

Withdrawal/Redaction Sheet

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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. memo	Carol H. Rasco to Jennifer Palmieri et al. (1 page)	03/19/1996	P5
002. bio	Biography of Charles Augustus Ballard [partial] (1 page)	n.d.	P6/b(6)

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Domestic Policy Council
Lyn Hogan
OA/Box Number: 11027

FOLDER TITLE:

Dr. Henry Foster

2010-1083-S

rc122

RESTRICTION CODES

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- P1** National Security Classified Information [(a)(1) of the PRA]
- P2** Relating to the appointment to Federal office [(a)(2) of the PRA]
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- b(4)** Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
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- b(7)** Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
- b(8)** Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
- b(9)** Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

Withdrawal/Redaction Marker

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DR. HENRY FOSTER

**PREVENTING TEEN PREGNANCY IN AMERICA:
COORDINATING COMMUNITY EFFORTS**



**BRIEFING MATERIALS FOR
TESTIMONY BEFORE**

**HOUSE GOVERNMENT REFORM AND OVERSIGHT
SUBCOMMITTEE ON HUMAN RESOURCES AND
INTERGOVERNMENTAL RELATIONS**

**APRIL 30, 1996 @ 10:00 a.m.
2154 RAYBURN HOUSE OFFICE BUILDING**



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BRIEFING MEMORANDUM



Washington, D.C. 20201

MEMORANDUM

TO: Dr. Henry Foster

FROM: Irene B. Bueno *IB*
Deputy Assistant Secretary for Legislation
(Congressional Liaison)

DATE: April 26, 1996

SUBJECT: **HOUSE GOVERNMENT REFORM AND OVERSIGHT SUBCOMMITTEE ON
HUMAN RESOURCES AND INTERGOVERNMENTAL RELATIONS
HEARING on Tuesday, April 30, 1996 2154 Rayburn,
10:00 a.m. -- BRIEFING**

BACKGROUND

You have been invited to testify before the House Government Reform and Oversight Subcommittee on Human Resources and Intergovernmental Relations in a hearing entitled, *"Preventing Teen Pregnancy in America: Coordinating Community Efforts."*

The hearing will focus on community-designed and directed efforts to facilitate collaborative planning, problem solving, and the development of strategies to prevent and to reduce the occurrence of teen pregnancy in America.

You have been asked to discuss the success of the teen pregnancy program that you have pioneered and administered in Nashville and about your personal and/or professional experience and insights with respect to teen pregnancy prevention in general.

This hearing is expected to be an educational and constructive hearing. Chairman Shays and other members of the Subcommittee are interested in learning about the teen pregnancy problem, the programs that have succeeded in reducing teen pregnancy, and exploring the role of the federal government in fighting teen pregnancy.

MEMBERS' CONCERN

Since Congress will not be in session until 5 pm, attendance to the hearing may be light.

Republicans

Representative Christopher Shays (R-CT), Chairman of the Subcommittee on Human Resources and Intergovernmental Relations - will attend - As the Chairman of the Subcommittee, Chairman Shays is holding this hearing to learn more about teenage pregnancy and to hear about programs that have worked to prevent teenage pregnancies. For your information, I have attached a statement he made on the House floor concerning this issue.

Representative Mark Souder (R-IN) Vice Chairman - may attend -As a conservative member of the Subcommittee, Representative Souder may ask difficult questions. He supported the H.R. 1833, the late term abortion bill. He is the Vice-Chairman of the Freshman Class and an outspoken member of the class. Representative Souder is also a former staff director of the House Select Committee Children, Youth, Families and worked for Senator Dan Coats (R-IN).

Representative Steven Schiff (R-NM) - is not expected to attend. Representative Schiff is a moderate.

Representative Constance Morella (R-MD) - will likely attend. As a moderate, pro-choice Republican, Representative Morella is likely to ask thoughtful questions about teen pregnancy and programs that work.

Representative Thomas Davis (R-VA) - will likely attend. Representative Davis is a moderate, pro-choice Republican and is expected to ask thoughtful questions about teen pregnancy and programs that work.

Representative Dick Chrysler (R-MI) - may attend - As a member of the Freshman class, Representative Chrysler's views on this issue are not well known.

Representative William Martini (R-NJ) - will likely attend. As a moderate member of the Freshman class, Representative Martini is not expected to ask difficult questions.

Representative Joe Scarborough (R-FL) - may attend - Representative Scarborough, a freshman Republican with Christian-conservative views, may ask difficult questions. During his campaign, he promised to fight for pro-life legislation, but now says he believes the federal government should keep out of the abortion debate -- leaving it to the discretion of individual states.

Representative Marshall "Mark" Sanford (R-SC) - will likely attend. Representative Sanford is a freshman Republican and pro-choice.

Representative William Clinger (R-PA), Chairman of the House Government Reform and Oversight Committee - may attend - As the Chairman of the Full Committee, Chairman Clinger has been known to attend hearings briefly but not ask any questions.

Democrats

Representative Edolphus Towns (D-NY), Ranking Member - will attend. As the ranking member of the Subcommittee and former Chair, Representative Towns is expected to ask questions that highlight the Administration's accomplishments on teen pregnancy prevention programs.

Representative Tom Lantos (D-CA) - will unlikely attend. Representative Lantos is not expected to ask difficult questions.

Representative Thomas Barrett (D-WI) - will likely attend - Representative Barrett is very interested in this issue and has constituent groups that are active on this issue. Representative Barrett is interested in learning more about the problem and ways to combat teenage pregnancy.

Representative Gene Green (D-TX) - may attend. Representative Green is not expected to ask difficult questions.

Representative Chaka Fattah (D-PA) - may attend - Representative Fattah is interested in this issue and interested in learning more about the problem and ways to combat teenage pregnancy.

Representative Henry Waxman (D-CA) - may attend - Representative Waxman, the former Chairman of the Commerce Subcommittee on Health, will be helpful if he attends the hearing.

Independent

Representative Bernard Sanders (I-VT) - will not attend.

WITNESSES

The following is a list of the witnesses that will be testifying at the hearing. I have included background information about the witnesses in your briefing book.

Panel I

Representative Eva Clayton (D-NC) - has been a leader in the House on the issue of teen pregnancy. Recently, Representative Clayton sponsored a "special order" on the House floor to highlight the issue of teen pregnancy. I have attached the text of that special order for your review. Representative Clayton also sent a letter to the President commending him for his leadership on this issue.

Representative Clayton is expected to testify that in order to reform our current welfare system, we must fight teen pregnancy and that this effort must involve the entire community. Representative Clayton also will stress the importance of educating and providing contraceptives to teenagers.

Representative Nancy Johnson (R-CT) - will testify that there are no quick fixes to this problem and that there is a need for a more comprehensive teenage pregnancy prevention program. Representative Johnson may discuss a very successful teenage pregnancy prevention program in New Britain, Connecticut, that is funded by the private sector and also has a job placement service.

Panel II

Dr. Henry Foster

Dr. Kristin Moore, Board Member, National Campaign to Reduce Teenage Pregnancy - We expect that Dr. Moore will testify on the National Campaign's efforts to reduce teenage pregnancy and on her research and evaluation of teenage pregnancy prevention programs.

Pat Funderburk Ware, former Director of the Office of Adolescent Pregnancy Programs, U.S. Department of Health and Human Services - may be the most critical witness. Ms. Ware, a charismatic and convincing speaker and former Bush Administration official, will probably testify as to her personal experience living in Kenilworth Gardens, a public housing development in Washington, D.C. Kenilworth Gardens had teenage pregnancy prevention programs. Ms. Ware may make positive statements about those programs or she may be critical of Title X teenage pregnancy prevention programs. Ms. Ware believes that abstinence is the only way to go to reduce teenage pregnancy.

Katherine Kennedy Townsend, Lt. Governor of Maryland - According to staff, Lt. Governor Katherine Kennedy Townsend will testify on Maryland programs to prevent teenage pregnancies.

Panel III

Elayne Bennett, President, Best Friends Foundation (accompanied by a participant of the Best Friends Foundation) - will probably focus her testimony on their program, an abstinence-based program.

Charles Ballard, Director, Institute for Responsible Fatherhood and Family Revitalization, (accompanied by a participant of the Institute for Responsible Fatherhood and Family) - will probably focus on their program, an intensive counseling-based, community outreach approach to working with fathers. The Institute received a grant from the Administration on Children and Families (ACF) for promising program interventions to encourage and increase responsible fatherhood.

Barbara Huberman, Director of Training, Advocates for Youth - is a member of the *National Campaign to Prevent Teen Pregnancy*. Ms. Huberman has been working on teenage pregnancy issues for many years with much success. Ms. Huberman is from Charlotte, North Carolina where is pioneered a very successful teenage pregnancy prevention program that became a model for the state.

LETTER OF INVITATION

WILLIAM F. CLINGER, JR. PENNSYLVANIA
CHAIRMAN

BENJAMIN A. GELMAN, NEW YORK
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FRANK R. MURPHY, ILLINOIS
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MICHAEL PATRICK FLANAGAN, ILLINOIS
CHARLES F. BASS, NEW HAMPSHIRE
STEVE C. LITWACETTE, OHIO
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ROBERT L. BRIDGES, MARYLAND

ONE HUNDRED FOURTH CONGRESS

Congress of the United States

House of Representatives

COMMITTEE ON GOVERNMENT REFORM AND OVERSIGHT

2157 RAYBURN HOUSE OFFICE BUILDING

WASHINGTON, DC 20515-6143

SUBCOMMITTEE ON HUMAN RESOURCES AND INTERGOVERNMENTAL RELATIONS

Christopher Shays, Connecticut
Chairman

Room B-372 Rayburn Building
Washington, D.C. 20515

Tel: 202 225-2548

Fax: 202 225-2382

February 28, 1996

SENT VIA FACSIMILE AND MAILED

Dr. Henry W. Foster, Jr.
1005 D.B. Todd Boulevard
Nashville, Tennessee 37206

Dear Dr. Foster:

The Subcommittee on Human Resources and Intergovernmental Relations of the House Committee on Government Reform and Oversight has scheduled a hearing for Tuesday, April 30, 1996 starting at 10:00 a.m. in Washington, D.C., entitled "Preventing Teen Pregnancy in America: Coordinating Community Efforts." The focus of the hearing will be community-designed and directed efforts to facilitate collaborative planning, problem-solving and the development of strategies to prevent and reduce the occurrence of teen pregnancy in America. You are invited to testify.

You and other members of the *National Campaign to Reduce Teenage Pregnancy* are invited to testify about the successes of the teen pregnancy program that you have pioneered and administered in Nashville, about your and the members' personal and/or professional experience and insights with respect to teen pregnancy prevention in general, and about how each member of the *National Campaign to Reduce Teenage Pregnancy* plans to contribute to the success of the group effort.

At present, we are exploring the idea of holding the hearing off Capitol Hill, but in the metropolitan area, such as at a nearby school or the community center of a local public housing project. We are certain of the 10:00 a.m. starting time and the date. You will be contacted after we have discerned a hearing location.

Witnesses testifying before the Subcommittee are required to submit 100 copies of their written testimony (20 unstapled, 80 stapled) to the Subcommittee by 2:00 p.m., April 25, 1996. While written testimony may be of any length, opening remarks may be limited to five minutes at

CANDISS COLLINS, LINDA E.
HARRING VERNON, MISSOURI
HENRY A. WADSWORTH, CALIFORNIA
TOM LANTOS, CALIFORNIA
ROBERT E. WIRE, JR., WEST VIRGINIA
MAJOR H. OWENS, NEW YORK
EDOLPHUS THOMAS, NEW YORK
JOHN M. SPRATT, JR., SOUTH CAROLINA
LOUISE MCINTOSH SCAUDATEL, NEW YORK
PAUL E. KANJORSKI, PENNSYLVANIA
DARY A. CONDIT, CALIFORNIA
COLLYN C. PETERSON, MINNESOTA
KAMEN L. THURNMAN, FLORIDA
CAROLYN B. MALONEY, NEW YORK
THOMAS W. BARTLEY, MISSISSIPPI
GENE TAYLOR, MISSISSIPPI
BARBARA-ROSE COLLINS, MICHIGAN
ELCANNON POLAKIS MORTON, IDAHO
JAMES P. MORAN, VIRGINIA
GENE GRIED, TEXAS
CARRIE P. MECK, FLORIDA
CHAKA FATTAN, PENNSYLVANIA
BILL K. BROWNETT, RHODE ISLAND
TIM HOLDEN, PENNSYLVANIA

BERNARD SANDERS, VERMONT
INDEPENDENT

MAJORITY - (202) 225-8074
MINORITY - (202) 225-6051

the hearing so as to facilitate open and full discussion of questions from the Members.

While the Subcommittee requests a timely verbal response to this invitation, your attendance should be confirmed in writing. Questions and responses should be directed to Doris Jacobs, Associate Counsel of the Subcommittee, at (202) 225-2548.

We appreciate your time and cooperation.

Sincerely,

A handwritten signature in black ink, reading "Christopher Shays". The signature is written in a cursive, flowing style with a large initial "C".

Christopher Shays
Chairman

cc: Rep. Edolphus Towns

WITNESS LIST

Witness List
Preventing Teen Pregnancy: Coordinating Community Efforts
April 30, 1996
Room 2154 Rayburn House Office Building

Panel One

The Honorable Eva M. Clayton (D-NC)
The Honorable Nancy L. Johnson (R-CT)

Panel Two

Dr. Henry W. Foster, Jr.
Senior Advisor to the President and White House Liaison
National Campaign to Prevent Teen Pregnancy

Dr. Kristin A. Moore
Board Member, National Campaign to Prevent Teen Pregnancy
Executive Director, Child Trends, Inc.

Pat Funderburk Ware
former Director of the Office of Adolescent Pregnancy Programs
at the U.S. Department of Health and Human Services

The Honorable Kathleen Kennedy Townsend
Maryland Lieutenant Governor

Panel Three

Elayne Bennett
President
Best Friends Foundation
Accompanied by a participant of the Best Friends Foundation

Charles Ballard
Director
Institute for Responsible Fatherhood and Family Revitalization
Accompanied by a participant of the Institute for Responsible Fatherhood and Family
Revitalization

Barbara Huberman
Director of Training
Advocates for Youth

POLITICAL PROFILE

Representative Eva Clayton, the first African-American woman to be elected to the House from North Carolina, is one of the few African-Americans to be elected since 1901. She has been seen as a natural go-between two groups: women and the black caucus.

In the 104th Congress, Minority Leader Gephardt chose Clayton to serve on a new Democratic Policy Committee. She and Representative David Obey are the co-chairs for reasearch on the leadership panel.

From 1977 to 1981, Representative Eva Clayton served as Assistant Secretary for Community Development in the North Carolina State Department of Natural Resources and Community Development, where she focused her attention on rural housing and welfare reform. She served from 1982 to 1990 as a Warren County Commissioner and chaired the Commission for awhile. When the county hospital was in financial trouble, Representative Clayton headed the development of the Warren Health Institute, which now combines services from the county health department and a federally funded clinic.

The representative a member of the Executive Committee of the Congressional Caucus on Women's Issues, as well as President of the Freshmen Democratic Class during the 103rd Congress. She is also a member of the Congressional Black Caucus.

Representative Clayton participated in many meetings with the Co-Chairs of the Welfare Reform Team as part of the Congressional Caucus on Women's Issues, the Congressional Black Caucus and the Freshmen Caucus during the 103rd Congress.

Representative Eva Clayton (D-NC) 1st



Born:	9/16/34, Savannah, GA
Education:	Johnson C. Smith Central U, BS; North Carolina Central U, MS; U of NC at Chapel Hill Law School
Military:	None
Prev. Occup:	Businesswoman, educator
Family:	Married; four children
Religion:	Presbyterian
Pol. Career:	Assistant Secretary for Community Development in the State Department of Natural Resources and Community Development, 1977-1981; Warren County Commissioner, 1982-1990;
Elected:	1992
Residence:	Littleton
Committees:	Agriculture, Small Business

LEGISLATIVE INTERESTS

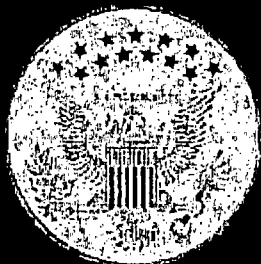
104th:

Representative Clayton has co-sponsored the Family Stability and Work Act of 1995 (Mink, H.R. 1250); the Child Support Responsibility Act of 1995 (Johnson, H.R. 785); the Hearing Loss Testing Act of 1995 (Walsh, H.R. 396); the Medicaid Mammography Coverage Act of 1995 (Vucanovich, H.R. 777); the Health Insurance Affordability Act of 1996 (Peterson, H.R. 3130); the Teen Pregnancy Prevention Responsibility Act (Lowey, H.R. 1115); the Health Centers Consolidation Act of 1996 (Richardson, H.R. 3081); the Health Care Fraud Prosecution Act of 1995 (DeLauro, H.R. 1758); the Access to Emergency Medical Services Act of 1995 (Cardin, H.R. 2011); and the Uniform Child Support Enforcement Act of 1995 (Hyde, H.R. 801).

She has also co-sponsored a bill to promote greater equity in the delivery of health care services to American women through expanded research on women's health issues and through improved access to health care services, including preventive health services (Slaughter, H.R. 3178).

103rd:

Representative Clayton has co-sponsored Congresswoman Woolsey's (D-CA) Secure Assurance for Families Everywhere Act (H.R. 4051), Working Off Welfare Act (Woolsey, H.R. 4318), and Job Start for Americans Act of 1994 (Mink, H.R. 4498).

**Biographical Directory
of the
United States Congress****1774 - Present**

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CLAYTON, Eva M., (1934 -)



*Image, Congressional Pictorial
Directory, 107th Congress.*

CLAYTON, Eva M., a Representative from North Carolina; born in Savannah, Chatham County, Ga., September 16, 1934; B.S., Johnson C. Smith University, Charlotte, N.C., 1955; M.S., North Carolina Central University, Durham, N.C., 1962; director, University of North Carolina Health Manpower Development Programs; assistant secretary for community development, North Carolina Department of Natural Resources and Community Development, 1977-1981; unsuccessful candidate for nomination to the Ninety-first Congress in 1968; chair of the Warren County, N.C., board of

commissioners, 1982-1992; elected as a Democrat to the One Hundred Second Congress, by special election, to fill the vacancy caused by the death of United States Representative Walter B. Jones, and reelected to the four succeeding Congresses (November 3, 1992-January 3, 2003); not a candidate for reelection to the One Hundred Eighth Congress in 2002.

Bibliography

"Eva M. Clayton" in *Black Americans in Congress, 1870-2007*.

Prepared under the direction of the Committee on House Administration by the Office of History & Preservation, U. S. House of Representatives. Washington: Government Printing Office, 2008.

cut by 25 percent. What that means is that you have these environmental laws on the books but you do not have any way of enforcing them. The polluters know if no one is out there watching them and they continue to pollute, discharging materials, violating their water discharge permits, discharging into waters and harbors, they do what they think they can get away with.

I would venture one other thing we found in our report and found in the forum, the cuts in environmental enforcement do not save money. In other words, the Republican leadership argues if we cut back on this environmental enforcement, somehow we are going to save money.

Nothing could be further from the truth. I mean, essentially what happens is that the environmental cop on the beat, if you will, those who go out there to find the polluters, they do not find them, they do not issue them summonses and, as a result, no fine is incurred and the Treasury actually loses money because they are not penalizing the polluters.

In addition, a lot of times, when pollution takes effect, it costs even more money in the long run to clean it up, whether it is the water, whether hazardous waste, whatever it happens to be, so the bottom line is it costs the Federal Government more money in the long run.

Some of the previous speakers on the Republican side also made the argument we do not need the Federal Government involved in all of this enforcement activity because the States can do it. I think the gentleman from Florida mentioned that almost every State or every State now has an environmental protection agency or something like it. But the reality is that the Federal Government sets preliminary standards, whether it is clean water, clean air, hazardous waste cleanup, whatever it happens to be. Without those Federal standards in place, many States simply have not historically established standards similar to the Federal ones. So I just wanted to point out we could talk all night. Of course, my time is up now. I just wanted to point out this fact. This Republican leadership is turning the clock back on the environment. I am glad the President came to New Jersey to point that out today.

PREVENTING TEENAGE PREGNANCY

The SPEAKER pro tempore. Under the Speaker's announced policy of May 12, 1995, the gentlewoman from North Carolina [Mrs. CLAYTON] is recognized for 60 minutes as the designee of the minority leader.

Mrs. CLAYTON. I have several of my colleagues who will participate with me on this special order as we are talking about the special order on preventing teenage pregnancy.

Mr. Speaker, 30 percent of all out-of-wedlock births are to teenagers below

the age of 20. That astonishing reality should be alarming to all Members of Congress and to all citizens of our country. More importantly, the current debate on welfare reform is accelerating the need to address the issue of out-of-wedlock teen births. We want to end welfare as we know it, all of us say, but we do not want to replace it with welfare as we do not want to know it. We do not want to enact legislation that leaves a policy of national abandonment.

As we consider solutions to this issue, we must keep in mind no other industrialized nations with the standard of living comparable to the United States has a problem of this dimension. On the problem of teenage pregnancy, we have the dubious distinction of leading the world.

In January, the national campaign to prevent teen pregnancy began. This campaign is a privately funded non-partisan effort. The goal of the campaign is to reduce teenage pregnancy rate by one-third by the year 2005. The mission of the campaign is to reduce teenage pregnancy by supporting values and stimulating actions that are consistent with a pregnancy-free adolescence. In order to accomplish this mission and reach the goal, the campaign will first work to raise the awareness level concerning this crisis. The campaign will reach out to national media to help raise awareness and to attract the interest of national leaders and organizations. It is critical that our Nation take a clear stand against teenage pregnancy and that the position be widely publicized.

Enlisting the support of the State and local media will be a vital part of this outreach to strengthen the knowledge base and to educate the public on this issue. These actions will force a national discussion about how religious, cultural and public values influence both teenage pregnancy and the way our society responds to the dilemma.

