DHHS agencies. A committee, made up of agency and program representatives from all existing programs relate to teen pregnancy, will advise ACF on the development and administration of this new program.

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.

- Demonstration programs will be encouraged to involve many sectors of the community, including the business, media, education, religious, health and social service sectors.

- 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.

- 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

- 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.

- 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:

- It is a complementary effort. We are not trying to recreate the wheel here, and we expect the new program to work in tandem with existing efforts in HHS.

- 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) Each program that is funded will be rigorously evaluated;

  3) It will emphasize the need to target both young men and young women.

- Building on what we have learned from previous programs, this new initiative is multi-faceted -- it combines activities which will provide opportunities for youth and promote responsible behavior.

- The goal of the program is to communicate the President's key message on teen pregnancy prevention, by convincing young men and young women that staying in school, postponing pregnancy, and preparing to work are the right things to do.

Background Information:

Existing programs within HHS

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

- 13 demonstration grants were awarded at an average of $250,000 each. The CDC program emphasizes coalition building and serves communities with a population of at least 200,000; 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 is a clinic-based family planning program which serves adults as well as adolescents. While decreasing teen pregnancy is one goal of the program, a wide range of family planning services are made available. The ACF program will target adolescents and serve their economic, social, and health needs.

OPA (Adolescent Family Life Program; $6.3 million)

- Awarded 15 grants totaling $4.2 million in September 1995 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. Innovative features of these projects include improving communications with parents and involving parents in discussions about life choices and sexual values; having older teens serve as mentors and models; teaching assertiveness skills and modeling responses to pressures; and conveying age-appropriate abstinence messages.

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 the statistic you have cited cannot be supported by research.** What is known is that surveys conducted in the 1970s by the well known researchers M. Kantner and J.F. Zelnick showed that 75 percent of adolescent women reported their first sexual encounter occurred either in their own home, their partner's home, or a friend's home. A comparable proportion reported their most recent sexual encounter also occurred in one of those three places.

- 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.

- The old African adage says, "It take a village to raise a child."

- We must be that village--parents, teachers, religious leaders, older siblings, businesses, and elected officials. All of us must talk straight with our children and teach them to say “no” to sex. But, we must also given them something to say “yes” to.

- We need to give them positive alternatives--like athletics, art, music, and a job. Only then, will we truly be that village, and only then will our children truly have a chance at fulfilling and productive futures.

BACKGROUND:

While the statement that teenagers engage in sexual activity between the hours of 3 and 5 pm (or 3 and 7 pm) has been cited time and time again the research simply does not support it. Studies which have asked teenagers at what time they engage in sexual activity have not been conducted.The research we can point to indicating that lack of parental supervision may provide teenagers with the opportunity to be sexually active is relatively old and was not conducted during the time period of the late 1980s when teenage birth rates began to rise.

Given that we do not know when teenagers are having sex we cannot determine a particular time during which they become pregnant. Until studies of teenagers are conducted which asks them about the times during which they are sexually active statements about statistics referring to such data must not continue to be cited.

TRENDS -- TEEN BIRTH RATES AND CHILDBEARING

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 aged 15-19 years increased by more than 25 percent. The most recent data (60.7 and 59.6 births per 1000 girls aged 15-19 in 1992 and 1993, respectively) indicate a slight decrease but the rates are still substantially higher than those observed during the early 1980s.

- Data from a number of sources indicate that contraceptive use among adolescents has increased somewhat. For example, the proportion of adolescent women aged 15-19 years of age using a contraceptive method at first intercourse increased from 53 to 71 percent during the periods 1980-82 to 1988-1990. Similarly, the proportion of sexually active high school students reporting condom use at last intercourse increased from 46 to 53 percent between 1991 and 1993 and oral contraceptive use increased from 15 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 to 56 percent and the proportion of adolescent boys sexually active by age 18 increased from 63 to 73 percent. Increased contraceptive use was not sufficient to cancel out the effect of the larger proportion of adolescents at risk of pregnancy.

UNPLANNED PREGNANCY RATES

QUESTION:

Why are our rates of unintended pregnancy so high compared to other Western nations? What can we do about this? Isn't this an indication of the failure of the Title X program?

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 specifiy 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 occuring in the U.S. are clearly possible.

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.

- Considering that more than one-half of all pregnancies in the United States are unintended and that the proportion unintended, by age of mother, ranges from 21 percent for women aged 25 to 34 years to 77 percent for women over 40 years of age, it is not really surprising that 82 percent of adolescent pregnancies--where the young mother is probably unmarried, has not completed her education, and is not able to adequately support her child--are unintended.

- 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).

- It is recognized that many disagree with this definition and some, in fact, disagree with the concept of unintended pregnancy and childbearing. It is also recognized that almost everyone sees limitations and ambiguities in the definition. Nonetheless, it is the standard, accepted and used by the field, and facilitates research in an extremely complex and important area of human sexual and reproductive behavior.

Congressional Black Caucus Foundation
Legislative Conference
Dr. Henry Foster's Participation

The 26th Annual Legislative Conference of the Congressional Black Caucus Foundation will begin on September 11 - 15, 1996. The theme of the conference is Yesterday, Today & Tomorrow.

Dr. Henry Foster has been asked to participate in two issue forum sessions on Teenage Pregnancy Prevention. All issue forums are being held at the Washington Convention Center.

He was invited by:

- **Representative Eva M. Clayton (D-N.C.)**
  Issue Forum Entitled: Teenage Pregnancy Prevention
- **Thursday, September 12, 1996 2:30 - 4:00 pm**
- At this issue forum, Dr. Foster is expected to serve as the wrap-up speaker and include remarks about the National Campaign to Prevent Teen Pregnancy.

- **Representative Louis Stokes (D-OH)**
- Issue Forum Entitled: A Cry for Help: The Violence Epidemic (Dr. Foster will address Teenage Pregnancy Prevention.)
- **Friday, September 13, 1996 9:00 a.m. - 12:30 p.m.**
- At this issue forum, Dr. Foster will be the third or the fourth speaker. He will address Teenage Pregnancy Prevention.

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, consquences 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