The campaign's second focus is to encourage and to stimulate innovative solutions through local schools, churches, civic groups, as well as local and State officials. The campaign does not advocate any plan other than community involvement. Each community would determine what would be appropriate and acceptable based on a community's standards and values. Let me again emphasize the national campaign encourages community involvement, but it does not recommend any plan of action. Again, each community would determine the action appropriate for their community plan. The parents, families, churches, teachers, Scout leaders, community members who know these teenagers best would determine what kind of program their communities could use to help their young people avoid teenage pregnancy and becoming teenage parents too early.

I think you will agree these decisions should be made by the community and at the community level by individuals

and families who care the most about the greatest need to influence these young people.

I am delighted to have several people to join me today, and Congresswoman MEEK of Florida is going to share some of her remarks with us.

Mrs. MEEK of Florida. Mr. Speaker, I am very pleased to bring the subject of teenage pregnancy to the consciousness of everyone in this Nation, and I think this special order you have tonight will take us a long way to doing that and having people aware of what is going on to some of our best and most valuable resources, and that is our teenagers.

We all know that statistics show us that the baby boomers now have produced a new crop of teenagers, much larger than the baby boomers' population itself, so we are beginning to have more and more of the problems which you have described here.

Tonight I am going to take a few minutes and just talk about what is happening in the State of Florida. Most people know about Florida as a beautiful tourist State. They know about it as the State where the Sun shines all the time. They know about it as being a very warm climate.

The one thing people do not talk about a lot in the State of Florida is that our rate of teenage pregnancy is growing. Our rate of AIDS is growing. As a matter of fact, we are in the top five in this country as far as AIDS and teenage pregnancies. It is something that many of us as policymakers have been afraid or maybe a little reluctant to address as being a problem. But until we change some of the policies, and I think that is where you are on your way to changing some of the policies which underwrite what we do with our wonderful teenage children, certainly we will keep going the helter-skelter way as we are doing now; that is, one State may have a very strong policy, another one may have very little, and another one may have sort of a lukewarm policy.

I guess what we would like to see is that this country would face this as a problem, not to sweep it under the rug. Policymakers would no longer be afraid or a little concerned about the political incorrectness of addressing this problem.

□ 2115

Just to look at the social significance of teenage pregnancies in Florida, and I am talking about births by teenagers who are 18 years or younger in the State of Florida, if you will notice, this particular, I call it an epidemic, is almost a pandemic. But it is an epidemic in that some groups of teenagers, who once did not even have this problem, are now beginning to show an advancement in their teens whether they are white or black or any other ethnic group.

However, because of the policy related circumstances with minorities, teenage pregnancy incidence is much

higher than it is among some other ethnic groups, particularly with nonwhite teenagers. The growth in Florida since 1991, there were 8,274 teenage pregnancies. But now it is reduced a little bit because of some of the many things we are trying to do in Florida to sort of alleviate this problem.

But I do not think we are doing enough teaching and education and teaching youngsters that abstinence is the best policy. I go to the age-old dictum that we were taught, that that was the only way to prevent teenage pregnancy. Now we say safe sex, we say a lot of things. But I think perhaps we may have to go back to some of the age-old policies of combating this, that being not forced, but supported by a State policy.

It costs a lot. Teenage pregnancies cost Florida a lot of money. In doing so, it takes away some other programs that need the same kind of financial assistance.

The regular prenatal care and delivery of teenage babies costs the State of Florida \$15.3 million. Now, think in terms of the health care delivery system in Florida. If this money could be placed toward fighting some of the many other health problems in Florida, then certainly we would have had that money to put in that pot.

Also in Florida, teenagers who have babies usually are at-risk babies. The prenatal care is much higher than a regular adult having a baby. So these teenagers bring with them certain deficiencies. One is that, with many of them, the babies have to be treated through neonatal care. That has a very high price tag on it. No matter what you say, these things cost money, and we must do our best to prevent them.

Just take the at-risk prenatal care that Florida spent in 1994 for teenage pregnancies; \$16.4 million was spent just for the prenatal care. This has nothing to do with those who repeat and have a second pregnancy after the first one.

The emergency room and hospitalization is \$1.7 million, prenatal intensive care, \$10.8 million. My hospital in Miami, the public hospital, has a very high cost of parental intensive care.

Also, there is neonatal intensive care. Per client it costs more than any other care. In addition to that, many of them during the first year of life must be rehospitalized, because you remember the teenager's body is not as strong and not built for pregnancy as the adult's body. So that is a problem.

Then what happens when a lot of teenagers have a lot of youngsters? Then there is the cost of special education. Up until the time they are 14 years of age, that carries with it a great cost. I do not think I am trying to say that this is cost prohibitive. I am saying the money the State of Florida spends with teenage pregnancies, which are usually low birth weight babies which need neonatal care, which need very strong prenatal care, that it costs a lot of money.

Then the developmental kinds of services that are needed for the babies which are already born with a strike against them, and that is like the special education, costs \$939 million. That is a lot more money, because these children who were born into the bodies of young teenage mothers that are not physiologically prepared costs this special social significance.

Then there are the developmental services, \$6.8 million. That is why it is so very important, when you look at AFDC, at least 8 percent of the 8 years of age spends 14 percent in food stamps. If you take 2.5 years, 14.9 percent, and 8 years for 14 percent, the food stamps for 10 years would cost \$129.8 million. These figures are statistically correct, but many times a lot of these figures do not include all the youngsters that go through the teenage pregnancy syndrome.

Medicaid in Florida ran up \$40.8 million because of the teenage pregnancy problem. The crime, not including the cost, that is \$2.6 million.

So I think that education is a key to our problems with teenage pregnancies. I do not think that it can be done altogether in the school. It is a problem in the home, the school, and the community. There is a lot to be done, a lot can be done, because right now many of the teenagers do not understand what makes them pregnant as well as how to take care of a baby born to a teenage mother. There are a large percentage of them born in Florida to teenage mothers. In 1994 it is 13 percent of the babies were born to teenage mothers, and the teenage birth rate was very high as well. Repeat births was like 23 percent in Florida. I can go on and on.

I guess the point I am making here is that teenage pregnancies have a high cost attached to them, not only in the problems to the teenage mother herself, but to the baby.

Regarding the impact of the teenage mother's baby, as it brings forth many things which, I think, if properly educated soon enough and the intervention is made soon enough, something can be done.

Florida has a lot of good programs and is fighting this problem. But we have not come to the point yet that we are able to stop that first child. Usually through education and through programs, we are able to slow down the rate of the second baby. But we still have problems with the first.

I think it is important that you brought this to our attention tonight, and I think we have to really put more focus on it. We need to look at it because it is interlinked very closely with Medicaid, and it is going to cause a problem which many of my colleagues have talked about. I want to thank you for bringing this to our attention.

Mrs. CLAYTON. I want to thank the gentlewoman from Florida for bringing up the Florida experience. Just to emphasize, the gentlewoman shared that indeed there are a myriad of solutions,

but basically she felt education was one of them.

In addition to the educational part of abstinence, other educational programs of conception are also needed in that area. They have been successful in maintaining or reducing the second birth, but not as successful in intervening early on.

So I think there is much we can learn from the Florida experience. I certainly want to express sincere appreciation for the gentlewoman sharing that with us this evening.

The gentlewoman from Texas [Ms. JACKSON-LEE] is with us, and I appreciate her joining us.

Ms. JACKSON-LEE of Texas. Mr. Speaker, I thank the gentlewoman for yielding. Let me thank the gentlewoman for her leadership on this issue and bringing to the focus of America the importance of supporting the National Campaign to Reduce Teenage Pregnancy. I join the gentlewoman in the support.

I support the National Campaign to Reduce Teenage Pregnancy, especially enlisting the aid or help of the media, because teen pregnancy and too early teen births impact the teenager's health, education, and long-term self-sufficiency.

Educational attainment and poverty are related to adolescent child bearing. One million teenagers become pregnant every year, and most of these pregnancies are unintended. A lot of it comes from the lack of information about one's body, a lack of sex education information, and the youngster is simply a child guided by the words of her peers, or maybe the individual that has enticed her into a sexual act that results in the pregnancy.

We have heard much about the social cost of teenage pregnancy in terms of welfare and Medicaid. One-quarter of teen mothers live below the poverty level. But there is also a psychological cost. There is a cost in the future of that young mother and the future of that child.

Advocates for Youth have estimated the annual public cost in 1992 for AFDC, Medicaid and food stamps attributable to families begun when the parents are teens are \$34 billion. I imagine that also includes the cost of the prenatal care that they do not get really and the neonatal costs that they have when the babies are low birth rate babies.

However, if we want to address the issue of teen pregnancy, then we must assist teens with a multidimensional program that provides reproductive health information and access, as well as teaching teens to communicate with their partners and their parents. And, yes, I wholeheartedly support the teaching and communication of abstinence and the ability to build one's self-esteem around the ideas of waiting and looking forward to a future and the availability and ability to raise one's child with the best resources possible.

Prevention of at-risk teen behavior should include attention to educational

and employment opportunities. All of us should be concerned when intergenerational teen motherhood affects the long-term chances of teenagers and their families.

I believe that teenage pregnancy prevention must be targeted at both boys and girls. That is a very important point. I have found times when we have spent time with young men, it is very valuable time, to inform them that it is their responsibility too; that their manhood is not intertwined with the creating of a life, and that that life then becomes dependent on them, and their future opportunities may be shortchanged because of the responsibility to this wonderful new life.

Treating teen pregnancy as if it is an issue that affects only young girls is shortsighted and is unlikely to be effective. Adult men are frequently the fathers of children born to teenage mothers. I hope that the link between sexual abuse and teen child bearing are also examined by the National Campaign to Reduce Teen Pregnancy. That is certainly an issue that I am hoping to address in my district.

I urge the media, parents, educators, and all those who care about children to talk with our young people about abstinence and postponement of sexual activity. Teen mothers have approximately a 60-percent chance of graduating from high school by the age of 25. Remember now, a 60-percent chance of graduating, way beyond the normal graduation time, but maybe by the age of 25, and only 60 percent, compared to 70 percent of those who postpone child bearing.

African-American and Hispanic teens who delay child bearing to age 20 are 3 to 5 times more likely to attend college as their counterparts who do not delay childbirth. Again that goes back to the quality of life of that new life that this young parent would bring into the world, the ability of taking care of that child, and warding that child away from the ills of life, the social ills, the lack of getting an education, drugs, the lack of self-esteem because they have not had the nurturing and care that would come about from a more mature parent.

For an African-American family in which the mother began child bearing before the age of 16, the average income is only 96 percent of the poverty level, not even the poverty level, but only 96 percent. The average income rises to 236 percent of the poverty level if she is between 26 to 27 years of age when her first child is born, and 275 percent if she postpones child bearing past the age of 27.

I am concerned about teen pregnancy because too-early births impact the teens and families in my State. In Texas there were 52,859 births to those age 12, underlined, age 12 to 19, in 1994 alone. The combined cost of maternity care and newborn care for these teen births in Texas was \$339,407,639.

I have visited the Lyndon Baines Johnson Public Hospital in my commu-

nity and have seen the neonatal unit with these very low birth weight babies. Loving as they are, and your great desire to love them and care for them and cry for them, we also recognize that we are in some way diminishing their quality of life by their low birth rate. Because of the lack of prenatal care, many of them are born to our teen mothers.

This is something that, if for nothing else, for that child that we want to bring into this world, giving her or she the most that we can give them, that we should emphasize this effort with respect to teen pregnancy. The combined costs of maternity care and newborn care for these teen births in Texas, as I said, some \$330 million-plus.

In my district in Harris County, TX, in 1994, there were 3,598 births to teen aged 11 to 17. The estimated cost of maternity and newborn care for these teen births in Harris County alone was \$23,102,758. Just a couple of weeks ago we saw the emphasis on teen pregnancy in Texas take national status when it was thought that a 10 year old was on the run who was about to give birth to a child out of wedlock. We now find out it was a youngster of 14. But just the horror of it and the thoughts of youngsters having children, and that does occur in my community.

□ 2130

Let me applaud, however, the school districts, particularly HISD, who have several schools that deal with pregnant teens and teens that have had children, and in particular, they provide child care for those teens. But they also expressed to me the difficulty of keeping those teens in school and again ensuring that those children are getting the best protection and help that they possibly can, both the child that has had the newborn and the newborn, of course.

It is encouraging that the pregnancy rate among sexually experienced teens has declined 19 percent in the last two decades, but there remains much that we as parents and friends of teens must do if we truly care about our young people.

I would also like to applaud the teen clinic in the hospital district supported by Baylor College of Medicine. That has been an outstanding light, Congresswoman CLAYTON, in prevention measures, in encouraging young teens to look differently or in another direction, and certainly after the first child, to discourage them from a future birth until they get their education and secure a marriage partner and have the opportunity to provide for that young child or that newborn.

There is no one program, however, that will work for all teenagers. When we look at the teen programs which have been effective, the teen pregnancy prevention programs have approached this social and personal issue holistically and comprehensively. That is the key. Adolescent pregnancy prevention must include reproductive health,

education and access to contraception, along with the emphasis of education and prevention and certainly abstinence.

The media must take responsibility for the explicit images of sexual activity that our children see on a daily basis. Might I add, even the media that shows television programs during the hours that you think young children are safe, during the 6 to 8 hours, maybe 6 to 9, the media has to take responsibility without enforcement and without regulation to do that. I am very glad that we have at least passed legislation that will give parents the V-chip to ward off violence, but it will also allow them to ward off unnecessary sexual activities.

The Internet, we must be concerned about that, as we saw sexual connotations and messages coming across the Internet. We must be diligent as parents and guardians of our children to ensure that they are viewing the right messages, and the media must help us do that.

A discussion of the postponement of sexual activity should be coupled with developing teens' communication skills and partners and parents. Finally, teen pregnancy must focus beyond the sexual activity of adolescence. When we talk about at-risk teens, we need to confront the environment which our young people are growing up with. When we see how early teen pregnancy can impact our children's educational attainment and long-term self-sufficiency, we need to confront this national issue of adolescent pregnancy and help our children flourish and develop their full potential.

It is key that we support this national campaign. It has to be combined with schools and churches, religious institutions, parents and nonparents, volunteers and community-based groups and youth support groups, so that we can in fact make sure that this is an effective effort, Congresswoman CLAYTON, and it is one that I accept the challenge of your leadership, but as well as this national campaign, one that I know that we will be working with our community leadership in the 18th district in Texas and Harris County to make sure we continuously work to put our young people first, but to ensure that they provide a good quality of life for the newborn child.

Mrs. CLAYTON. Well, I want to thank the gentlewoman from Texas for that very substantial statement, and also for her sharing what she understands to be a very interrelated problem that is not purely one approach. It is a holistic approach. We have to be engaged from various sectors, and to recognize the value of having good programs in the high school and good programs to encourage people, the young people, not only in terms of sex education but their self-esteem.

You know as I know, young people who feel that they have a future are going to not risk being an early parent. So we have to give hope, we have to

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give that, and I am delighted that you are going to do your part in raising the awareness and giving that positive message to young people in your district. I applaud you for what you have done already, hope that you will continue that effort. Thank you for participating.

Ms. JACKSON-LEE of Texas. Well, I thank you very much, and I think that as I close on one point, you raised a very valuable point. I will close on this. When that teen has that first child, we should not abandon them, because we can still work with them to stem the tide or stop any additional births.

Mrs. CLAYTON. Absolutely.

Ms. JACKSON-LEE of Texas. We should continue to keep them in the system, as well.

Mrs. CLAYTON. We should stop a national policy of abandoning children simply because of the mistakes of their parents, but we should not give up on that parent themselves.

Ms. JACKSON-LEE of Texas. That is right.

Mrs. CLAYTON. Because they made the first error. We can still have them turn their lives around.

Ms. JACKSON-LEE of Texas. I think we must do that. Thank you.

Mrs. CLAYTON. This is not just a debate with women and by women. It is a debate that all people are joining, and I am pleased to have the gentleman join this debate. We have the distinguished gentleman from Virginia (Mr. SCOTT).

Mr. SCOTT. Mr. Speaker, I would like to first thank Mrs. CLAYTON for organizing this special order in support of the goals of the national campaign to reduce teen pregnancy. Representative CLAYTON's efforts to highlight this issue of teen pregnancy prevention are certainly timely as Congress continues to debate welfare reform and children and youth issues.

Mr. Speaker, last month I sponsored a public policy forum on health care issues confronting adolescents in the 1990's. That forum was sponsored with the Advocates of Youth, a national organization committed to public outreach and education on adolescent health issues.

The four panelists that were involved in that forum covered issues ranging from the increase in HIV/AIDS in the youth population to the current battles surrounding family life education in school districts. Everyone who attended that policy forum agreed that today's youth face greater challenges than ever before.

The challenges presented by teen pregnancy can seem insurmountable in light of the correlation between adolescent childbearing and education and economic attainment. According to research compiled by the Advocates for Youth, the chance of graduation from high school increases by 30 percent for teenagers who postpone childbearing, and among dropouts, teen mothers are less likely to return to school than

The organization goes on to report that early childbearing has an impact on the economic status of teens by not only affecting job opportunities and marital options and family structure, but particularly because of the effect it has on education. In fact, across all ethnic groups, delaying childbirth by just 1 year leads to significant improvement in subsequent economic vitality.

Not only does teen pregnancy affect the teen, but it also affects the entire community. Teen pregnancy prevention has been a priority in my State of Virginia because we have long recognized the devastating effects that early childbearing has on teens and their children and also on the community.

Representative JACKSON-LEE and Representative MEEK both indicated that teenage pregnancy caused expenses in their States. The statement is true in Virginia. One study found that one-half of all of our AFDC case loads, one-half of the people receiving AFDC, began their families with a teen pregnancy. You not only have AFDC, you also have the related expenses like Medicaid and other social services, so we see that it is a very expensive proposition for the community.

As a result, in response to this we have developed several programs to educate adolescents on the issue of teen pregnancy prevention. These programs function at the local level and place their emphasis on mentoring, parental involvement, postponing sexual activity, and the promotion of abstinence.

In addition, Virginia has a mandatory family life education curriculum in its elementary and secondary schools. We have found that these programs have been very instrumental in reducing teen pregnancy, particularly the programs that focus on education, increasing opportunity for our young people, giving them something constructive to do with their time, and giving them adult guidance. As Representative JACKSON-LEE indicated, those who feel that they have a future are not the ones getting pregnant.

We have found that these programs have been instrumental in reducing teen pregnancy and, thus, we have provided Virginia's youth with an opportunity to grow into adulthood without the burdens of early childbearing. These programs share the goals of the National Campaign on Teen Pregnancy, and I enthusiastically support both efforts.

Mr. Speaker, I would be remiss if I did not mention that there are programs in place right now that have been integral in reducing teen pregnancy by offering teens the opportunity for success. These programs involve job training, summer jobs and other activities, other activities to help them stay in school.

Unfortunately, Mr. Speaker, the Summer Jobs Youth Program, job training, Head Start and other dropout prevention initiatives are now at risk

because of the misguided priorities in some of our budget initiatives. The recently passed omnibus appropriations bill targeted the Summer Jobs Youth Program for elimination, and drastically reduced Head Start youth training and school-to-work activities. If our goal is to eliminate the obstacles that young people face and instead provide them with opportunity, these programs must be fully funded.

Again, I would like to thank Representative CLAYTON for inviting me to participate in this special order, and I look forward to working with the national campaign on the important issue of teenage pregnancy prevention.

Mrs. CLAYTON. I want to thank the gentleman from Virginia, to say apparently Virginia may be leading the way, and hopefully we can share some of your positive and effective programs that you have. We, too, in North Carolina are beginning that. There are many programs like the Coalition to Prevent Teenage Pregnancy, which indeed has helped that.

I also want to just reemphasize something the gentleman said, and I understood you to say that there are special developmental programs that we need to have in place, too, if we expect young people to be able to have positive opportunity, and those are after-school programs. There is a summer training program, and these programs need to be in place because there indeed is evidence and research that when young people have idle time, and we feel for them because there is a lot of idle time is going to come in the summer, even when young people have idle time between 3 and 6, between the time they get out of school and when they go home, we know also that young people need supervision.

So we need to interject programs where young people can get engaged in that, and I think it is very helpful.

Mr. SCOTT. You mentioned the time between 3 and 6, between the time they leave school. It is also the time, 6 is the time the parents finally come home from work.

Mrs. CLAYTON. Right.

Mr. SCOTT. It is a time they are unsupervised.

Mrs. CLAYTON. Right.

Mr. SCOTT. Studies have shown that during that time, a significant number of pregnancies occur. We also found that those who think they have a future are less likely to get pregnant. Therefore, college scholarships and other activities designed to make sure those opportunities are available must be fully funded, and cutting back in that area will increase teen pregnancies.

Mrs. CLAYTON. My point is to suggest that young people, we want to instill responsibility in them and positive behavior, but also there is a reciprocal responsibility for society to make sure there are opportunities for work and career and positive development there, and we in Congress can play a part. Others also must play a part.

Again, I want to thank you for participating with that. I also know that this is not just one-sided, it is not a partisan view. Republicans and Democrats have an interest in this, to prevent teenage pregnancy, and I am delighted that my colleague CHRIS SHAYS, the gentleman from Connecticut, is joining me, and welcome your participation.

Mr. SHAYS. I am grateful to have this opportunity. Congresswoman CLAYTON, to participate in this very important dialog, and to salute you for your taking the leadership and making sure that we as a Congress begin to confront what is an extraordinarily serious problem for our country.

I am here to salute you, to participate in this issue, and also to compliment and to praise the President for establishing the National Campaign to Reduce Teen Pregnancy. I know that you circulated a letter, which I would like to read later in this special order. But first to tell you that as someone who is chairing the Committee on Human Resources and Intergovernmental Relations, we are going to be having a hearing on this issue and will obviously be inviting you to help lead that off.

It is incredible, the more I get into it, and candidly, I have not spent the kind of time that I should have, but to think that up to 1 million teenagers become pregnant in the United States, and that 85 percent of those pregnancies are unplanned and that the vast majority of mothers are simply unmarried, to think that teenage mothers are more likely to be impoverished, go on welfare and never finish school, to think what kind of future they have for themselves and the promise that they have for their children who they grow to love dearly.

I think probably more than anything else in my own childhood, what I value the most was that my parents taught me to dream, but my dreams were realistic. I mean, I really felt I could meet those dreams. It is hard for me to understand how a pregnant teenager, a young 15-year-old or 14-year-old who is giving birth is able to think of dreams that get that individual, get her out of the welfare cycle and get her the opportunity to think of being able to live what the American dream is, to think of what it must be like for her children.

□ 2145

I am stunned by the statistics that say that adult males are the fathers of approximately 68 percent of babies born to teenage girls. I am talking about adults impregnating young kids, the thought that, according to the U.S. New and World Report, that 65 percent of teenage mothers are unmarried, up from 48 percent in 1980 and that, most importantly, that 39 percent of 15-year-old mothers say the father of their babies are 20 years or older. Fifteen-year-old kids.

I have a 16-year-old daughter, and it is hard for me to comprehend a 15-year-

old daughter, and it is hard for me to comprehend a 15-year-old young girl describing the fact that nearly 40 percent of these young girls are saying that they were impregnated by 20-year-olds or older, and for 17-year-old mothers, 55 percent of the fathers are adults, and for 19-year-olds, 78 percent are the fathers, are adults who have been involved in this relationship.

You sent a letter that you circulated, and hundreds of Members of Congress signed this letter, and I would love to read this letter for the RECORD. You drafted this letter to President Clinton. You said:

"Dear President Clinton, we write to applaud your efforts and those who have agreed to serve in the bipartisan National Campaign to Reduce Teenage Pregnancy. The mission of the National Campaign," quote, 'to reduce teenage pregnancy by supporting values and stimulating actions that are consistent with a pregnancy-free adolescence is,' end of quote, "one that each of us supports, and the goal to," quote, 'reduce the teenage pregnancy rate by one-third by the year 2005' is one that each of us endorses."

We are trying to reduce the pregnancy rate in the next 10 years by one-third. It seems to me obviously like a goal that all Americans could unite behind.

You go on in your letter to say: "The increase in out-of-wedlock childbearing is alarming. Even more alarming is the vicious cycle into which pregnant teenagers are thrust. The young women, as well as the young men, who become teen parents have few expectations, few ties to community institutions, few adult mentors and role models, and little hope. Many live in communities where crime and drug use are common and where dropping out of school and chronic unemployment are even more common. This is a very costly human burden for our society."

You then go on to say: "In addition, teenage pregnancies cause a heavy burden on the federal budget, especially Medicaid funds, one of the elements of the budget that is spiraling. Food stamps and AFDC funds are also taxed by these young people is the dawn of their lives. Indeed, teen pregnancy is a strong predictor of a new generation of disadvantaged. As poverty is the most accurate predictor of teen pregnancy, teen pregnancy is a near certain predictor of poverty."

Your letter then goes on in three more paragraphs:

"We believe the approach to this problem that will be undertaken by the National Campaign is correct. It is critical that this Nation first take a clear stand against teen pregnancy and, in doing so, attract the interest of more national leaders and organizations. Enlisting the support of the national media in supporting and stimulating State and local action are necessary steps in the effort to reduce teen pregnancy. These and other activities will help to foster a national discussion

about how religion, culture, and public values influence both teen pregnancy and the responses to this dilemma. But most importantly we believe the intent of the National Campaign to strengthen the knowledge base, to educate, will be invaluable."

And your last paragraph: "The National Campaign to Reduce Teenage Pregnancy should not be bound by politics, party or philosophy. The situation is urgent. By our endorsement of this letter, please note that we stand behind you in the National Campaign. The goal is ambitious, but it is within our reach."

And I would just salute the President for his establishment of this committee, the appointment of Dr. Henry W. Foster, Jr., as the senior adviser. He will be coming before our committee to begin that hearing, and we are grateful for his participation and for the non-partisan approach which the President took in naming former Senator Warren Rudman, a Republican from New Hampshire, the former New Jersey Governor, Thomas Kean, a Republican from New Jersey, obviously, and the former Surgeon General, Everett Koop, actress Whoopi Goldberg, MTV President Judy McGrath, chairman of the executive committee of the Washington Post, Katherine Graham. I mean this is a distinguished committee and one which I salute the President for forming.

And again, I thank you for giving me the opportunity to, one, take a stand on this issue, to announce that our committee, because of your work and the work of others, will be holding hearings to alert the Nation of this nearly desperate problem and to hope that we, as American citizens, can do a better job of helping to have our young kids, our young kids, have dreams and hopes and to let them know that they can always be parents, they can always have a child. They just do not need to have a child when they are in school. They can grow to lead blessed lives, and they can grow to mature as individuals before they then try to help a young person grow as well.

Kids raising kids is kind of insane, and it is, I think, that history will look back on our generation, look back on Congress, look back on the White House, not just this White House and this Congress, but for the last few years and the last few presidencies, and say we were really asleep when we should have been awake. I thank you for this opportunity.

Mrs. CLAYTON. I want to thank the gentleman for his very important remarks, but also for his important announcement that his committee is going to have hearings on this subject which I think is going to be substantial, adding to the debate in that you will bring out a myriad of problems. One of the problems you identified indeed is adult males having some liability and responsibility for this whole problem, and we have not been focusing on that. So I am looking forward for the deliberation and thoughtfulness.

Mr. SHAYS. I look forward to working with you and other Members of Congress.

Mrs. CLAYTON. And we are joined by the gentlewoman from California. I am delighted to have Ms. MAXINE WATERS.

Ms. WATERS. Thank you very much, Congresswoman EVA CLAYTON, for your leadership on this issue. I join with you and others in congratulating the President for placing this very, very important issue high on his agenda. I think whether you are a Democrat or a Republican, you cannot help but be concerned about the rate of teenage pregnancy. I understand over 1 million teenagers are getting pregnant each year here in this country and that this rate of teenage pregnancy far outdistances what is happening in other advanced nations in this world.

Mr. Speaker, I have tried to pay some attention to this issue, and when I came to Congress a few years ago, I called Health and Human Services and asked them what could they do, using some discretionary money, to come into an area in my district where this is a problem and help us to create a program to deal with teenage pregnancy, at least find out what is going on. And so Health and Human Services, along with Family Planning, did come into one of the housing projects in my district known as Avalon Gardens Housing Project, and we were very fortunate that we were able to hire a young woman who is greatly interested in working with teen mothers, a young woman who has a background in working with troubled youngsters, and she has been doing an interesting job.

We worked with males and females between the ages of 12 and 25 years old, and in the first year, after the first year, we are very pleased to report that no pregnancies or repeat pregnancies have occurred. Some of the young ladies that we worked with had already borne a child, others had not, and we hoped to prevent them from doing so. And in the first year we have had no pregnancies or repeat pregnancies. But it is very, very work-intensive. We find that the young people in the program, both male and female, are looking for attention. Many have very low self-esteem. Many or all of them are poor. They have very few activities. They travel not far from their home in the housing project. They do not interact in programs and projects outside of the immediate community. They have very little information available to them. When we started to work with them, we found that very few knew much of anything about contraception.

And so the 15 to 20 people per day that she is working with are now involved in various kinds of activities. Some are athletic activities. We have formed a men's club, and we have been able to create opportunities to take them out of the community on some trips. I am pleased to say that some of them were with us last week when we took a group of boys and girls, young men and women, from Los Angeles, so-

called south central Los Angeles, to Selma, AL, the commemorate the march from Selma to Montgomery. We did that because we found that most of them did not know very much about their history, surprisingly, not a lot about Martin Luther King, nothing about the marchers, the work that had been done. And in building this self-esteem, we think that that is very important, that they understand who they are, the kinds of sacrifices that have been made for them so that they could be successful in a democratic society, and we think unless there is self-esteem, people do not take responsibility, they do not feel comfortable, they do not have the confidence, and therefore many of their actions are irresponsible until you are able to build self-esteem.

So we are working very hard. This is but a drop in the bucket to what is needed in this Nation to deal with this problem.

Mrs. CLAYTON. It is a good example that you are sharing with us that others can do as well.

Ms. WATERS. It is, and we are very pleased because we really are hopeful. We are very, very optimistic about the possibilities for stemming the tide of teenage pregnancies. We believe that you can create real prevention. It does cost money, and some of the work that is being done that has helped in this area under the title XX is now threatened, and we believe that it is important for us to say to everybody that, if you really care about this issue, if you want to do something to stop babies from having babies, if you really want to get a hold of poverty in America, then we will invest some dollars to create opportunities for these young people and recognize that many of them are from so-called dysfunctional families, families where they, they come from one-parent families, where fathers are missing, and the cycle, this vicious cycle, continues because we have done nothing really to break the cycle.

We know everything we need to know about poverty, and one thing we know for sure is that when poor children bear children, that those children are going to be poor, and most likely those children are going to be the school dropouts. These are going to be the children with health problems. These will be the children who will be caught up in poverty and will not be successful. They will drop out of school because they are being born into the same conditions that their parents were born into when we do not break this cycle.

And so, EVA, I thank you for creating this opportunity for more discussion on this issue. I think we must urge our colleagues to get involved in this in a real way. This cannot be just a political issue used during the campaign. We have got to commit ourselves to embracing our young people, to providing for them opportunities that have not been available, to provide resources to get them out of these situations. And if

we do this, I think we can do something about this problem.

Mrs. CLAYTON. I want to thank the gentlewoman from California in not only participating, but also sharing examples of her initiatives and what they do in Los Angeles to bring so much hope.

But she demonstrates one point. As we try to counsel young people, we should not think that this is easy, or not intensive, and is costly because we are dealing with troubled young people. We are not dealing with adults. So you cannot use the same formula that you have in counseling adults in family planning. You have to raise the esteem, you have to do development, you have to have a myriad of opportunity.

And I think she raised another point, is that as we are beginning to use the whole teenage pregnancy issue in pursuing the debate of welfare reform, we should not just do it as a political scapegoating of finding opportunity to hit at vulnerable children, we should not have a national policy of abandoning our children.

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Certainly as we move toward welfare reform, both sides say we want to reform welfare as we know it, but we should not move to welfare reform as we do not want it. We do not want a welfare system that, whether by accident or on purpose, we have a national abandonment of children by saying we will not support children if they are born while the parent is on welfare.

This is not to suggest we are condoning it. We do not want it any more than anyone else. But we understand that you cannot punish young people by punishing their parents to make them do the behavior you want them to do. You have to give them a reason, counsel them, and discipline them, and that discipline has to be with having them be responsible.

I again thank all those who have participated. I look forward to continuing this debate, that our colleagues would understand that everybody here has something at stake. If we do not think we do, I think we are missing the opportunity to be responsible as Members of Congress, and we are missing the responsibility of being adults if we do not raise this issue to see our role or our way of participating in bringing the awareness out.

This is not an issue that Congress can do alone. This is an issue, obviously, where we can make a difference. But this is an issue where we have to encourage, as many of you have indicated in your community, where we get many sectors of our community, whether it is the church, the home, Boy Scouts, PTA, a variety.

Also, we have to understand that abstinence is one of those things we teach, but we also have to understand we have to teach contraceptives and family planning. The reality of where our young people are is that. When I was growing up, it was implicit that it

was abstinence. Now we have to make it explicit, to make sure that is one of the things young people know that they have that option.

But we reinforce that when we have opportunity that expands their future, expands their horizon of dreaming. You can dream dreams when people make that opportunity, the connection between work, the connection between education as a future for them.

As Members of Congress, we ought to consider in the whole budget debate, what things are we doing that are disincentives for young people to stay in school. I would submit that our education budget is not one that encourages, that we are investing in education. Certainly taking away the summer program is the wrong way to go if we are talking about making sure that young people are fully engaged during the time of the summer, but there are other programs that we can also do.

Mr. Speaker, I thank all my colleagues who have participated in this special order.

As we consider how and where to reduce spending, we must also not forget that teenage pregnancies cause a heavy burden on the Federal budget.

Medicaid funds, food stamps, and AFDC funds are especially hard hit by the teenage pregnancy problem.

If we want to balance the budget, let us begin by working to bring some balance to the lives of thousands and thousands of our teenagers, involved in premature childbearing.

A recent report to Congress on out-of-wedlock childbearing indicates that 35 percent of all out-of-wedlock births are to women over age 25; 35 percent are to women 20 to 24 years of age, and 30 percent are to teenagers.

One objective of welfare reform, shared by both political parties, is to reduce teenage childbearing. Pending legislation on welfare reform, however, embraces an unreasoned approach to reduce the number of out-of-wedlock births, by denying cash benefits to unwed teenage mothers.

This unreasoned approach is based on the perception that the system has failed and contends that any proposed change, no matter how austere, must be a good change.

Thus, those who propose eliminating welfare benefits to young unwed mothers argue that their approach can't make matters any worse than they already are.

Such proposals appear premised on the belief that if Government ignores teen parents, they will go away or get married. There is little or no research to support such contentions.

Reason, on the other hand, suggests that even if the belief held true for some, there would be many young children and mothers left destitute.

To have true welfare reform we must eliminate the need to pay these monetary benefits rather than just eliminating the funding.

As I stated earlier, we want to "end welfare as we know it." But we do not want to replace it with welfare as we do not want to know it. We do not want to enact legislation that leads to a policy of national child abandonment.

An effort to reduce teenage childbearing is why to require more than eliminating or manipulating welfare programs.

In fact 76 of the top researchers in this field signed a statement saying, "welfare programs

are not among the primary reasons for the rising number of out-of-wedlock births."

My opinion on the issue revolves around three unanswered questions. First, if welfare is fueling the growth in out-of-wedlock births, why do many of the States with the lowest AFDC payment levels have some of the highest out-of-wedlock birth rates? Second, why have out-of-wedlock births increased as the relative value of welfare benefits have gone down over the last 20 years? And third, why do other nations with more generous welfare benefits have lower teenage birth rates?

Teenage pregnancy is just one marker of disadvantaged—one result of growing up poor and poorly nurtured.

But, teen pregnancy is also a strong predictor of a new generation of disadvantaged.

The equation is as simple as this: As poverty is the most accurate predictor of teen pregnancy, teen pregnancy is a near-certain predictor of poverty.

While one in four American children now live in poverty, a 1991 report from the Casey Foundation compares the children of two groups of Americans: those who finished high school, got married, and reached age 20 before having a child and those who did not.

Of children in the first group, the poverty rate was 8 percent; in the second group the poverty rate was 79 percent.

Among teens, more births occur out-of-wedlock today than occurred 35 years ago.

This increase in out-of-wedlock births can be attributed to the certain changes in marriage patterns, sexual behavior, contraceptive practices, abortion, and the composition of the teenage population.

Young men and women are increasingly delaying marriage but not sexual activity. Teens make three sets of choices about sexual behavior and its consequences.

The first is whether and when to start having sex.

The second is whether to use contraceptives.

According to studies, in making the third choice—whether to become pregnant—the distinctions by income are dramatic.

In 1994, of all women age 15 to 19, 38 percent are defined as "poor" or "low-income"; of these same women, 73 percent were projected to become pregnant. Of the 1 million teens who become pregnant each year, about half give birth, about 40 percent choose abortion, and the remaining 10 percent miscarry.

Once a teenager becomes pregnant there is no good solution. There is pain in adoption, there is pain in abortion, there is pain and suffering in giving birth and parenting a child. The best solution is to prevent the pregnancy.

Young people who believe that they have real futures to risk have real incentives to delay parenting. That is why when we demand responsible behavior, we have a reciprocal obligation to offer a real future beyond early parenting and poverty.

Reducing teenage childbearing is likely to require more than eliminating or manipulating welfare programs. Experience tells us that threats and punishment are not the best way to get teens to behave in a way that is good for them.

The most successful approach to reducing teenage childbearing is to design policies and procedures that are targeted to encourage positive developmental behavior through beneficial adult role models and job connections.

We must implement pregnancy prevention programs that educate and support school-age youths—10 to 21—in high-risk situations and their family members through comprehensive social and health services, with an emphasis on pregnancy prevention.

On average, it takes teens 1 year after becoming sexually active to receive family planning services.

The pregnancy rate among sexually experienced teens actually fell 19 percent from 1972–90, suggesting that teenagers who have access to birth control and are motivated have been successful at preventing pregnancies.

A recent study conducted by the Johns Hopkins School of Hygiene and Public Health analyzed the value reproductive clinics and other health care providers had when given an opportunity to intervene and provide contraceptive counseling to a group of sexually active teenage girls before they became pregnant.

The study shows that spending money on counseling these teenagers could help reduce future pregnancies.

Teenage girls seeking pregnancy tests are already sexually active, so even the most determined fundamentalist cannot claim that the clinics are telling these teens to have sex.

Unfortunately, clinics struggling for funds have a disincentive to serve teenagers who, by and large, cannot pay.

In addition, counseling teenagers is quite expensive because they need more attention than older women.

In the study, most girls who came for a test had reason to believe they might be pregnant: a late or a missed period.

But, a significant number—almost 14 percent—believed there was little chance they were pregnant.

One has to wonder why they came to the clinic. Perhaps it was a way to get someone that they could trust to talk to them.

Devoting more resources to preventing teen pregnancy will not only save us money in the long run, but it will improve the health, education, economic opportunities, and well-being of these young women and their families.

Supporting the National Campaign to Prevent Teen Pregnancy is an ideal way to acknowledge the problem of out-of-wedlock teen births. I urge all of my colleagues, Democrats, Republicans, and Independents to join in the campaign's effort.

THE 100TH ANNIVERSARY OF SPARROW HOSPITAL, LANSING, MI

The SPEAKER pro tempore (Mr. METCALF). Under a previous order of the House, the gentleman from Michigan [Mr. CHRYSLER] is recognized for 5 minutes.

Mr. CHRYSLER. Mr. Speaker, I rise today to recognize the proud history and accomplishments of Sparrow Hospital of Lansing, MI, which celebrates its 100th anniversary on March 18, 1996.

In the spring of 1896, a group of young women met at Lansing's Downey Hotel to discuss the growing need for a community hospital in the developing capital city. Armed with sheer determination, the 114 charter members of the Women's Hospital Association set about to raise funds to buy the local DeViney House, located on West Ottawa Street. Having just \$400, they were forced to rent instead.

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NEW HHS PREGNANCY PREVENTION PROGRAM

QUESTION:

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

ANSWER:

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

BACKGROUND:

- ▶ 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.
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POLITICAL PROFILE

In the House of Representatives, Representative Nancy Johnson has been an active and effective legislator. Her voting record is mostly market-oriented on fiscal matters and is fairly liberal on foreign policy and social issues.

Currently, Representative Johnson serves on the Ethics committee and as the Chairman of the Ways and Means Oversight Subcommittee. A moderate on social issues, she has publicly challenged the GOP's position on abortion at two successive national conventions. Representative Johnson became the first Republican woman ever to serve on the Ways and Means Committee in the 102nd Congress, and she uses her current seat to influence two issues: health care and trade. Her priority issues have been Medicare, health, child care, and trade.

She is pro-choice and has spent a great deal of time working on child care. In 1988, she unsuccessfully joined with Representative Lowell Weicker to moderate the GOP's opposition to abortion rights and restore support for the Equal Rights Amendment in the party's platform. Her legislative interest in child care has led her to eliminate the former day care tax credit which mostly benefitted high-income parents, replacing it with a voucher system that benefits low-income working mothers. She strongly believes that those closest to children can best make decisions regarding child care and is weary of federal bureaucrats and their burdensome directives.

Representative Johnson's health reform views are shaped in part by her strong insurance industry constituency. Moreover, her husband is a physician and this has had a profound impact on her beliefs. She repeatedly opposes Medicare cuts because of their detrimental effects on providers, but also complains about the growth rate in the Medicare program.

One aspect of Medicare is of particular interest to Congresswoman Johnson, Medicare Select. The Medicare Select program, a demonstration project of which Florida is a

Representative Nancy Johnson (R-CT) 6th



Born:	1/5/35, Chicago, IL
Education:	Radcliffe College, B.A.; attended U. of London,
Military:	None
Prev. Occup.:	Civic leader
Family:	Husband, Theodore Johnson; 3 children
Religion:	Unitarian
Pol. Career:	CT Senate, 1977-83; Republican candidate for New Britain Common Council, 1975
Elected:	1982
Residence:	New Britain
Committees:	Ways and Means; Standards of Official Conduct

part, allows seniors to purchase supplemental insurance through managed care organizations, is set to expire in June. Congresswoman Johnson has been a strong supporter of the program and will seek to extend it or permanently authorize it. The Department has had some reservations about this program, in particular, the lack of consumer protection that apply to these policies which is potentially a problem.

Representative Johnson expressed her belief that a job search must begin when an individual begins receiving benefits. She is pleased that there are many similarities between the Administration's welfare reform legislation and expressed her hope the White House will work with Republicans on welfare reform. She has interest in child support enforcement issues.

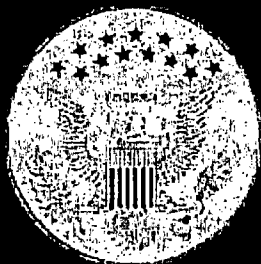
LEGISLATIVE INTERESTS

104th Congress:

Congresswoman Johnson has sponsored the following legislation: the Federally Supported Health Centers Assistance Act of 1995 (H.R. 1747); the Child Support Responsibility Act of 1995 (H.R. 785); the Welfare to Work Act of 1995 (H.R. 819); and, the Working Families Health Access Act of 1995 (H.R. 1604). She has also sponsored a bill to permit Medicare select policies to be offered in all states on an extended basis (H.R. 1391).

In addition, Congresswoman Johnson has co-sponsored the following legislation: the Medicare Preservation Act of 1995 (Archer, H.R. 2425); Medicaid Certification Act of 1995 (Barton, H.R. 1791); Health Information Modernization and Security Act (Hobson, H.R. 1766); Basic Health Care Reform Act of 1995 (Thomas, H.R. 1234); Safety and Health Improvement and Regulatory Reform Act of 1995 (Ballenger, H.R. 1834); Health Care Savings Plan Act of 1995 (Porter, H.R. 354); Antitrust Health Care Advancement Act of 1996 (Hyde, H.R. 2925); Family Medical Savings and Investment Act of 1995 (Archer, H.R. 1818); Women's Health Office Act of 1995 (Morella, H.R. 1736); Morris K. Udall Parkinson's Research, Assistance, and Education Act of 1995 (Waxman, H.R. 1462); Prostate Cancer Diagnosis and Treatment Act of 1995 (Fields, H.R. 1496); Physician Assistant Incentive Act of 1995 (Towns, H.R. 1751); Colon Cancer Screening and Prevention Act (Cardin, H.R. 922); Colorectal Cancer Screening Act of 1995 (Hastings, H.R. 1046); and, Advanced Medical Devices Access Assurance Act of 1995 (Thomas, H.R. 1744).

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JOHNSON, Nancy Lee, (1935 -)



Image, Congressional Pictorial Directory, 109th.

JOHNSON, Nancy Lee, a Representative from Connecticut; born Nancy Elizabeth Lee in Chicago, Cook County, Ill., January 5, 1935; graduated from elementary and secondary classes of the University of Chicago Laboratory School, Chicago, Ill., 1953; B.A., Radcliffe College, Cambridge, Mass., 1957; attended, University of London Courtauld Institute, 1957-1958; teacher; member of the Connecticut state senate, 1977-1982; delegate, Republican National Convention, 1980; elected as a Republican to the Ninety-eighth and to the eleven succeeding Congresses

(January 3, 1983-January 3, 2007); chair, Committee on Standards of Official Conduct (One Hundred Fourth Congress); unsuccessful candidate for reelection to the One Hundred Tenth Congress in 2006.

Dr. Moore is a social psychologist and Executive Director/Director of Research of Child Trends. She has been with Child Trends, Inc. since 1982, studying trends in child and family well-being, the effects of family structure and social change on children, the determinants of early sexual activity and parenthood, and the consequences of adolescent parenthood. With Dr. Martha Zaslow and the Manpower Development Research Corporation, she is conducting an evaluation of the impact of the Federal JOBS program on young children whose mothers receive AFDC. This study includes a longitudinal survey study and an observational sub-study of mother-child interactions. Also, four years after Baseline, school-records data and teacher questionnaire data will be collected with funding from the Department of Education. Dr. Moore is a member of the Family and Child Well-being Research Network established by the National Institute of Child Health and Human Development to examine over a five-year period the factors that enhance the development and well-being of children. As a Network member, She is working on several projects to enhance child indicators data and to develop new analytic data resources to inform both scientific research and policy making. Dr. Moore has testified on numerous occasions for members of the U.S. Congress and the Administration, most recently at briefings for the United States Senate Committee on Finance pertaining to prevention of teen pregnancy. She served on the National Academy of Sciences panel on Work, Family and Community between 1980 and 1982, and on the panel on Adolescent Pregnancy and Childbearing between 1984 and 1986. Dr. Moore has served as an advisor on teenage pregnancy and family issues regarding the National Survey of Family Growth, the National Survey of Families and Households, and the National Longitudinal Survey of Youth; and the Data Archive on Adolescent Pregnancy and Pregnancy Prevention. She also serves on the Science Advisory Panel of the Alan Guttmacher Institute. In 1991, Dr. Moore was selected to receive the Presidential Award from the National Organization on Adolescent Pregnancy and Parenting.



Elayne Bennett

Elayne Bennett received her M.Ed. in Special Education from the University of North Carolina at Chapel Hill. As a doctoral student there, she concentrated on resource and program development for special needs students and their families. She has provided teacher training and program evaluation nationwide for seven years as the Project Coordinator of an Office for Special Education grant to the Chapel Hill Outreach project.

Her interest in adolescent issues prompted her to organize a group of teenage girls from private and public schools in the Washington D.C. area. (The basis of their discussions was the videotape "How Can I Tell When I'm Really In Love?", produced by Paramount Pictures.) The conversations and advice from these girls resulted in the Best Friends message.



Dr. Phyllis Magrab

Dr. Phyllis R. Magrab is Professor of Pediatrics and Director of the Child Development Center at Georgetown University. As a psychologist she has worked with children and adolescents for over twenty years in providing consultation, developing service programs and assisting in planning public policy. She has had a long standing commitment to improving the lives of children and adolescents with special needs and to this end has published numerous articles and books.

Dr. Magrab initiated one of the first infant follow-up programs in this country and through this became concerned about the issues of adolescent pregnancy. Through Dr. Magrab's leadership, the Child Development Center, a service, training and research program, has incorporated these issues in its broader mission.



Best Friends

a program about
decision making and
self respect for adolescents

"I think that you have a point because a friend's support is very important with a girl's decisions. I think often the only reason girls do have sex in high school is because of pressure from peers and lack of knowledge and support from friends."

Introduction

The Georgetown University Child Development Center serves as a national resource center for training service development and policy analysis. The foundation of the program calls for an interdisciplinary approach to service, research training and community outreach for children and adults with special needs.

The concept of the Best Friends program came from discussions between Center Director Phyllis Magrab and Elayne Bennett as a means of offering guidance and support to adolescent girls as they learn to cope with growing up. They were concerned that the girls who will be the future mothers of a new generation develop a sense of self-worth and a healthy and positive approach to life.

As schools and educational programs nationally and internationally request training and consultation in the area of preventive programs for adolescents, the Best Friends program offers a model that is easily replicated at a minimal cost. It is based upon building a support network of peers and adults who cooperate in the true spirit of friendship.

The pilot project began in June 1987 at a large suburban high school with the support and cooperation of school officials and appropriate notification of parents. A series of 1-hour presentations and discussions led by Phyllis Magrab and Elayne Bennett were offered through Health and Physical Education classes to 9th and 10th grade girls in a setting that allowed only for female participation.

"I think that you should present the program to younger people. Many girls our age (15-16) have already been 'forced' into having sex and wanted to be able to say no."



Best Friends girls at the "Health is Happiness Workshop"

The Problem

Teenage pregnancy is now an epidemic. Staggering statistics have been cited in newspapers and periodicals. More than one million teens become pregnant each year. Of these, 400,000 elect to have abortions while another 400,000 give birth. These figures are considerably higher than those of other industrialized countries: a 15 year-old American girl is five times more likely to give birth than her foreign contemporary. In a study of 1,000 sixteen-year-old unwed girls who had given birth at Grady Hospital in Atlanta, Georgia, an overwhelming number cited the cause of their pregnancy as an "inability to say no." These girls wanted to learn how to say no!

Pregnancy is not the sole issue of critical importance. In February 1986, the New York City Bureau of Sexually Transmitted Disease Control reported that syphilis, which had been declining steadily for 20 years, was showing a marked increase. Dr. Willard Cates of the Center for Disease Control reported that in 1989 the syphilis infection rates among the general population were at the highest levels since post-World War II. The syphilis rate for teenagers ages 15-19 has increased 67% since 1985. In addition, former Surgeon General Koop reported an 80% increase in penicillin-resistant gonorrhea among adolescents in 1987.

"I felt the program was very informative and answered the many questions we have, but don't like to ask."

The Approach

Best Friends is a pilot program designed for adolescents in grades 6-12. Its purpose is to foster self-respect, to present to students the reasons for deferring sexual intercourse and to promote decision making skills.

The Carnegie Foundation in its report "Turning Point-Preparing America's Youth for the 21st Century" states, "Caring is crucial to the development of young adolescents into healthy adults. Young adolescents need to see themselves as valued members of a group that offers mutual support and trusting relationships. They need to be able to succeed at something, and to be praised and rewarded for that success. They need to become socially competent individuals who have the skills to cope successfully with everyday life. They need to believe that they have a promising future, and they need the competence to take advantage of real opportunities in a society in which they have a stake." We think our program offers the kind of caring this statement describes.

The Best Friends message is promoted through group sessions on the curriculum topics of Friendship, Love & Dating, Decision Making and Self-Respect. Our program utilizes teachers as mentors for girls in an effort to reach each girl individually as well as within a group. The role model program is a significant part of the Best Friends curriculum. These role models are older women who encountered difficulties as young girls, but now lead successful and happy lives. They share their experiences and reinforce the Best Friends message that decisions made at an early age are important and that they have an impact on later life.

"It gets information across without preaching."



Barbara Bush receives Best Friends' heart pin

The Best Friends Message

The pressures of the young girl in an intimate relationship call for good judgment. Anxiety results when a 13, 14, 15 or 16 year old girl enters into an intimate relationship with a boy. Finding the strength to say no and feeling vulnerable at the same time often creates intense conflicts for young girls. This is a time when teenage girls turn to their friends for support and advice. An important part of friendship is helping a friend make difficult decisions.

Best Friends emphasizes the joy of the preteen and teenage years, unencumbered by the problems sexual intercourse can create. This program does not employ scare tactics; it is positive and upbeat in its message. One important and critical aspect of Best Friends is that teens help each other to recognize that their goals can be set and achieved. Lack of self-respect has been repeatedly cited as a contributing factor to promiscuity and pregnancy. With all of the negative pressures that society places on our adolescents today, Best Friends offers a positive alternative. Nearly 500 students attending urban and suburban schools have participated in Best Friends sessions since 1987 and the evaluations have been overwhelmingly positive. We believe we can say that the Best Friends approach works.

TIME Magazine

January 22, 1996 Volume 147, No. 4

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PUBLIC EYE

A GIRL'S BEST FRIENDS

ALMA POWELL AND ELAYNE BENNETT, ONE PRO-CHOICE, THE OTHER PRO-LIFE, FIND COMMON GROUND ON TEENS AND SEX

MARGARET CARLSON

Right before Christmas, Elayne Bennett, head of Best Friends, an organization that encourages schoolgirls to forgo sex, reached into her purse and found a piece of paper that board member Alma Powell had slipped in there a few days before. It turned out to be a check from General Colin Powell providing the major portion of matching funds for a \$200,000 challenge grant. "I couldn't believe it, and I almost lost it," confesses Bennett. "Alma gave it to me with so little fanfare."

Best Friends started on a shoestring and a smile in a bedroom of Bennett's Chevy Chase, Maryland, home nine years ago, and now operates in 29 public schools nationwide. Beginning in sixth grade, the Friends curriculum pounds into girls--through one-on-one sessions with mentors, dance classes, outings to the theater and an awards lunch with speakers (General Powell in June)--that a happy life is more likely for those who put off sex. "Best Friends works because we have fun," says Bennett. "We glamourize abstinence as much as the culture glamourizes sex." Of the 600 Washington girls who have participated for two years or more, two have become pregnant (1.1%), as opposed to a 25% citywide rate for girls ages 13 to 18. Some are going to college with the help of a scholarship fund started with \$25,000 in royalties from *The Book of Virtues*, a best seller by Bennett's husband William.

As notable as the program's success is the fact that two pro-lifers, the Bennetts, and two pro-choicers, the Powells, have found common ground at a time when any deviance from abortion orthodoxy creates seismic splits in the Republican Party. For his moderation--opposing a human-life amendment and distinguishing between early abortions and those post-viability, which he would restrict--Bennett has been labeled "pro-abortion" by Dr. James Dobson of the Focus on the Family. General Powell's revelation that he was

pro-choice made him anathema to his party's right wing. In December, when Senator Bob Dole said he no longer supported a constitutional amendment to ban all abortions, he felt compelled to get off a letter immediately to the Christian Coalition's Ralph Reed explaining that he didn't really mean it.

William Kristol, editor of the Weekly Standard, who wants Republicans to rethink their hard-line abortion position, wishes Dole's remark had engendered an open debate.

"Obviously, Dole has a more nuanced view," says Kristol. "A Dole Administration is not going to spend any political capital advancing a human-life amendment he doesn't believe in." The amendment grants the right to life from the moment of conception, a view that none of the leading Republican candidates except Pat Buchanan trumpets and one whose logical consequences--murder charges against doctors and women--only a minority of Americans would accept.

Those who oppose abortion could better spend their time working as hard as Elayne Bennett to make abortion unnecessary instead of banishing those who deviate from the party line.

Candidates might consider discussing their beliefs instead of their positions and acknowledge what both sides know to be true: a late-term abortion is almost always wrong; but forcing a 13-year-old who accidentally becomes pregnant into motherhood by making first-trimester abortions illegal is its own kind of evil. Then maybe we could get somewhere. The Bennetts and the Powells have made an admirable start.



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might find funding.

Diplomats say Mr. Boutros-Ghali may be looking for ways to reduce the influence of any single country in the 185-member United Nations. The United States is by far its largest contributor, paying 25 percent of the operating budget and nearly one-third of peace-keeping expenses.

Although most Western diplomats say they doubt international consensus could be found to levy a global tax now, they concede some kind of alternative financing in the future should not be ruled out.

Similar proposals have been heard before. In October, Australian Foreign Affairs Minister Gareth Evans said in a speech to the U.N. General Assembly that it should consider "external sources" for "supplementing member states' contributions," including collecting a levy on foreign exchange transactions, which total \$300 billion a year.

"Simple arithmetic tells us that

see TAXES, page A11

By Paul Badard
THE WASHINGTON TIMES

Hillary Rodham Clinton is considering paid television ads to plead her case on Whitewater and "Travelgate," or even testifying before congressional committees investigating the scandals, in an effort to avoid being a political liability to her husband.

"If people want to accuse us of things that are not true, then we will make sure that the truth gets out," Mrs. Clinton said yesterday.

Two possible avenues:

• Testimony by Mrs. Clinton before the committees investigating Whitewater and Travelgate. "It may come to that," she said on

The book tour continues: Hillary Rodham Clinton leaves WAMU after appearing on "The Diane Rehm Show."

Hillary considers testimony, ads to repair her image

"The Diane Rehm Show" on Washington's WAMU-FM. This could catch Republicans flat-footed because their investigations have not yet collected enough ammunition to throw at her.

• Paid advertising. "In a political campaign, unlike in the sort of daily back-and-forth of public service, you can focus people's attention, and if worst comes to worst, you can pay to advertise what the

facts are," the first lady said. "I'm considering everything, including going to the South Pole," she joked.

Mrs. Clinton also said her comments to presidential aides about her concern over reported financial mismanagement at the White House travel office could have been misinterpreted to mean she wanted the seven employees dismissed.

"The mere expression of concern could be, I guess, taken to mean something more than was meant," she said.

The developing strategy to combat suspicions that the first lady

see HILLARY, page A8

More girls say no to sex with Best Friends' help

By Cheryl Wetzstein
THE WASHINGTON TIMES

The first independent study of the Best Friends abstinence program for teen-age girls has found that nearly all of its D.C. participants strongly believe in and practice sexual abstinence.

"I can say no in seven different ways," said one of the 88 Best Friends teens in D.C. schools who participated in the study, con-

Study finds abstinence program works

ducted and financed by David R. Rowberry for his doctoral dissertation at the University of Colorado.

The Rowberry study could become an important addition to research on the effectiveness of abstinence-only programs.

In his yearlong study, Mr. Rowberry found that nine of the 88

Best Friends girls, ages 12 to 18, had engaged in sexual intercourse. One became pregnant.

In contrast, a 1993 survey of 990 D.C. public school girls in the same age group found that 72 percent had had sexual intercourse, with 200 becoming pregnant.

The District has the highest rate of unwed teen births in the nation,

with 68 births per 1,000, according to the 1995 Kids Count survey, a project of the Annie E. Casey Foundation.

Mr. Rowberry's work is the first independent evaluation of the Best Friends program, which Elayne Bennett founded in 1986.

"This validates us," Mrs. Bennett said of the study. "We knew, by talking with the girls, that we were

see GIRLS, page A17

By R. an Scarborough
THE WASHINGTON TIMES

inner circle that prosecuted the Gulf war five years ago in the belief that the victory isolated Saddam, sparked the Middle process and brought pride in the armed forces. President Bush's policies and generals also acknowledged feelings that the end was not as well as its synchronized stage on Jan. 16, 1991. Or less night, waves of all-ers struck downtown, inaugurating a 45-day rying force from Kuwait that ejected Saddam's think the war's primary that Saddam Hussein,

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GIRLS

From page A1

truly making a difference. But now we have quantifiable documentation from an objective researcher."

The privately funded Best Friends program, which now operates in schools in several states, serves girls in the sixth to ninth grades. It teaches girls how and why to say no to drugs, alcohol, violence and sexual intercourse. When Best Friends girls enter the 10th grade, they can join the program's less-structured "Diamond Girls" phase.

The Diamond Girls program is the "weakest" aspect of the program, Mr. Rowberry wrote. Seven of the nine girls who reported having sex were in high school.

Best Friends officials say that of the 400 girls who have completed at least two years of the program, 1 percent have become pregnant.

Best Friends does not take the approach preferred by most schools, which is a "comprehensive" message of abstinence combined with information about how to have "safe sex."

The nation's teen birth rate has dropped by 4 percent since 1992, possibly because of increased condom use, a federal official said. Research on dual-message programs has shown that some are effective in getting teens to delay sexual activity, but none of the programs has been shown to decrease teen pregnancy.

Moreover, a comparison of data from the Centers for Disease Control and Prevention and state sex-education profiles showed that states that eschew sex education or stress abstinence in such programs appear to have fewer teen pregnancies than states that promote condom use.

"There has been a pretty definitive shift in interest and acceptance of abstinence as a viable option for kids," said Stan E. Weed, a respected researcher on teen sexuality and abstinence issues who is based in Salt Lake City.

Still, there is reluctance to rely on abstinence-only approaches because of the lack of research showing whether such programs work, he said. To get accurate pregnancy data for any prevention program

track the girls for several years.

Mr. Rowberry, who received his Ph.D. in December, said the Best Friends program's success appears to stem from its:

- Unique combination of class work, group talk sessions, one-on-

TEENS AND SEX

Doctoral candidate David R. Rowberry examined the Best Friends abstinence program for girls and compared his findings with two surveys of D.C. public school students.

Best Friends

Base: 88 girls, ages 12-18

Sexual intercourse: 76 said no, nine said yes, three did not answer

Pregnancies: 1

1993 youth risk behaviors surveillance survey

Base: 990 girls, ages 12-18

Sexual intercourse: 278 said no, 712 said yes

Pregnancies: 200

1993 evaluation of D.C. sexuality education/HIV training

Base: 299 male and female seventh- and 10th-graders

Sexual intercourse: 48.5 percent said no, 45.8 percent said yes, data not available for 4.7 percent

Pregnancies: Not available

Source: "An Evaluation of the Washington, D.C., Best Friends Program," David R. Rowberry, 1995

WHAT BEST FRIENDS SAY

Teen-age girls who are part of the Best Friends program told researchers why the program is important to them:

- "A lot of the girls in the project are doin' it. Some even laughed at me last night 'cause I said I like being a virgin."
- "I don't want to be lonely like Mom is, and I don't want guys always hangin' around. I hate it when those men try to put their hands on me."
- "I talk to my Best Friends friends about everything! They are always there for me. They taught me how to get away from an old man that would hang around my house when I came home from school."
- "One time, I was going to go with this guy who had this great line, but they [Best Friends girls] wouldn't let me. I'm really glad. He got another friend of mine pregnant and left her alone. She's sad. We watch out for each other. I can say no in seven different ways."
- "Once you [younger Best Friends girls] get to high school, it's like all the freshman girls coming in are like new meat. You are going to have to realize that no matter what you say to a guy now, if they want you, they're going to keep trying."
- "If you don't respect yourself, then they're not going to respect you. If your girlfriend's out there sleeping with everybody, they think you are too. Watch who you associate with and watch out, period."

Source: "An Evaluation of the Washington, D.C., Best Friends Program," David R. Rowberry, 1995

one talks with mentors, role models, aerobics classes and an annual "recognition ceremony" where the girls are feted.

• Presentation of the "same, clear normative values concerning sexual and social behavior" that the girls would receive from religious sources.

• Consistency with many girls staying through the three-year program and entering the Diamond Girls program.

• Future-oriented approach that encourages girls to plan on attaining an education, job and career, marriage and family.

• Emphasis on the girls support-

had not had sexual intercourse; three girls declined to answer the question.

Of the nine girls who said they had had sexual intercourse, three said they had been forced into the act and three said they were working toward "renewed virginity."

Mr. Rowberry compared his findings with the 1993 Youth Risk Behavior Surveillance Survey and a 1992-93 sexuality study that used a CDC questionnaire.

The youth risk survey found that of 990 D.C. public school girls, 712 had had intercourse, with most losing their virginity on or before their 15th birthday. The CDC-

and 10th grade teens believed that more than half their classmates were having sex.

Mr. Rowberry cautioned that "care must be taken in generalizing the results" of his study because of the lack of comparable data and its small sample size.

Mr. Rowberry collected data via a confidential questionnaire and selected interviews with the girls, mentors, school officials, parents and neighbors.

Seventy-six of the 88 Best Friends girls reported that they

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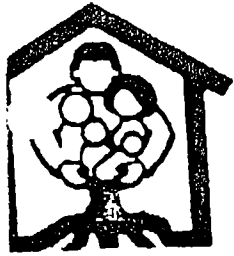
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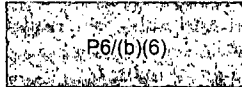
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THE NATIONAL INSTITUTE FOR RESPONSIBLE FATHERHOOD AND FAMILY DEVELOPMENT

8555 Hough Avenue • Cleveland, Ohio 44106-1519 • (216) 791-1468 • Fax: (216) 791-0104

Biography of Charles Augustus Ballard



Charles Augustus Ballard was born in Underwood, Alabama in June, 1936 to Lee Myer and Myrtha Lee Tolbert Ballard. At age 17 he became a young father, joined the Army and became a Paratrooper with the former 101 Screaming Eagles' Division.

He returned to his home town, Bessemer, Alabama in December, 1959, adopted his son (age 5 1/2) and moved to Huntsville, Alabama. In 1963, he moved to Oakwood College, a Seventh Day Adventist Institution designed to prepare Christian African Americans for service to their fellow men.

In 1966, he enrolled at Oakwood College as a fulltime student and graduated in June, 1970 with a Bachelor of Art Degree in Sociology/Psychology.

In September 1970, he entered the School of Applied Social Sciences at Case Western Reserve University with a full scholarship for a Masters Degree in Social Welfare Administration. In May, 1972 he completed the course work and received his Master of Arts Degree.

In 1976, he went to work at a local city hospital. While there he conducted a research project which included 400 fathers ages 14-55. This study indicated that in many ways the fathers' presence or absence had a profound affect on mothers and their children. In 1978, he stated, "In order to increase life opportunities for mothers and children, comprehensive non-traditional services must be provided for fathers."

In August, 1978 he started the organization the Teen Father Unit at Cleveland Community Health Services. After four years of working with the agency, in June, 1982, he founded The Teen Father Program: A Family service, now The National Institute For Responsible Fatherhood And Family Development.

Mr. Ballard's primary mission is to build bridges between the generations. Mr. Ballard feels the very best way to carry out this mission, is to create environments that are father friendly, child friendly and family friendly.



having to act responsibly without the proper understanding can be too much for them to handle. As a male who was separated from his father at three and became a father at seventeen, I can relate to this, intimately.

Thus, the Teen Father Program was born as an answer to this need. Our goal was, and is, to help young men become responsible, nurturing, resourceful fathers who create environments that are nurturing and responsive to their children. The original idea was to affect an environment where fathers would feel empowered to

"Our first responsibility is the well being of the child and we address that through empowerment of the father."

positive, strengthening family interaction. The program therefore takes a holistic approach to family dynamics by offering services to both mothers and grandparents. This service expansion is reflected in the renaming of the organization to The National Institute for Responsible Fatherhood and Family Development.

The Vision...

While working with the Metro Health System in 1976, I recognized there was a void in the lives of the mothers and children we served. This void was created by the absence of a strong father in the home. I talked to fathers and mothers across the county and realized that too many children went to bed at night never having heard their fathers' voice. Or through circumstance, the fathers who had once been in the home were no longer there to be heard. There is something missing in the lives of children who grow up without committed, caring fathers. The potential problems can follow a family for generations. The effects are especially hard on young males. Without that special dimension of guidance a father can give, these young men are at risk of becoming fathers too soon themselves. The pressure of

make life safer for their children. What that meant was giving these fathers positive images, relevant visions and the support necessary for them to assimilate these images and visions into their daily lives. Through one-on-one counseling and crisis management, our many proteges have found the inner strength to handle their responsibilities, life's challenges and changes, become better men — and better fathers.

In today's society, the family unit faces increased challenges. It is therefore imperative that we create a foundation upon which the families of tomorrow can build. The Institute intends to proactively address this issue by helping other metropolitan areas incorporate our stratagem. Our ultimate goal is to share our vision with fathers the world over. We help young men become better fathers so they can teach the next generation how to make a better world.

A father's first responsibility is the well being of his child and we address that through empowerment of the father. We know that many factors influence how a young father, or any father, interacts with his child. The mothers and the grandparents play integral parts in the relationship and often their problems and circumstances are an impediment to the development of

Charles A. Ballard, MSW
President/CEO

**POPULATION
RESOURCE
CENTER**

**TEENAGE PREGNANCY IN THE U.S.:
WHERE DO WE GO FROM HERE?**

A Congressional Program
in cooperation with
The Congressional Caucus for Women's Issues

**Population Resource Center
1725 K Street, N.W., Suite 1102
Washington, D.C. 20006
(202) 467-5030**

**Wednesday, April 10, 1996
10:00 a.m. to 12:00 noon
2247 Rayburn House Office Building
Washington, D.C.**

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FROM DHHS/PHS/PUBLIC AFFS

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TEENAGE PREGNANCY IN THE U.S.: WHERE DO WE GO FROM HERE?

Welcome and Introduction

M. Faith Mitchell
Board of Directors
Population Resource Center

Moderator

Shelley E. Kossak
Vice President
Population Resource Center

Speakers and Topics

Framing the Issue of Teen Pregnancy:
How to Think About the Problem

Laurie S. Zabin, Ph.D.
Professor, Department of
Population Dynamics
Johns Hopkins University,
School of Public Health

What We Know About What Works

Barbara K. Huberman
National Director of Training
Advocates for Youth

A Perspective From the Community
Level

Lorraine Williams Greene, Ph.D.
Clinical Psychologist and
former director,
"I Have a Future" Program

Support for this program was provided by
The Charles Stewart Mott Foundation

BIOGRAPHICAL SKETCHES

Laurie S. Zabin, Ph.D., is Professor, Department of Population Dynamics at the Johns Hopkins University School of Public Health. She is a leading expert on adolescent pregnancy prevention, having worked at the national, state, and community levels for thirty years as a community organizer, service provider, and researcher. Prior to joining the faculty of Johns Hopkins University, Dr. Zabin was Acting Director of the Planned Parenthood Association of Maryland and the Director of the Community Action Agency Neighborhood Family Planning Center in Baltimore. She has served on panels at the American College of Obstetrics and Gynecology, the Centers for Disease Control, and the National Academy of Sciences/National Research Council. Dr. Zabin is the author of numerous publications including Adolescent Sexual Behavior and Childbearing and Adolescent Pregnancy in an Urban Environment.

Barbara K. Huberman is the National Director of Training at Advocates for Youth, responsible for sexuality education and youth development programs. She has been involved with human sexuality education and adolescent sexuality issues for over 25 years. Before accepting her recent position, she served as president of the Adolescent Pregnancy Prevention Coalition in North Carolina. Ms. Huberman is one of the founders of the Mecklenburg Council on Adolescent Pregnancy, a nationally recognized model of comprehensive community-based teen pregnancy prevention programs. She serves on the Board of the National Campaign to Prevent Teen Pregnancy and is past president of the National Organization on Adolescent Pregnancy and Parenting. She is an adjunct professor in the College of Health Promotion at the University of North Carolina at Charlotte. She has been published in numerous professional journals and publications and has lectured at many colleges and universities.

Lorraine Williams Greene, Ph.D., a clinical psychologist, is the former director of the "I Have a Future" Comprehensive Adolescent Health Promotion and Disease Prevention Program in Nashville. She is currently assisting communities across the United States in replicating the program and mobilizing citizen groups in preventing teen pregnancy. In addition, Dr. Greene is the Acting Police Counseling Services Manager for Metropolitan Nashville/Davidson County Police Department, overseeing Police Support Services, the Domestic Violence Counseling Unit, Youth Guidance Department and the Victim Intervention Program. Dr. Greene also serves as an evaluator for a high risk youth grant designed to prevent alcohol and substance abuse among inner-city African American girls. She serves on a number of national boards and has served as an advisor to the Centers for Disease Control and Prevention and the Minister of Health and Reproduction in Accra, Ghana.

Group guides men back to family

Fatherlessness is the biggest problem in American society today, says Charles A. Ballard.

"It's not jobs, not education; but the feeling of self as a human being that's important," says the 57-year-old president of the National Institute for Responsible Fatherhood and Family Development (NIRF).

And it is the quality of male nurturance during a child's development that is a key factor in establishing a strong sense of identity and self-esteem, says the former social worker, who has helped more than 2,000 young men become better fathers.

Mr. Ballard was in the District recently trying to establish a national headquarters for his Cleveland-based nonprofit organization, which teaches young men and boys how to become better fathers. A small referral service already exists in the Empowerment Network office in Alexandria.

Mr. Ballard contends it is difficult to teach males to nurture children when they have not had fathers themselves.

Recognizing that young black males are "under extreme stresses," the NIRF helps them determine how to be the best father they can be. No matter how unconcerned the young men seem, Mr. Ballard says, most of them want to be connected to their children but just don't know how.

"Proteges," as those who participate in the program are called, must first sign documents officially acknowledging their offspring.



Charles A. Ballard

Each of the young men is then asked to recount his own childhood and relationship with his children.

Mr. Ballard's "one-to-one" approach includes an emphasis on sexual abstinence, which helps decrease out-of-wedlock births. The fathers must also return to school, work toward a General Equivalency Degree and obtain full- or part-time jobs to help support their children.

The program currently relies on word-of-mouth referrals. Some are voluntarily placed under NIRF's supervision by juvenile court judges. The group, which depends heavily on volunteers, is supported by government grants and United Way funds.

A Christian Scientist, the soft-spoken Mr. Ballard was himself fatherless. His father was placed in a mental institution, where he died before his

son's 10th birthday.

Mr. Ballard in turn abandoned his own son, born when his father was just 17. He joined the Army, wound up in prison and went through a religious conversion before reinvolving himself in his son's life. He adopted the boy and worked two jobs to support him.

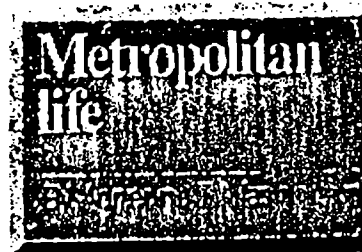
The NIRF is an outgrowth of Mr. Ballard's independent research and work in a Cleveland maternity ward. He would approach pregnant women in the hospital or on city buses and encourage them to give him the names of their husbands and boyfriends. He would seek out the men to counsel them. Eventually six men's groups were established throughout Cleveland.

"When a guy is helped, he wants to help someone else," Mr. Ballard believes. As a result, many of his proteges become role models for their younger peers.

While fatherlessness may cause some young men to seek out drug dealers and gang members as surrogate fathers, it may also cause young women to subject themselves and their children to all sorts of abuse in order to have a male around.

How much of the country's illegitimacy can be attributed to a young girl's lack of self-esteem due to a father's abandonment? How many young single mothers can, in turn, teach boys how to become responsible men in the absence of a male role model? Why are so many of their fathers absent?

Lack of education and employment are contributing factors, but long-standing welfare



policies also forbid a male presence in the home. Many social reformers believe new incentives must be established that encourage men to be more involved in family life.

"Getting Men Involved," a booklet written by James A. Levine of the Fatherhood Project of the Families and Work Institute in New York, provides real-life examples and practical suggestions on how to get men more involved in rearing children.

Saint Bernardine's Head Start program in Baltimore is one project the book highlights. The school sponsors a weekly group for fathers who have been estranged from their families and are becoming reconnected.

"We will never find a solution to child care if we keep defining it as a woman's issue instead of a family issue," Mr. Levine writes.

It is men, not women, who are critical to the salvation of today's troubled youth. Men must develop better relationships with their children.

People just want to be loved and treated tenderly," says Mr. Ballard, a man who would have "given anything" for a hug from his own father.

RESPONSIBLE FATHERHOOD PROJECTS

BACKGROUND

On April 4, 1995, ACF published in the Federal Register a program announcement of the availability of federal funding to demonstrate promising program interventions to encourage and increase responsible fatherhood. Selected programs are expected to encourage and increase basic responsible acts among fathers, such as establishing paternity and encouraging contact between fathers and children. Moreover, programs should teach fathers how to understand their children's development, how to understand and positively affect their children's behavior, how to be positive role models for their children, and how to work constructively with the children's mother for the benefit of the children regardless of whether both parents live in the same household as the children. ACF received 149 applications in response to the program announcement, and awarded five 2-year grants of \$85,000 each.

The five grantees are St. Bernardine's Head Start in Baltimore, Wishard Memorial Hospital in Indianapolis, Addison County Parent/Child Center in Middlebury, VT, and two sites of the Institute for Responsible Fatherhood headed by Charles Ballard (described below).

The Institute for Responsible Fatherhood and Family Revitalization in Washington, D.C., submitted applications on behalf of five different sites which are currently part of its national replication program. The Institute's replication sites in Washington, D.C., and San Diego, California, will add two geographically diverse opportunities to learn more about an intensive counseling-based, community outreach approach to working with fathers. These sites will provide valuable information about how to implement this approach in different environments. In 1984 the applicant developed a program in Cleveland to increase responsible fatherhood among disadvantaged, non-custodial parents through intensive counseling and case management. The program's recruitment process employs a community outreach strategy that also seeks referrals from welfare agencies, hospitals, and the justice system. Counselors act as role models and aim to motivate non-custodial fathers by example. Counselors create fatherhood development and treatment plans with participants that include personal objectives necessary to improve one's fathering abilities and educational and employment objectives necessary to become a supportive father. The counselor facilitates father support groups; makes referrals to other services, e.g., employment and training; and makes home visits to engage participants and monitor participation.

REDUCING TEEN PREGNANCY THROUGH ABSTINENCE

QUESTION:

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

ANSWER:

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

IS ABSTINENCE REALISTIC?

QUESTION:

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

ANSWER:

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

CAUSES OF TEEN PREGNANCY

QUESTION:

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

ANSWER:

- ▶ Tragically, each year about one million adolescent girls in the U.S. become pregnant. Too often, these young women are unmarried -- most often, their pregnancies are unintended.
- ▶ The statistics are staggering -- but the causes are complex, numerous, and in fact, not completely understood. Let's talk about what we do know:
 - The proportion of adolescents who are sexually active has been steadily increasing for the past two decades. Adolescents are initiating sexual activity at younger ages.
 - And while contraceptive use has increased, the proportion of adolescents who are sexually active has also increased -- and thus, so has the rate of pregnancies.
 - It is increasingly recognized that many adolescents become sexually active by force or coercion and that this has serious implications for their development and ability to protect themselves against pregnancy and STD infection.
 - There's also the role of our media and entertainment culture -- which often glorifies sexual behavior without helping teenagers understand the consequences of high-risk behavior.
 - Data show that adolescents from low-income families are more likely to initiate sexual activity at a young age, less likely to use contraceptives, and more likely to become pregnant than adolescents from higher-income families.
- ▶ As I said, these are complex and diverse factors -- and that's why we all need to help lead a comprehensive effort to attack this problem from every possible angle. Nothing less than the lives of our young people -- and the future of our country -- is at stake.

WHAT MAKES AN EFFECTIVE PREVENTION PROGRAM?

QUESTION:

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

ANSWER:

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

WHEN/WHERE DOES TEEN SEXUAL ACTIVITY OCCUR?**QUESTION:**

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

ANSWER:

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

DO CONTRACEPTIVES LED TO TEEN SEXUAL ACTIVITY?

QUESTION:

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

ANSWER:

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

THE ROLE OF ADULT MALES IN TEEN PREGNANCY

QUESTION:

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

ANSWER:

- ▶ 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 births. 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.
- ▶ We need to use a variety of strategies to educate adult men that this behavior is unacceptable, and, depending on the circumstances, illegal.

TRENDS -- TEEN BIRTH RATES AND CONTRACEPTIVE USE

QUESTION:

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

ANSWER:

BIRTH RATES:

- ▶ According to the CDC, the birth rate for teens age 15-19 declined 4 percent from 1991-1993.
- ▶ The birth rate for teens age 15-17 declined 2 percent from 1991 to 1992, and remained stable in 1993.
- ▶ And teen pregnancy rates declined from 1991 to 1992 in 30 of 41 reporting states.

CONTRACEPTIVE USE:

- ▶ 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.

JAMA ARTICLE ON TEEN PREGNANCY DATA

QUESTION:

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

ANSWER:

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

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

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

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

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

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

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

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

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DESPITE EFFORTS to reduce adolescent pregnancy in the United States, pregnancy and birth rates among US adolescents were higher than those in most other developed countries in 1990.^{1,2} Both the public health impact and the societal and individual costs of adolescent pregnancy are well known.³ The financial costs of early adolescent childbearing are high, and the human costs to young mothers and their children are substantial.^{4,5} Adolescent mothers are less likely to complete their education and are more likely to have limited career and economic opportunities, to rely on welfare, and to have failed marriages and future unintended pregnancies.^{6,7} They also are less likely than older women to have the skills needed for parenting and have a higher incidence of pregnancy-related complications, such as hypertension, anemia, and cephalopelvic disproportion.⁸ Infants born to adolescent mothers, particularly girls younger than 15 years, have a higher risk of negative health outcomes, such as prematurity, low birth weight, and death.¹⁰

For editorial comment see p 1030.

This article updates an earlier report that presented data through 1983 for 15- to 19-year-olds¹¹ and presents pregnancy, abortion, and birth rates for girls younger than 15 years. We examined national trends in pregnancy, abortion, and birth rates for girls younger than 15 years and for teens aged 15 to 19 years (divided into subgroups of those aged 15 to 17 and 18 to 19 years) separately because of differences among these groups in physical, social, and psychological development.

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

Age, y	Abortions, No. (%)	Births, No. (%)
10	14 (0.6)	15 (0.1)
11	27 (1.1)	36 (0.3)
12	102 (4.3)	223 (2.1)
13	483 (20.4)	1804 (17.0)
14	1737 (73.5)	8510 (80.4)
Total	2363 (100.0)	10588 (100.0)

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

Pregnancies, abortions, and births among girls younger than 15 years cluster around the ages of 13 and 14 years. However, researchers have used a wide variety of denominators in calculating pregnancy, abortion, and birth rates for these girls.¹²⁻¹⁷ One study used the entire population of girls 10 to 14 years old as the denominator and reported a pregnancy rate of 3.3 per 1000,¹⁴ whereas another study for that same year used only girls aged 14 years as the denominator and reported a pregnancy rate of 17.5 per 1000.¹⁷ The lack of a standard denominator seriously limits our ability to compare pregnancy, abortion, and birth trends from different sources and times. Thus, we propose standardizing the ages included in the denominator for calculating rates for girls younger than 15 years.

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

METHODS

Pregnancies, Abortions, and Births

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

Data Sources

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

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

Race	Age Group, y	Sexually Experienced Adolescent Girls, % (95% Confidence Interval)		
		1982	1988	1990
All†	<15	8.5 (7.2-9.8)	8.4 (6.8-10.0)	8.4 (6.8-10.0)
	15-19	46.9 (42.8-51.0)	52.9 (48.5-56.3)	54.9 (50.4-59.5)
	15-17	32.2 (27.6-36.8)	38.3 (33.5-43.0)	41.0 (34.9-47.0)
	18-19	64.1 (58.1-70.0)	73.9 (68.9-78.8)	74.4 (68.7-80.2)
White	15-19	44.9 (40.4-49.5)	52.1 (48.2-56.0)	53.0 (47.6-58.5)
	15-17	30.1 (25.0-35.2)	35.8 (30.0-41.6)	38.8 (31.4-46.2)
	18-19	61.5 (54.7-68.3)	74.3 (69.0-79.6)	73.6 (67.4-79.8)
Black	15-19	59.0 (53.2-64.7)	60.2 (54.2-66.1)	69.6 (61.3-77.7)
	15-17	44.1 (35.4-52.7)	50.4 (41.8-59.0)	56.5 (46.7-66.2)
	18-19	79.5 (72.7-86.3)	75.7 (66.0-85.4)	83.2 (74.3-92.1)

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

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

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

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

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

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

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

Rates

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

All rates are based on unrounded numbers.

Population Estimates

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

Estimates of Sexual Experience

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

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

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

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

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

RESULTS

Pregnancies

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

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

Group of Adolescent Girls	Age Group, y	Pregnancy Rate		
		1980	1985	1990
All	<15	6.3	6.9	7.1
	15-19	88.8	87.7	95.9
	15-17	57.5	57.0	62.8
	18-19	133.1	131.9	136.3
Sexually experienced	<15	74.2	82.1	84.8
	15-19	189.3	175.8	174.6
	15-17	178.6	161.7	153.2
	18-19	207.7	191.3	185.9

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

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

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

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

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

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

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

In 1990, pregnancies among girls younger than 15 years accounted for approximately 3% of all adolescent pregnancies.^{9,18} In 1990, the pregnancy rate was 7.1 per 1000 girls 13 and 14 years old (Table 3). From 1980 to 1990, the pregnancy rate in that group increased by 13% (10% between 1980 and 1985 and 3% between 1985 and 1990).

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

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

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

Abortions

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

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

Race/Ethnicity	Age Group, y	No. of Births		
		1980	1985	1990
All adolescent girls All races†	<15	2.8	2.9	3.6
	15-19	53.0	51.0	59.9
	15-17	32.5	31.0	37.5
	18-19	82.1	79.6	88.6
White	<15	1.4	1.4	1.9
	15-19	45.4	43.3	50.9
	15-17	25.5	24.4	29.5
	18-19	73.2	70.4	78.0
Black	<15	10.4	10.7	12.7
	15-19	97.9	95.4	112.8
	15-17	72.5	69.4	82.3
	18-19	134.9	132.4	153.0
Hispanic‡	<15	...	...	6.2
	15-19	...	...	99.9
	15-17	...	...	65.7
	18-19	...	...	147.2
Sexually experienced adolescent girls All races†	<15	33.0	34.1	43.1
	15-19	113.0	102.1	109.1
	15-17	100.9	88.1	91.5
	18-19	128.1	115.4	119.1
White	15-19	101.0	89.2	95.9
	15-17	64.4	74.0	76.0
	18-19	119.1	103.8	105.9
Black	15-19	166.0	160.3	162.1
	15-17	164.5	146.9	145.8
	18-19	169.7	170.6	183.9
Births		No.		
		1980	1985	1990
Sexually experienced adolescents	<15	10 169	10 220	11 657
	15-19	552 161	467 485	521 826

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

†Includes races other than white or black.

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

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

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

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

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

Births

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

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

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

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

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

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

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

COMMENT

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

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

crease in the abortion rate (1%). However, during the second half of the decade, the abortion rate among girls younger than 15 years declined by 13% while the pregnancy rate remained nearly stable, resulting in a large increase in the birth rate (26%) during the decade in which the US Public Health Service had set a national goal to eliminate births among girls aged 14 years or younger by 1990.²²

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

The decline in pregnancy rates among sexually experienced teenagers 15 to 19 years old may be associated with the increased use of contraceptives by teenagers during the 1980s. The proportion of teens using contraception at first premarital intercourse increased from 53% during the period 1980 through 1982 to 71% during the period 1983 through 1988.²⁴ Most of the increase in use at first premarital intercourse was due to an increase in condom use from 28% to 55%. During the latter part of the decade, the birth rate among sexually experienced teens increased as abortion rates declined. Furthermore, the increasing proportion of sexually experienced teens suggests that efforts at primary prevention (encouraging sexual abstinence) have not been as effective on a population basis as needed^{25,26}; however, recent reports suggest that the increase in rates of sexual experience that occurred during the 1980s slowed during the early 1990s.²⁷

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

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

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

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

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

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

To reduce teen pregnancies, two basic types of approaches are needed: interventions to delay the initiation of sexual activity among adolescents and interventions to prevent pregnancy among adolescents who are sexually active. Most evaluations of sex education programs suggest a positive effect on delaying sexual initiation.³⁵ There is evidence that appropriate family planning interventions for sexually active adolescents may increase contraceptive use among both youths who attend school and those who do not.³⁶

Despite similar rates of sexual experience, rates of adolescent pregnancies and births are higher in the United States than in other developed countries, and an estimated 95% of pregnancies among adolescents are unintended.^{3,34} Possible explanations include the continued controversy regarding sex education, the lack of access to contraceptives, and the reluctance of the media to present sexual behavior in a responsible manner.³⁵ National health objectives for the year 2000 include reducing the pregnancy rate for adolescent girls aged 17 years or younger to no more than 50 pregnancies per 1000.³⁶ Even without including fetal losses, the 1990 rate for teens 15 to 17 years old is about 26% higher than this goal. Considering the increase in pregnancy rates from 1985 to 1990 among teenagers 15 to 17 years old, substantially more efforts are needed to achieve this goal. Unfortunately, the data from the 1980s suggest that the public health goals for the year 2000 are unlikely to be achieved.

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Editorial

Editorials represent the opinions of the authors and THE JOURNAL and not those of the American Medical Association.

Pregnancy in Adolescence

In this issue of THE JOURNAL, Spitz et al¹ examine childbearing rates for US teenagers in the decade of the 1980s. The authors wisely divide these data into 5-year periods. To have done otherwise would have been misleading, for these rates prove to have been mercurial: stable from 1980 to 1985, markedly increased for 1985 to 1990. An analysis of more recent data shows rates declining in 1991 to 1992.² Accordingly, before attributing meaning to these data, one must take a longer view. In the 1970s, birth rates among adolescents declined sharply, probably owing to the legalization and availability of abortion; for reasons that are not clear, these rates then leveled off until 1988, when they rose to a new peak for 10- to 17-year-olds.^{3(p334)}

See also p 989.

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

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

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

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

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

Multiple factors are responsible for the high rates of pregnancy and childbearing among adolescents. Comparisons with other developed countries with equally high rates of adolescent sexual activity but lower rates of pregnancy and STDs than ours⁶ suggest some of these. Failure to provide age-appropriate education, both in home and in school, limited access to effective birth control methods and to systems of care that monitor and support sexual decision making, presentation of sex irresponsibly in the media, and poverty have all been cited as possible societal explanations. Personal factors such as poor self-image, depression, and substance abuse also contribute to vulnerability to adolescent pregnancy.

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

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

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UNPLANNED PREGNANCY RATES

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).

COST OF TEEN PREGNANCY TO TAXPAYERS

QUESTION:

What is the cost of teen pregnancy to taxpayers?

ANSWER:

- ▶ There is no definite federal statistic to answer this question. But what is clear is that we could save precious resources -- and precious futures -- by heeding the President's call for sustained nationwide efforts to prevent teen pregnancy.

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:

- ▶ I'm not here to testify about welfare reform. Secretary Shalala has testified on this subject many times.

BACKGROUND:

- ▶ The Clinton Administration's 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.

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."

1996 authorizations and reducing the remaining authorizations by half. These reductions were applied equally among all affected Senate authorizations, with minor exceptions.

The managers are committed to achieving a balanced budget, and intend that all authorizations be considered as part of the levels within the Balanced Budget Act of 1995, if enacted, or any subsequent balanced budget act.

Section 811—House recedes to Senate section 521 with modifications. Total authorization is \$468 million. Funds may be used for, among other purposes, to create a Federal Bureau of Investigation counterterrorism and counterintelligence fund; expand and improve the instructional, operational support, and construction of the Federal Bureau of Investigation academy; and construct an FBI laboratory, provide laboratory examination support.

Section 812—House recedes to Senate sections 522 and section 912 with modifications. Total authorization is \$31 million. Funds may be used to help the Customs Service meet the increased demands occasioned by the enactment of this Act.

Section 813—Senate recedes to House Section 601 with modifications. Total authorization is \$20 million. Funds may be used to help Immigration and Naturalization Service meet the increased demands occasioned by the enactment of this Act, including the purpose of detaining and removing alien terrorists.

Section 814—House recedes to Senate section 524 with modifications. Total authorization is \$172 million. Funds may be used by the Drug Enforcement Administration to fund antiviolenence crime initiatives; fund major violators of Federal antidrug statute initiatives; and enhance or replace the infrastructure of the Drug Enforcement Administration.

Section 815—House recedes to Senate sections 503 and 525, with modifications. Total authorization is \$41 million. Funds may be used by the Department of Justice to hire additional Assistant United States Attorneys, and provide for increased security at facilities housing Federal workers.

This section also increases the maximum reward authority available to the Attorney General for information relating to international terrorists.

Section 816—House recedes to Senate section 526 with modifications. Total authorization is \$30 million. Funds may be used by the Department of the Treasury to augment counterterrorism efforts, augment White House security, and expand Presidential protection activities.

Section 817—House recedes to Senate section 910 with modifications. Total authorization is \$2 million. Funds may be used to help the U.S. Park Police meet the increased demands occasioned by the enactment of this Act.

Section 818—House recedes to Senate Section 911 with modifications. Total authorization is \$41 million. Funds to be used for the activities of the Federal Judiciary, including increased workload of the Federal courts occasioned by the enactment of this Act.

Section 819—Senate recedes to House Section 701 with modifications. Total authorization is \$5 million. Funds to be used to provide grants for specialized training or equipment to enhance the capability of local fire and emergency service departments to respond to terrorist attacks and acts of mass violence.

Section 820—Senate recedes to House Section 702 with modifications. Total authorization is \$20 million. Funds may be used to provide assistance to foreign countries facing an imminent danger of terrorist attack that threatens the national interest of the

United States or puts United States nationals at risk.

Section 821—Senate recedes to House Section 703 with modifications. Total authorization is \$10 million. Funds may be used to develop technologies to combat terrorism.

Section 822—Byrne grant program is modified include a program to develop and implement antiterrorism training programs and to procure equipment for use by local law enforcement authorities. Total authorization is \$100 million.

Section 823—House recedes to Senate Section 527 with modification. This section provides that funding for this subtitle is authorized to be made from the Violent Crime Reduction Trust Fund, established by Title XXXI of the Violent Crime Control and Law Enforcement Act of 1994 (P.L. 103-322).

TITLE IX—MISCELLANEOUS

Section 901—House recedes to Senate Section 622. This section codifies the extension of United States territorial sea, as defined by a 1988 Presidential Proclamation. This area would then be included within the special maritime and territorial jurisdiction of the U.S. for purposes of the criminal law. This section also adopts non-conflicting state law in the territorial sea.

Section 902—House recedes to Senate section 904. This section provides that voter registration cards (or similar documents) will not qualify as proof of U.S. citizenship.

Section 903—Senate recedes to House amendment title XIII. This section provides limitations on fees for representation of defendants in criminal cases.

Section 904—House recedes to Senate section 913. This section provides severability for the provisions of the Act.

HENRY HYDE,
BILL MCCOLLUM,
STEVEN SCHIFF,
STEVE BUYER,
BOB BARR,
CHARLES SCHUMER,

Managers on the Part of the House.

ORRIN G. HATCH,
STROM THURMOND,
ALAN K. SIMPSON,

Managers on the Part of the Senate.

PARTIAL-BIRTH ABORTION BAN ACT—VETO MESSAGE FROM THE PRESIDENT OF THE UNITED STATES (H. DOC. NO. 104-198)

The Speaker pro tempore laid before the House the following veto message from the President of the United States:

To the House of Representatives:

I am returning herewith without any approval H.R. 1833, which would prohibit doctors from performing a certain kind of abortion. I do so because the bill does not allow women to protect themselves from serious threats to their health. By refusing to permit women, in reliance on their doctors' best medical judgment, to use their procedure when their lives are threatened or when their health is put in serious jeopardy, the Congress has fashioned a bill that is consistent neither with the Constitution nor with sound public policy.

I have always believed that the decision to have an abortion generally should be between a woman, her doctor, her conscience, and her God. I support the decision in *Roe v. Wade* pro-

tecting a woman's right to choose, and I believe that the abortions protected by that decision should be safe and rare. Consistent with that decision, I have long opposed late-term abortions except where necessary to protect the life or health of the mother. In fact, as Governor of Arkansas, I signed into law a bill that barred third trimester abortions, with an appropriate exception for life or health.

The procedure described in H.R. 1833 has troubled me deeply, as it has many people. I cannot support use of that procedure on an elective basis, where the abortion is being performed for non-health related reasons and there are equally safe medical procedures available.

There are, however, rare and tragic situations that can occur in a woman's pregnancy in which, in a doctor's medical judgment, the use of this procedure may be necessary to save a woman's life or to protect her against serious injury to her health. In these situations, in which a woman and her family must make an awful choice, the Constitution requires, as it should, that the ability to choose this procedure be protected.

In the past several months, I have heard from women who desperately wanted to have their babies, who were devastated to learn that their babies had fatal conditions and would not live, who wanted anything other than an abortion, but who were advised by their doctors that this procedure was their best chance to avert the risk of death or grave harm which, in some cases, would have included an inability to ever bear children again. For these women, this was not about choice—not about deciding against having a child. These babies were certain to perish before, during or shortly after birth, and the only question was how much grave damage was going to be done to the woman.

I cannot sign H.R. 1833, as passed, because it fails to protect women in such dire circumstances—because by treating doctors who perform the procedure in these tragic cases as criminals, the bill poses a danger of serious harm to women. This bill, in curtailing the ability of women and their doctors to choose the procedure for sound medical reasons, violates the constitutional command that any law regulating abortion protect both the life and the health of the woman. The bill's overbroad criminal prohibition risks that women will suffer serious injury.

That is why I implored Congress to add an exemption for the small number of compelling cases where selection of the procedure, in the medical judgment of the attending physician, was necessary to preserve the life of the woman or avert serious adverse consequences to her health. The life exception in the current bill only covers cases where the doctor believes that the woman will die. It fails to cover cases where, absent the procedure, serious physical harm, often including losing the ability to have more children,

is very likely to occur. I told Congress that I would sign H.R. 1833 if it were amended to add an exception for serious health consequences. A bill amended in this way would strike a proper balance, remedying the constitutional and human defect of H.R. 1833. If such a bill were presented to me, I would sign it now.

I understand the desire to eliminate the use of a procedure that appears inhumane. But to eliminate it without taking into consideration the rare and tragic circumstances in which its use may be necessary would be even more inhumane.

The Congress chose not to adopt the sensible and constitutionally appropriate proposal I made, instead leaving women unprotected against serious health risks. As a result of this Congressional indifference to women's health, I cannot, in good conscience and consistent with my responsibility to uphold the law, sign this legislation.

WILLIAM J. CLINTON.

THE WHITE HOUSE, April 10, 1996.

The SPEAKER pro tempore. The objections of the President will be spread at large upon the Journal, and the message and the bill will be printed as a House document.

Mr. CANADY of Florida. Mr. Speaker, I ask unanimous consent that the message of the President and the bill be referred to the Committee on the Judiciary.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Florida?

There was no objection.

APPROVING REGULATIONS TO IMPLEMENT THE CONGRESSIONAL ACCOUNTABILITY ACT OF 1995 WITH RESPECT TO EMPLOYEES OF THE HOUSE OF REPRESENTATIVES

Mr. THOMAS. Mr. Speaker, I move to suspend the rules and agree to the resolution (H. Res. 400) approving regulations to implement the Congressional Accountability Act of 1995 with respect to employing offices and covered employees of the House of Representatives.

The Clerk read as follows:

H. RES. 400

Resolved,

SECTION 1. APPROVAL OF REGULATIONS.

(a) IN GENERAL.—The regulations listed in subsection (b) are hereby approved, insofar as such regulations apply to employing offices and covered employees of the House of Representatives.

(b) REGULATIONS APPROVED.—The regulations referred to in subsection (a) are the following regulations issued by the Office of Compliance on January 22, 1996, as published in the Congressional Record on January 22, 1996 (Volume 142, daily edition), each beginning on the page indicated:

(1) Regulation on rights and protections under the Family and Medical Leave Act of 1993, page S200.

(2) Regulation on rights and protections under the Fair Labor Standards Act of 1938, page S273.

(3) Regulation on use of lie detector tests by the Capitol Police, page S261.

(4) Regulation on rights and protections under the Employee Polygraph Protection Act of 1988, page S263.

(5) Regulation on rights and protections under the Worker Adjustment and Retraining Notification Act, page S271.

The SPEAKER pro tempore. The gentleman from California [Mr. THOMAS] and the gentleman from California [Mr. FAZIO] each will be recognized for 20 minutes.

The Chair recognizes the gentleman from California [Mr. THOMAS].

Mr. THOMAS. Mr. Speaker, I yield such time as he may consume to the gentleman from Pennsylvania [Mr. GOODLING], the chairman of the Committee on Economic and Educational Opportunities.

(Mr. GOODLING asked and was given permission to revise and extend his remarks.)

Mr. GOODLING. I thank the gentleman for yielding this time to me.

Mr. Speaker, I rise in support of the resolution before us with regard to congressional coverage.

While largely ministerial, they represent one more important step in bringing ourselves under the workplace laws we have long imposed, often too cavalierly in my view, on other employees.

Let me just say that I still occasionally express some wonderment that this day is finally here. The Congressional Accountability Act regulations represent the culmination of a several-year process in the Opportunities Committee in which the now-majority party repeatedly attempted to extend the laws of the workplace to our own employees, with proper enforcement mechanisms including access to the courts with jury trials.

Enactment of the Congressional Accountability Act, like the unfunded mandate legislation which was also enacted this Congress, has created a long-needed institutional brake—a yellow flag—on the passage of laws this institution too easily imposed in the past on all other workplaces while exempting itself. As importantly, the law finally extended the same workplace protections other workers have to our own employees. While these laws are not perfect there is no reason why our workers should be under different standards. And now that we are forced to comply with these laws, we will learn from experience and better identify with problems of compliance endured by our constituents. In fact, I can guarantee it. Proposals for future workplace requirements and reform of existing laws will gather a lot closer attention by every member of the Opportunities Committee and the House. And it's about time.

True, the protections of some laws had been applied in the past to the House, but the protections were hollow because employees never had the same right to court enforcement that their counterparts in the private sector and the executive branch enjoyed. And there were no signs there would ever be such enforcement! Indeed, as recently as 1991 when I had CRS do an analysis of the issue, we were still arguing over whether court enforcement posed constitutional concerns. Fortunately, that analysis, which found there were not significant concerns, growing public awareness over the double standard enjoyed by

Congress, and, most importantly, the outcome of the last election, brought us here today. Yes, the issue is now bipartisan, and I am glad it is, but it is clear that real—truly effective—congressional coverage was the result of the last election. We've come a long way in a year's time.

Indeed, the only shadow cast over today is that it took so long in coming. As I have noted in the past, the irony of Congress in exempting itself from the laws it imposed on others is so obvious that one wonders how it so long escaped criticism. But I am gratified that those of us who long fought for strong congressional coverage enforcement now have amply company.

The first House resolution before us, House Resolution 400, simply provides for approval of the regulations issued by the Office of Compliance, including those under the Fair Labor Standards Act and the Family and Medical Leave Act, as applicable to House employees.

After we proceed with this resolution, we will take up House Resolution 401 which provides for educational assistance by the Office of Compliance by employees who are not involved in deciding cases, and only to the same extent as such assistance is provided by the Department of Labor to the employers it regulates. The resolution also provides for a settlement procedure to ensure that taxpayer funds are protected from abuse.

Last, we will take up Senate Concurrent Resolution 51, already passed by the Senate, applying the regulations issued by the Office of Compliance to certain of the so-called instrumentalities of the House and Senate. These are offices administered by both the House and the Senate—such as the Congressional Budget Office, the Architect of the Capitol, and the Capitol Police—and, therefore, have to be covered through a concurrent resolution.

Mr. Speaker, I support these resolutions.

Mr. THOMAS. Mr. Speaker, I yield myself such time as I may consume.

(Mr. THOMAS asked and was given permission to revise and extend his remarks.)

Mr. THOMAS. Mr. Speaker, the Congressional Accountability Act—Public Law 104-1—became effective on January 23, 1996. This law created the Office of Compliance, an independent office within the legislative branch, which is responsible for educating Congressional offices on how to comply with the laws made applicable to the Congress, as well as for providing a procedure for resolution of employee grievances, and for adopting regulations to implement these laws. These regulations must be approved by the House.

The Board of Directors of the Office of Compliance adopted regulations which were published in the CONGRESSIONAL RECORD on January 22, 1996. In anticipation of these regulations, on December 19, 1995, the House agreed to House Resolution 31 and House Concurrent Resolution 123, which provided for provisional approval of these regulations until the Committees of jurisdiction could review them and make a final recommendation to the House.

MEMBER PROFILES

SEP

**HOUSE GOVERNMENT REFORM AND OVERSIGHT
SUBCOMMITTEE ON HUMAN RESOURCES
AND INTERGOVERNMENTAL RELATIONS**

Christopher Shays (R-CT), Chairman

Edolphus Towns (D-NY), Ranking Member

Mark Souder (R-IN) Vice Chairman

Tom Lantos (D-CA)

Steven Schiff (R-NM)

Bernard Sanders (I-VT)

Constance Morella (R-MD)

Thomas Barrett (D-WI)

Thomas Davis (R-VA)

Gene Green (D-TX)

Dick Chrysler (R-MI)

Chaka Fattah (D-PA)

William Martini (R-NJ)

Henry Waxman (D-CA)

Joe Scarborough (R-FL)

Marshall "Mark" Sanford (R-SC)

Chairman William Clinger (R-PA), Chairman of the House Government Reform and Oversight Committee

POLITICAL PROFILE

Representative Christopher Shays is the Chairman of the Government Reform and Oversight Subcommittee on Human Resources and Intergovernmental Relations. He is one of only a few Republican members of the Committee who represents an urban district (Bridgeport), and he is viewed as a moderate Republican, especially when dealing with environmental and social issues. For example, Representative Shays supports parental leave and abortion rights. However, when it comes to Federal spending, he is more conservative than many of his fellow Republicans and takes a hard line in support of deficit reduction.

Representative Shays is also a member of the Budget Committee, and has repeatedly proposed alternative budgets and individual amendments to make specific spending cuts. He was a leading author of both the 1993 and 1994 Republican Budget alternatives, as well as the Penny-Kasich amendment. In 1994, Representative Shays was listed at the "most fiscally responsible" member of the House of Representatives by the Concord Coalition (headed by former Senators Warren Rudman and Paul Tsongas). He was the only member of the House to earn a 100 percent score from the Coalition.

According to a recent *National Journal* article, Representative Shays "has become a true believer in Newt Gingrich and a leading player in his 'working group' of advisors." Representative Shays worked closely with Representative Armey and others in developing the *Contract with America*." He worked for two years to gain bipartisan support for a bill that would apply to Congress many laws regulating the private workplace, and this legislation (H.R. 1, Shays) was included in the Contract and passed by both the House and the Senate and signed into law (P.L. 104-1). While he did not prevail in keeping term limits out of the *Contract*, he successfully argued that sensitive social issues, such as abortion and school prayer be left out.

Representative Christopher Shays (R-CT) 4th



Born:	10/18/45, Stamford, CT
Education:	Principia College, B.A.; NYU, M.B.A., M.P.A.
Military:	None
Prev. Occup:	Real estate broker
Family:	Wife, Betsi; 1 child
Religion:	Christian Scientist
Pol. Career:	CT House, 1975-87; Republican candidate for mayor of Stamford, 1983
Elected:	1987
Residence:	Stamford
Committees:	Budget, Government Operations

Representative Shays turned down a likely seat on the Appropriations Committee, preferring the chairmanship of the Subcommittee on Human Resources and Intergovernmental Relations. According to the *National Journal*, he "plans to seek major savings in such departments as Health and Human Services and Housing and Urban Development."

LEGISLATIVE INTERESTS

104th: In addition to sponsoring the Congressional Accountability Act of 1995 (H.R. 1), Representative Shays has co-sponsored a number of the "Contract With America" bills, including the Line-Item Veto Act (H.R. 2, Clinger), a constitutional amendment for a balanced budget (H.J.Res. 1, Barton), and the Unfunded Mandate Reform Act (H.R. 5, Clinger). He has also co-sponsored three other "Contract" bills that have an impact on seniors and health care: The American Dream Restoration Act (H.R. 6, Crane) permits the use of IRA funds for medical expenses, including the purchase of long-term care insurance. The Senior Citizens Equity Act (H.R. 8, Bunning) lowers the taxes seniors would pay on Social Security benefits and increases the amount of income subject to the earnings tax. H.R. 8 also clarifies the tax treatment of long-term care insurance. The Family Reinforcement Act (H.R. 11, Vucanovich) gives a \$500 tax credit to families caring for a family member at home.

103rd: Representative Shays has co-sponsored H.R. 3080, the House Republican leadership's health care reform bill as well as H.R. 3222, the Cooper managed competition bill. He has also co-sponsored the Family and Medical Leave Act of 1993 (P.L. 103-3); and the NIH Reauthorization (H.R. 4, Waxman).

Again, I want to thank you for participating with that. I also know that this is not just one-sided, it is not a partisan view. Republicans and Democrats have an interest in this, to prevent teenage pregnancy, and I am delighted that my colleague CHRIS SHAYS, the gentleman from Connecticut, is joining me, and welcome your participation.

Mr. SHAYS. I am grateful to have this opportunity. Congresswoman CLAYTON, to participate in this very important dialog, and to salute you for your taking the leadership and making sure that we as a Congress begin to confront what is an extraordinarily serious problem for our country.

I am here to salute you, to participate in this issue, and also to compliment and to praise the President for establishing the National Campaign to Reduce Teen Pregnancy. I know that you circulated a letter, which I would like to read later in this special order. But first to tell you that as someone who is chairing the Committee on Human Resources and Intergovernmental Relations, we are going to be having a hearing on this issue and will obviously be inviting you to help lead that off.

It is incredible, the more I get into it, and candidly, I have not spent the kind of time that I should have, but to think that up to 1 million teenagers become pregnant in the United States, and that 85 percent of those pregnancies are unplanned and that the vast majority of mothers are simply unmarried, to think that teenage mothers are more likely to be impoverished, go on welfare and never finish school, to think what kind of future they have for themselves and the promise that they have for their children who they grow to love dearly.

I think probably more than anything else in my own childhood, what I value the most was that my parents taught me to dream, but my dreams were realistic. I mean, I really felt I could meet those dreams. It is hard for me to understand how a pregnant teenager, a young 15-year-old or 14-year-old who is giving birth is able to think of dreams that get that individual, get her out of the welfare cycle and get her the opportunity to think of being able to live what the American dream is, to think of what it must be like for her children.

□ 2145

I am stunned by the statistics that say that adult males are the fathers of approximately 66 percent of babies born to teenage girls. I am talking about adults impregnating young kids, the thought that, according to the U.S. New and World Report, that 65 percent of teenage mothers are unmarried, up from 48 percent in 1980 and that, most importantly, that 39 percent of 15-year-old mothers say the father of their babies are 20 years or older. Fifteen-year-old kids.

I have a 16-year-old daughter, and it is hard for me to comprehend a 15-year-

old daughter, and it is hard for me to comprehend a 15-year-old young girl describing the fact that nearly 40 percent of these young girls are saying that they were impregnated by 20-year-olds or older, and for 17-year-old mothers, 55 percent of the fathers are adults, and for 19-year-olds, 78 percent are the fathers, are adults who have been involved in this relationship.

You sent a letter that you circulated, and hundreds of Members of Congress signed this letter, and I would love to read this letter for the RECORD. You drafted this letter to President Clinton. You said:

"Dear President Clinton, we write to applaud your efforts and those who have agreed to serve in the bipartisan National Campaign to Reduce Teenage Pregnancy. The mission of the National Campaign," quote, 'to reduce teenage pregnancy by supporting values and stimulating actions that are consistent with a pregnancy-free adolescence is,' end of quote, "one that each of us supports, and the goal to," quote, 'reduce the teenage pregnancy rate by one-third by the year 2005' is one that each of us endorses."

We are trying to reduce the pregnancy rate in the next 10 years by one-third. It seems to me obviously like a goal that all Americans could unite behind.

You go on in your letter to say: "The increase in out-of-wedlock childbearing is alarming. Even more alarming is the vicious cycle into which pregnant teenagers are thrust. The young women, as well as the young men, who become teen parents have few expectations, few ties to community institutions, few adult mentors and role models, and little hope. Many live in communities where crime and drug use are common and where dropping out of school and chronic unemployment are even more common. This is a very costly human burden for our society."

You then go on to say: "In addition, teenage pregnancies cause a heavy burden on the federal budget, especially Medicaid funds, one of the elements of the budget that is spiraling. Food stamps and AFDC funds are also taxed by these young people is the dawn of their lives. Indeed, teen pregnancy is a strong predictor of a new generation of disadvantaged. As poverty is the most accurate predictor of teen pregnancy, teen pregnancy is a near certain predictor of poverty."

Your letter then goes on in three more paragraphs:

"We believe the approach to this problem that will be undertaken by the National Campaign is correct. It is critical that this Nation first take a clear stand against teen pregnancy and, in doing so, attract the interest of more national leaders and organizations. Enlisting the support of the national media in supporting and stimulating State and local action are necessary steps in the effort to reduce teen pregnancy. These and other activities will help to foster a national discussion

about how religion, culture, and public values influence both teen pregnancy and the responses to this dilemma. But most importantly we believe the intent of the National Campaign to strengthen the knowledge base, to educate, will be invaluable."

And your last paragraph: "The National Campaign to Reduce Teenage Pregnancy should not be bound by politics, party or philosophy. The situation is urgent. By our endorsement of this letter, please note that we stand behind you in the National Campaign. The goal is ambitious, but it is within our reach."

And I would just salute the President for his establishment of this committee, the appointment of Dr. Henry W. Foster, Jr., as the senior adviser. He will be coming before our committee to begin that hearing, and we are grateful for his participation and for the non-partisan approach which the President took in naming former Senator Warren Rudman, a Republican from New Hampshire, the former New Jersey Governor, Thomas Kean, a Republican from New Jersey, obviously, and the former Surgeon General, Everett Koop, actress Whoopi Goldberg, MTV President Judy McGrath, chairman of the executive committee of the Washington Post, Katherine Graham. I mean this is a distinguished committee and one which I salute the President for forming.

And again, I thank you for giving the opportunity to, one, take a stand on this issue, to announce that our committee, because of your work and the work of others, will be holding hearings to alert the Nation of this nearly desperate problem and to hope that we, as American citizens, can do a better job of helping to have our young kids, our young kids, have dreams and hopes and to let them know that they can always be parents, they can always have a child. They just do not need to have a child when they are in school. They can grow to lead blessed lives, and they can grow to mature as individuals before they then try to help a young person grow as well.

Kids raising kids is kind of insane, and it is, I think, that history will look back on our generation, look back on Congress, look back on the White House, not just this White House and this Congress, but for the last few years and the last few presidencies, and say we were really asleep when we should have been awake. I thank you for this opportunity.

Mrs. CLAYTON. I want to thank the gentleman for his very important remarks, but also for his important announcement that his committee is going to have hearings on this subject which I think is going to be substantial, adding to the debate in that you will bring out a myriad of problems. One of the problems you identified indeed is adult males having some liability and responsibility for this whole problem, and we have not been focusing on that. So I am looking forward for the deliberation and thoughtfulness.

POLITICAL PROFILE

Elected in 1994, Representative Mark Souder, a Republican, started out in his Amish family business 10 miles outside Fort Wayne, Souder's of Grabill, originally a harness shop and now a furniture store and manufacturer of store fixtures.

In the House, Souder was elected vice president of the freshman class and became one of its more outspoken advocates of change. He voted against the balanced budget amendment, stating that "without a tax limitation provision . . . I'm skeptical of the spending cuts and certain of the tax hikes."

In 1984 Souder went to work for then-Congressman Dan Coats, as minority staff director of the Select Committee on Children, Youth and Families in Grabill. In 1993 he returned to Fort Wayne and started running against Democratic Incumbent Jill Long. In the 1994 election Souder, who easily won the six-candidate Republican primary with 40% of the vote, beat Long in the general election with a 55%-44% victory.

LEGISLATIVE INTERESTS

104th: Representative Souder has co-sponsored the ERISA Targeted Health Insurance Reform Act of 1995 (H.R. 995, Fawell); Targeted Individual Health Insurance Reform Act of 1995 (H.R. 996 by Fawell); Medical Procedures Innovation and Affordability Act (H.R. 1127, by Ganske); Newborn Infant HIV Notification Act (H.R. 1289, Ackerman); Family Medical Savings and Investment Act of 1995 (H.R. 1818, Archer); Partial-Birth Abortion Ban Act of 1995 (H.R. 1833, by Canady); Safety and Health Improvement and Regulatory Reform Act of 1995 (H.R. 1834, Ballenger); Regulation of Tobacco Products or Advertising Used by the National Association of Stock Car Automobile Racing (H.R. 2265, Funderburk); Health Care

Representative Mark Edward Souder (R-IN) 4th



Born:	7/18/59, Fort Wayne, IN
Education:	IN University, B.S.; Notre Dame U., M.B.A.
Military:	None
Family:	Married
Religion:	Protestant
Pol. Career:	Legis. Dir., U.S. Sen. Dan Coats, 1989-91, Dep. COS, 1991-93. Staff Director, U.S. House Select Committee on Children, Youth & Families, 1984-89; General Store Owner
Elected:	1994
Residence:	Grabill, IN
Committees:	Economic & Ed Opprtunities (Early Childhood, Youth and Families); Government Reform & Oversight (Human Resources & Intergovernmental Affairs); Small Business

Fraud and Abuse Prevention Act of 1995 (H.R. 2326, Schiff); FEHBP - Medical Savings Account Promotion Act of 1995 (H.R. 2341, Salmon); and Self-Employed Health Fairness Act (H.R. 2435, Kelly).

POLITICAL PROFILE

As the new chairman of the Science Committee's Basic Research Subcommittee in the 104th Congress, Representative Steven Schiff is in a position to shape federal spending priorities in an area of considerable interest to his scientifically-inclined district. The 1st is home to Sandia National Laboratories, a nuclear and solar research and testing center, along with other high-technology concerns.

Representative Schiff tends to go where his sense of right and wrong take him, regardless of politics. He is pro-choice on abortion, but believes the Freedom of Choice Act goes too far. He wrote an amendment allowing 16-and 17 year-olds accused of violent federal crimes to be tried as adults.

Representative Schiff is a native of Chicago who came to Albuquerque to attend law school; he is Jewish in a state made up mostly of Anglo Protestants and Hispanic Catholics. Schiff has served in the New Mexico Air National Guard, and is now a lieutenant colonel in the Air Force Reserves. After law school, he became a prosecutor and, after a few years of private practice, in 1980 was elected district attorney of Albuquerque's Bernalillo County.

Representative Steven H. Schiff (R-NM) 1st



Born:	3/18/47, Chicago, Illinois
Education:	University of Illinois, B.A.; University of New Mexico Law School, J.D.
Military:	Air Natl. Guard, 1969-91; Air Force Reserves, 1991- present
Prev. Occup:	Attorney
Family:	Marcia, 2 children
Religion:	Jewish
Pol Career:	None
Elected:	1989
Residence:	Albuquerque
Committees:	Government & Oversight; (Human Resources and Intergovernmental Affairs; National Security: (Intn'l. Affairs and Criminal Justice); Judiciary: (Crime); Science: (Basic Research-Chmn); Energy and Environment; Standards of Official Conduct.

LEGISLATIVE INTERESTS

104th:

Representative Schiff has sponsored the Health Care Fraud and Abuse Prevention Act of 1995 (H.R. 2326). He has co-sponsored the Unfunded Mandate Reform Act (H.R. 5, Clinger); the Interstate Child Support Act of 1995 (H.R. 95, Kennelly); a bill to retroactively restore and make permanent the limited deduction for the health insurance costs of self-employed individuals (H.R. 442, Meyers); a bill to permit Medicare select policies to be offered in all states (H.R. 483, Johnson); the Social Security Trust Funds Integrity Act of 1995 (H.R. 491, Solomon); the Child Care Availability Incentive Act (H.R. 881, Pryce); the Newborn Infant HIV Notification Act (H.R. 1289, Ackerman); and the Antitrust Health Care Advancement Act of 1996 (H.R. 2925, Hyde).

103rd:

Representative Schiff co-sponsored the legislation to repeal the Social Security Earnings Test (H.R. 37); the Medicaid Prostrate Screening Act (H.R. 243); the Medicaid Mammography Coverage Act (H.R. 425), H.R. 1130, the Medicare Waste and Fraud Reduction Act (H.R. 1130), the Affordable Health Care Now Act (Michel health reform bill, including insurance and malpractice reform) (H.R. 3080); and the Health Care Anti-Fraud Act (H.R. 3653).

POLITICAL PROFILE

Representative Constance Morella is one of the three or four most liberal Republicans in the House by almost any gauge. Her votes against seven items of the Contract With America were three more than any other Republican.

In the Montgomery County tradition, she takes liberal positions on social issues from abortion rights to gun control to contra aid. She was one of three Republicans to vote against the Gulf war resolution. She is more conservative on economic issues: the 8th district has the second highest median household income of any district in the country (number one is the New Jersey 11th). But she favors more federal funding for early childhood intervention and after-school activities for at-risk kids.

LEGISLATIVE INTERESTS

104th: Representative Morella is the co-sponsor of the Public Health Service Act, Amendment (H.R. 248, Greenwood); the Medicaid Mammography Coverage Act of 1995 (H.R. 777, Vucanovich); the Lupus Research Amendments of 1995 (H.R. 835, Meek); the Medicare Prostate Cancer Screening Act of 1995 (H.R. 779, Vucanovich); the Medicaid Prostate Cancer Screening Act of 1995 (H.R. 780, Vucanovich); the Ricky Ray Hemophilia Relief Fund Act of 1995 (H.R. 1023, Goss); the Long-Term Care Insurance Consumer Protection Act of 1995 (H.R. 1221, Wyden); and, Comprehensive Fetal Alcohol Syndrome Prevention Act (H.R. 1649, Richardson).

103rd: Representative Morella's legislative interests are protecting software produced by federal scientists with limited copyrights and opening more apprenticeships to women and domestic violence issues.

Congresswoman Constance A. Morella (R-MD) 8th



Born:	2/12/31, Somerville, MA
Education:	Boston University, A.B., American University, M.A.
Military:	None
Family:	Husband, Anthony; 9 children
Religion:	Catholic
Pol. Career:	MD House of Delegates, 1979-86.
Elected:	1986
Residence:	Bethesda
Committees:	Government Reform & Oversight; Science.

POLITICAL PROFILE

Representative Thomas M. Davis, formerly chairman of the Fairfax County Board of Supervisors, is the Republican who won the seat in 1994 from Virginia's first woman representative, Democrat Leslie Byrne, who was elected in 1992.

Representative Davis is a moderate Republican. He supports abortion rights in most cases, like rape, incest or when the life of the mother is in danger; he opposes taxpayer-supported school vouchers for private schools. He also supports a ban on certain semiautomatic weapons. However, he opposes raising taxes.

Representative Davis closely allied himself to Senate candidate Oliver North in the campaign, and pushed standard "tough on crime" and anti-regulatory themes. Davis won 53%-45%, a considerable achievement in these straight-ticket times, since Republican Oliver North trailed Democrat Charles Robb in the 11th by 51%-36%.

LEGISLATIVE INTERESTS

104th: Representative Davis is a co-sponsor of the Prostate Cancer Diagnosis and Treatment Act of 1995 (H.R. 1496, Fields); Working Families Health Access Act of 1995 (H.R. 1604, Johnson, Nancy); Comprehensive Fetal Alcohol Syndrome Prevention Act (H.R. 1649, Richardson); Women's Health Office Act of 1995 (H.R. 1736, Morella); FEHBP - Medical Savings Account Promotion Act of 1995 (H.R. 2341, Salmon); Family Medical Savings and Investment Act of 1995 (H.R. 1818, Archer); SSI Disability Benefits Reform Act of 1995 (H.R. 1974, Bass)

Representative Thomas M. Davis, III (R-VA), 11th



Born:	1/05/49, Minot, ND
Education:	University of Virginia, J.D.; Amherst College, B.A.
Military:	Army; National Guard; Army Reserves
Family:	Wife, Peggy; three children
Religion:	Christian Scientist
Pol. Career:	Fairfax County Board of Supervisors, Chairman, 1991-94; Fairfax County Bd of Supervisors, 1980-92.
Elected:	1994
Residence:	Falls Church
Committees:	Government Reform & Oversight (DC-Chairman, Government, Management, Information, & Technology; Human Resources and Intergovernmental Relations); Science (Energy & Environment; Space & Aeronautics

POLITICAL PROFILE

Freshman Representative Dick Chrysler defeated Democrat Bob Mitchell and two minor independent candidates in the general election race to replace Democratic Rep. Bob Carr, who made an unsuccessful bid for the Senate against Republican Spencer Abraham.

The 8th District was the only House seat Michigan Republicans picked up in 1994, leaving state Democrats with a 9 to 7 edge. Michigan's 8th District is evenly balanced between Democrats and Republicans.

After finishing high school, Chrysler went to work on the assembly line at an auto plant. He later founded RCI Inc., which builds state-of-the-art police cars and nickel metal hydride energy cells for electric vehicles. He also founded Cars & Concepts, Livingston County's largest employer.

Chrysler has served as chairman of the Livingston County United Way, president of the Brighton Chamber of Commerce, vice chairman of the Michigan Chamber of Commerce, board member for Michigan National Bank and vice chairman of Cleary College.

LEGISLATIVE INTERESTS

104th: Representative Chrysler cosponsored the Family Self-Sufficiency Act of 1995 (H.R. 4, Shaw); Family Reinforcement Act (Contract with America), (H.R. 11, Vucanovich); Health Insurance Equity Act of 1995 (H.R. 34, Lincoln); Family Medical Savings and Investment Act of 1995 (H.R. 1818, Archer); Safety and Health Improvement and Regulatory Reform Act of 1995 (H.R. 1834, Ballenger); Parental Rights and Responsibilities Act of 1995 (H.R. 1946); Choice in Welfare Tax Credit Act of 1995 (H.R. 2225, Knollenberg); FEHBP - Medical Savings Account Promotion Act of 1995 (H.R. 2341, Salmon); Self-Employed Health Fairness Act (H.R. 2435, Kelly).

Representative Dick Chrysler (R-MI), 8th



Born:	4/29/42, St. Paul, MN
Education:	Brighton, H.S.
Military:	None
Family:	Married, Katie; three children
Religion:	Presbyterian
Pol. Career:	Founder & Pres, RCI, 1993 - present; Founder & Pres., Cars & Concept, 1976-86.
Elected:	1994
Residence:	Brighton
Committees:	Banking & Financial Services; Domestic and International Monetary Policy; General Oversight and Investigations; Government Reform & Oversight; Human Resources and Intergovernmental Affairs; Small Business.

POLITICAL PROFILE

Elected in 1994, Representative Bill Martini defeated Democratic incumbent, Representative Herbert Klein by two percentage points in a costly contest that drew national GOP backing. Martini endured months of negative advertising that labeled him as a wasteful spender. But he responded with ads that blasted Klein for backing President Clinton's "tax and spend" policies.

Representative Martini president of the Nicholas Martini Foundation, a charitable organization started in 1986 by his late uncle. The group, one of the largest private charities in North Jersey, supports the arts and programs in education, health care and community service.

LEGISLATIVE INTERESTS

104th: Representative Martini is a co-sponsor of the Newborn Infant HIV Notification Act (H.R. 1289, Ackerman); Orphan Drug Tax Credit Amendments of 1995 (H.R. 1566, Johnson, Nancy); Newborns' and Mothers' Health Protection Act of 1995 (H.R. 1950, Pallone).

Representative Bill Martini (R-NJ), 8th



Born: 2/10/47, Passaic, NJ
Education: Villanova University, B.A.; Rutgers University, J.D.
Military: None
Family: Wife, Gloria; two children
Religion: Roman Catholic
Pol. Career: Passaic County freeholder, 1992-95; Clifton County Council, 1990-94; Assistant U.S. Attorney, 1974-77.
Elected: 1994
Residence: Clifton
Committees: Government Reform & Oversight (Human Resources & Intergovernmental Relations); Transportation & Infrastructure (Aviation; Surface Transportation; Water Resources & Environment).

POLITICAL PROFILE

Representative Scarborough, elected in 1994, turned his Christian-conservative views into a successful campaign to win a seat vacated by conservative Democrat Earl Hutto, who retired after 16 years in Congress. He defeated Democratic challenger Vince Whibbs with more than 61 percent of the vote in a conservative district at the southern end of the Bible Belt.

The first district of Florida includes the far northwest counties of the Florida Panhandle. Widely known in the Southeast, scarcely heard of anywhere else, are the Gulf Coast beaches of Florida's Panhandle, from Pensacola east to Destin. This area has always been part of "Dixie", an expanse of swamp and low farmland, and heavily dependent on the military.

More than 1,000 miles from Miami, the Panhandle is economically, culturally and politically far from most of Florida. Culturally, it is very conservative, an area of large families and traditional churches. It also has violent anti-abortion extremists, two of whom murdered doctors who performed abortions in March 1993 and July 1994.

Representative Scarborough, a friend of the family of Michael Griffin, the man convicted of the March 1993 shooting of Dr. David Gunn, tried to sign on as Griffin's attorney, but the judge said he lacked the criminal law experience necessary for the case. During his campaign he promised to fight for pro-life legislation, but now says he believes the federal government should keep out of the abortion debate -- leaving it to the discretion of individual states to legislate regulations governing the procedure if they choose.

Representative Scarborough, 31 in 1994, grew up in Pensacola. After college and law school, he ran a beauty contest company and then practiced law and was active in community affairs. During the campaign, he was described as a popular, easygoing but aggressive campaigner whose fundamental views on politics, religion and family values had wide appeal in Panhandle communities.

Representative Joe Scarborough (R-FL) 1st



Born:	April 9, 1963
Education:	Univ. of Alabama, B.A., 1985; Univ. of Florida, J.D., 1990
Military:	None
Prev. Occup:	Practicing attorney
Family:	Wife (Melanie)
Religion:	Baptist
Pol. Career:	None previous
Elected:	1994
Residence:	Pensacola
Committees:	Government Reform and Oversight, National Security

(In 1994, Representative Scarborough won his election by a huge margin: 62%-38%. In the House he has been one of the most enthusiastic backers of the Contract With America. He has been a frequent speaker on the House floor, eager to defend the new Republican majority and its program, even at the risk of doing rhetorical battle with more experienced Democrats. Assuming he can avoid a primary, he should be able to hold this seat comfortably.

LEGISLATIVE INTERESTS

Representative Scarborough has introduced one bill, H.R. 1883, the Back to Basics Education Reform Act, a bill to abolish the Department of Education. He has co-sponsored only a few health-related bills, including: the Family Medical Savings and Investment Act of 1995 (H.R. 1818, Archer); and the Partial-Birth Abortion Ban Act of 1995 (H.R. 1833, Canady).

POLITICAL PROFILE

Representative Sanford ran a classic "outsider" campaign for the seat of retiring Republican Representative Arthur Ravenel Jr., refusing PAC contributions and demanding term limits. He emphasized both his business experience and political inexperience in his pitch to voters. He ran as a conservative, though he supports a woman's right to choose abortion, with some reservations.

The 1st Congressional district of South Carolina, as designed in 1992, is the Charleston and Low Country district. It includes the old houses of the Battery of Charleston and the beachfront and affluent suburbs strung out on high ground in all directions. About two-thirds of the voters are in metropolitan Charleston. It is a solidly Republican district, so when incumbent Representative Arthur Ravenel ran for governor in 1994, it was clear the next Representative would be chosen in the Republican primary.

It also seemed fairly clear at the outset who that person would be--Van Hipp, Republican state chairman in 1987. Hipp led the primary with 31% of the vote; Mendel Rivers, Jr., son of the former congressman, got only 12%; former state Highway Commissioner Bob Harrell and state Senator Mike Rose ran just five votes apart, with 17% each. A little more than 1,000 votes ahead, with 19% of the vote, was the previously unknown Mark Sanford. At 34, he was two years older than Hipp, but had never run for office or worked in politics. He was a successful real estate developer. He called for term limits and cutting the deficit; he pledged to serve only three terms, to take no PAC money, to vote for no tax increases and to refuse any salary increase until the budget was balanced. The outcome was close, but with 55% in Charleston County, Sanford won the runoff 52%-48%.

Representative Marshall Sanford (R-SC) 1st



Born:	May 28, 1960
Education:	Furman Univ., B.A., 1983; Univ. of VA, MBA, 1988
Military:	None
Prev. Occup:	Owner, Norton & Sanford real estate investment firm
Family:	Spouse (Jenny)
Religion:	Episcopalian
Pol. Career:	None previous
Elected:	1994
Residence:	Charleston
Committees:	Government Reform and Oversight; International Relations; Joint Economic Committee

Arguing that Congressional experience is overrated, Sanford has said, "It's not like we're dealing with brain surgery." In Washington, he sleeps in his office rather than finding other local accommodations. "From a practical standpoint, you save a lot of time," Sanford explains. From a philosophical standpoint, it's less comfortable. The whole idea of getting up in the morning and walking three flights of stairs with your shampoo is not exactly the greatest, and I think the discomfort level is important, because it makes you all that much more anxious to head home."

LEGISLATIVE INTERESTS

104th:

Congressman Sanford is a firm supporter of the Contract with America. He has not sponsored any legislation. He has co-sponsored health bill: the Medical Procedures Innovation and Affordability Act (H.R. 1127, Ganske); the Antitrust Health Care Advancement Act of 1996 (H.R. 2925, Hyde). He has also co-sponsored a bill to retroactively restore and make permanent the limited deduction for the health insurance costs of self-employed individuals (H.R. 442, Meyers); and a bill to provide for hearing care services by audiologists to federal civilian employees (H.R. 1057, Gilman).

POLITICAL PROFILE

Representative Edolphus Towns is secure in his Brooklyn district which is overwhelmingly black and Hispanic and very poor. He is strongly liberal. He is the past chairman of the Congressional Black Caucus from 1991-92.

Representative Towns, a member of the Commerce Committee, is also the former chairman of the Human Resources and Intergovernmental Relations Subcommittee of the Government Operations Committee. During his tenure as chair, he pushed the FDA for more stringent enforcement of drug laws and regulations. He is very supportive of regulations that effect the quality of and increase the blood supply in America.

During the 103rd Congress he made affordable and universal/single-payer health care access his top priorities. Representative Towns has been a advocate of improving training opportunities for prospective minority physicians; equalizing quality of medical service in urban/rural communities; and ensuring that women's health concerns are protected.

Representative Edolphus Towns (D-NY) 11th



Born: 7/21/34, Chadbourn, NC
Education: North Carolina A&T U., B.S.; Adelphi U., M.S.W.
Military: Army 1956-58
Prev. Occup: Professor, hospital administrator
Family: Gwendolyn Forbes; 2 children
Religion: Independent Baptist
Pol. Career: Deputy Brooklyn borough president 1976-82 (appointed)
Elected: 1982 [Re-election: 1994]
Residence: Brooklyn
Committees: Commerce (Health & Environment; Telecommunications & Finance); Government Reform & Oversight (Human Resources & Intergovernmental Relations).

LEGISLATIVE INTERESTS

104th: Representative Towns is the sponsor of the Comprehensive Health Access District Act (H.R. 381); Primary Care Health Practitioner Incentive Act of 1995 (H.R. 1750); Health Fraud and Abuse Act of 1995 (H.R. 1850). He is also a co-sponsor of the Ricky Ray Hemophilia Relief Fund Act of 1995 (H.R. 1023 by Goss); American Health Security Act of 1995 (H.R. 1200 by McDermott); Newborn Infant HIV Notification Act (H.R. 1289 by Ackerman); Health Care Fraud and Abuse Prevention Act of 1995 (H.R. 2326 By Schiff); Ryan White CARE Act Amendments of 1995 (H.R. 1872 By Bilirakis); and, Medicare Mental Health Improvement Act of 1995 (H.R. 1456 By Stark).

103rd: Representative Towns sponsored the Primary Care Health Practitioner Incentive Act of 1993 (H.R. 2386); Physician Assistant Incentive Act of 1993 (H.R.2387); and, the Comprehensive Health Access District Act (H.R. 4294). He also co-sponsored the House "single-payor" bill to provide health care for every American and to control the costs of the health care system (McDermott, H.R. 1200). Representative Towns co-sponsored the Comprehensive Childhood Immunization Now Act of 1993 (Waxman, H.R. 940).

POLITICAL PROFILE

Representative Tom Lantos, has several distinctions, but none more important than the fact that he is one of the few members of Congress with personal experience living under tyranny. Congressman Lantos was born in Hungary and as a teenager fought in the underground against the Nazis; he was one of the Jews saved by Swedish diplomat Raoul Wallenberg.

Representative Lantos has spent much of his time in the House on foreign policy. He founded the Congressional Human Rights Caucus, focusing on Communist regimes as well as the right-wing dictatorships other liberal Democrats denounced. Lantos conducted high-publicity hearings on labor law violations by Food Lion and Jack-in-the-Box on his Government Operations subcommittee investigations. He was a founder of the Congressional Friends of Animals Caucus.

He has by far the most moderate voting record of Bay Area Democrats and since 1984 has been reelected easily. Redistricting helped by moving the district north into even more Democratic territory.

Representative Tom Lantos (D-CA), 12th



Born:	2/1/28, Budapest, Hungary
Education:	Univ. of California, Ph.D.; Univ. of WA, B.A., MA.
Military:	None
Family:	Wife, Annette; two children
Religion:	Jewish
Pol. Career:	Millbrae Board of Education, 1958-66
Elected:	1988
Residence:	Burlingame
Committees:	Government Reform & Oversight (Human Resources & Intergovernmental Relations; National Security, International Affairs & Criminal Justice); Internatn'l Relations (Internatn'l Operations & Human Rights - ranking member; Western Hemisphere).

LEGISLATIVE INTERESTS

104th:

Representative Lantos has co-sponsored the Women's Right to Know Act of 1995 (H.R. 641, Schroeder); Ricky Ray Hemophilia Relief Fund Act of 1995 (H.R. 1023, Goss); Newborn Infant HIV Notification Act (H.R. 1289, Ackerman); Morris K. Udall Parkinson's Research, Assistance and Education Act of 1995 (H.R. 1462, Waxman); and the Ryan White CARE Act Amendments of 1995 (H.R. 1872, Bilirakis).

POLITICAL PROFILE

Representative Barrett was elected to the House in 1992. After spending nearly a decade in the Wisconsin legislature, Representative Barrett earned a reputation as a dogged lawmaker. He was elected to the state house in 1984 at age 30; four years later he won a huge margin in a primary and was elected to the state Senate.

Representative Barrett and fellow Democrat Representative Louise Slaughter offered an amendment in February 1995 to a line-item veto bill that was identical to a proposal introduced in 1993 by then-Republican-leader Michel. The Representative tweaked the new majority, by offering House Republicans the "first opportunity" to go against their party and "do the right thing". But even though House Republicans had supported it unanimously two years before, only eight voted for it in 1995.

Representative Barrett represents the most liberal district in a liberal state, so he is a reliable vote for the Democratic party. In 1994, He won by more than a 2-to-1 margin over his Republican challenger.

LEGISLATIVE INTERESTS

104th: Representative Barrett has not introduced any health care legislation, but he has co-sponsored several health bills, including: the Newborn Infant HIV Notification Act (H.R. 1289, Ackerman); the Health Care Fraud Prosecution Act of 1995 (H.R. 1758, DeLauro); and the Ryan White CARE act Amendments (H.R. 1872, Bilirakis).

103rd: Representative Barrett was a cosponsor of the President's Health Security Act (H.R. 3600). He voted for the Family Leave Act, the deficit Reduction package and the Economic stimulus plan.

Representative Thomas Barrett (D-WI) 5th



Born:	12/8/53
Education:	U. of WI, B.A. 1976, J.D. 1980
Military:	None
Prev. Occup:	FDIC bank examiner, 1977; Law Clerk, Fed. Dist. Judge Robert Warren 1980- 1982; Atty., 1982- 1984; WI Assembly, 1984-1988; WI Senate, 1988-1992.
Family:	Wife, Kristine
Religion:	Catholic
Pol. Career:	WI Assembly, 1984- 88; WI Senate, 1988- 92
Elected:	1992
Residence:	Milwaukee
Committees:	Banking and Financial Services, Government Reform and Oversight.

POLITICAL PROFILE

Representative Gene Green represents Texas's 29th District, which is a Hispanic-majority district. In 1994 the freshman Anglo in the majority-Hispanic district increased his 1992 winning margin in a year when Democrats elsewhere in the state found themselves in trouble.

Representative Green was first elected to the Texas House in 1973 and served seven terms there before moving to the Texas Senate in 1985. He spent eighteen years in the state legislature supporting labor, teachers' unions, and trial lawyer positions. He switched from anti-abortion to pro-choice before his run for the U.S. House.

Born and raised in Houston, Representative Green is involved in many Houston-area activities including the Chamber of Commerce, Lindale Lions Club and the Gulf Coast Conservation Association.

Green did not co-sponsor any health care reform bills in the 103rd Congress, but stood out during the Education and Labor health care reform mark up as a loyal Democratic vote on tough issues, including the mandate vote. Despite his personal opposition, Green cast the tie-breaking vote for the single payer bill in Committee. He offered two successful amendments, one to aid teachers in obtaining early retirement benefits and another to guarantee diversity in the membership of the National Health Board.

Representative Gene Green (D-TX) 29th



Born:	10/17/47 Houston, TX
Education:	U. of Houston, B.A.; Bates College of Law at U. of Houston
Military:	none
Family:	Wife, Helen
Religion:	Methodist
Pol. Career:	TX House of Reps., 1972- 84; TX Senate, 1984-92
Elected:	1992
Residence:	Houston, TX
Committees:	Economic and Educational Opportunities; Government Reform and Oversight

LEGISLATIVE INTERESTS

104th:

Representative Green has co-sponsored the Health Insurance Equity Act of 1995 (H.R. 34, Lincoln); the Bartlett-Mfume Health Insurance Deductibility Act (H.R. 696, Bartlett); the Interstate Child Support Act of 1995 (H.R. 95, Kennelly); and the Work-First Welfare Reform Act of 1995 (H.R. 315, Lowey).

103rd:

Representative Green did not co-sponsor any key health care reform legislation. He co-sponsored the Secure Assurance for Families Everywhere Act (H.R. 4051, Woolsey); the Work-First Welfare Reform Act of 1994 (H.R. 4126, Lowey); the Independence for Families Act of 1994 (H.R. 4414, McCurdy); the Family and Medical Leave Act (P.L. 103-3); the Health Meals for Healthy Americans Act (H.R. 8, Kildee); the Freedom of Choice Act (H.R. 25, Edwards); the Child Support Economic Security Act (H.R. 915, Schroeder); and the Head Start Act Amendments (H.R. 3842, Martinez).

POLITICAL PROFILE

Representative Chaka Fattah won his first term in the House of Representatives by defeating incumbent Representative Lucien Blackwell (D-PA) in the Pennsylvania primary in 1994, and went on to win the 2nd Congressional District seat in November. The Second District, which includes all of West Philadelphia, parts of North and South Philadelphia, and three (3) boroughs in mostly suburban Delaware County, was represented from 1978 to 1991 by former Representative William (Bill) Gray, who resigned the seat in 1991.

An experienced legislator prior to his election to the House, Representative Fattah served in both the Pennsylvania State Senate (1988-1994) and the State House of Representatives (1982-88). The Fattah family, mother and son, were nationally recognized community activists and leaders on urban issues. In 1990, Representative Fattah led a group of businesses which raised \$34 million to keep the city of Philadelphia solvent, and founded the American Cities Conference and Foundation which convenes a national coalition of urban activists to examine the fiscal, infrastructure and social problems of the nation's cities.

Representative Fattah does not have an extensive record on federal health issues.

LEGISLATIVE INTERESTS

104th: Representative Fattah has co-sponsored a number of health-related bills including the following: H.R. 1200, the American Health Security Act of 1995, sponsored by Representative McDermott; H.R. 449, the Primary Health Care Education Act of 1995; H.R.. 548, the Menopause Outreach, Research, and Education Act of

Representative Chaka Fattah (D-PA) 2nd



Born:	November 21, 1956
Education:	Community College of Pennsylvania, B.A.; University of Pennsylvania, M.G.A.
Military:	None
Family:	Spouse: Patricia Renfro, Three children
Religion:	Baptist
Pol. Career:	PA State Senate, 1988-94; PA House of Representatives, 1982-1988, 1994
Elected:	1994
Residence:	Philadelphia
Committees:	Government Reform and Oversight; Small Business; Democratic Congressional Campaign Committee

1995; H.R. 587 the Biotech Process Patent Protection Act of 1995; H.R. 696, the Bartlett-Mfume Health Insurance Deduction Act; H.R. 1221, the Long-Term Care Insurance Consumer Protection Act of 1995; H.R. 1341, the Disadvantaged Minority Health Improvement Authorization Extension Act of 1995; H.R. 1496, the Prostate Cancer Diagnosis and Treatment Act of 1995; H.R. 1736, the Women's Health Office Act of 1995; H.R. 1758, the Health Care Fraud Prosecutions and Commission Acts of 1995; H.R. 1912, the Health Care Fraud Prevention and Paperwork Reduction Act; and H.R. 1952, the Women's Choice and Reproduction Health Protection Act of 1995.

Representative Fattah opposed H.R. 4, the Personal Responsibility Act. As a state legislator, Representative Fattah created the **Jobs Project** in Pennsylvania, which links employers and the unemployed through specialized jobs fairs, job training, and technical assistance to individuals in transition.

Representative Fattah has cosponsored the following welfare/human services related bills: H.R. 95, the Interstate Child Support Act of 1995; H.R. 586, the Omnibus Foster Care Improvement Act of 1995; H.R. 881, the Child Care Availability Incentive Act; and H.R. 1985, the Adoption Incentives Act of 1995.

POLITICAL PROFILE

Representative Henry Waxman, who is a highly respected and masterful legislator, chaired the Health and Environment Subcommittee of the Energy and Commerce Committee from 1978 to 1994. He currently serves as the Ranking Democrat of the subcommittee.

Representative Waxman grew up over his parents' grocery store in Watts. He started his political career at UCLA, with other now-famous Democrats like Howard Berman, Willie Brown, David Roberti, and John Burton. Representative Waxman went on to build an extremely effective political operation in Los Angeles in partnership with Representative Howard Berman.

Representative Waxman's West L.A. congressional district is affluent, but the Congressman's personal style is reserved. He persuades by carefully crafted argument, not force of personality. Since his election in 1974, Representative Waxman has been a quiet but effective tactician who can block legislation with carefully assembled support, or get bills passed in pre-dawn conference committees. After one all-night negotiating session with Representative Waxman, Senator Alan Simpson told reporters, "Henry Waxman is tougher than a boiled owl."

The House's leader on health issues, Representative Waxman has initiated numerous bills to expand Medicaid coverage, and is responsible for virtually all key Public Health Service legislation since 1980. In addition, he has championed environmental legislation such as the Clean Air Act and smoke-free environment proposals. While he is interested in most every health issue, some of Representative Waxman's keenest concerns are health care for the disadvantaged, maternal and child health, AIDS, preventive care, and health quality standards. He was the sponsor of the first comprehensive AIDS legislation. He is adept at achieving savings in omnibus budget reconciliation bills and using these to expand Medicaid coverage for poor women and children.

Representative Henry Waxman (D-CA) 29th



Born:	9/12/39, Los Angeles
Education:	UCLA, B.A.; UCLA J.D.
Military:	None
Prev. Occup:	Lawyer
Family:	Janet Kessler; 2 children
Religion:	Jewish
Pol. Career:	CA Assembly, 1969-75
Elected:	1975
Residence:	Los Angeles
Committees:	Commerce, Government Reform and Oversight

Related to his interest in improving health care, Waxman has been an outspoken and relentless opponent of the tobacco industry. At an April 1994 hearing of the Health Subcommittee, Waxman and other anti-smoking members subjected seven leading tobacco company executives to a six-hour grilling on the health effects of using tobacco.

LEGISLATIVE INTERESTS

104th:

Representative Waxman has sponsored the Ryan White CARE Reauthorization Act of 1995 (H.R. 42); and the Morris K. Udall Parkinson's Research, Assistance, and Education Act of 1995 (H.R. 1462). He has co-sponsored the Family Planning Amendments Act of 1995 (H.R. 833, Greenwood); the Lupus Research Amendments of 1995 (H.R. 835, Meek); the Colon Cancer Screening and Prevention Act (H.R. 922, Cardin); the Federal Prohibition of Female Genital Mutilation Act of 1995 (H.R. 941, Schroeder); the Birth Defects Prevention Act of 1995 (H.R. 1010, Ortiz); the Medical Procedures Innovation and Affordability Act (H.R. 1127, Ganske); the American Health Security Act of 1995 (H.R. 1200, McDermott); the New Borns' and Mothers' Health Protection Act of 1995 (H.R. 1948, Miller); the Women's Choice and Reproductive Health Protection Act of 1995 (H.R. 1952, Schroeder); and the Medicare and Medicaid Payment Integrity Act of 1995 (H.R. 2280, Dingell).

103rd:

Representative Waxman introduced the NIH Revitalization Act (H.R. 4); the Family Planning Amendments (H.R. 670); the Comprehensive Child Immunization Act (H.R. 1640); the Preventive Health Amendments (P.L. 103-183); the Smoke-Free Environment Act (H.R. 3434); the Tobacco Education and Child Prevention Act (H.R. 3614); and the Minority Health Improvement Act (H.R. 3869). Congressman Waxman co-sponsored the Health Security Act (H.R. 3600, Gephardt); the American Health Security Act (H.R. 1200, McDermott) and the Family Self-Sufficiency Act (H.R. 4767, Matsui).

POLITICAL PROFILE

Representative Sanders, the first Independent elected to the House in 40 years, served as Mayor of Burlington, Vermont from 1981-1989. As Mayor, Sanders worked to build affordable housing, revitalize the city's downtown and waterfront, and promote youth and woman's programs.

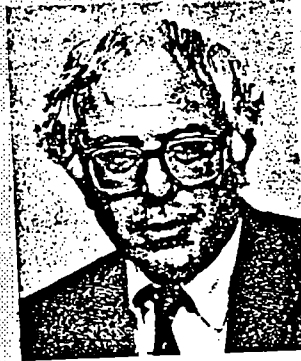
In the House, Representative Sanders had some leverage, since he often a liberal Democrat -- including active opposition to the Contract with America. Sanders supports health care reform but advocates the position that medical care is a right of all American citizens, without out-of-pocket expenses.

Sanders has also worked on the formation of a national energy policy, support for family farms, affordable housing, and cuts in military spending.

LEGISLATIVE INTERESTS

Representative Sanders has co-sponsored the Health Insurance Equity Act of 1995 (HR.34, Lincoln); the Ryan White CARE Reauthorization Act (HR.42, Waxman); the Medicaid Mammography Coverage Act (HR.777, Vucanovich); the Medical Procedures Innovation and Affordability Act (HR.1127, Ganske); the American Health Security Act (HR.1200, McDermott); the Domestic violence Identification and Referral Act (HR.1521, Wyden); and the Federally Supported Health Center Assistance Act (HR.1747, Johnson).

Congressman Bernard Sanders (I-VT) At-Large



Born:	9/8/41 New York, NY
Education:	U. of Chicago, B.A.
Military:	None
Family:	Wife, Jane; 4 children
Religion:	Jewish
Pol. Career:	Mayor of Burlington, 1981-89; independent candidate for U.S. Senate, 1972, 1974; independent candidate for Governor, 1972, 1976, 1986; independent candidate for U.S. House, 1988
Elected:	1990
Residence:	Burlington, VT
Committees:	Banking and Financial Services; Government Reform and Oversight Operations

POLITICAL PROFILE

Representative William F. Clinger, a veteran House Moderate Republican and Chairman of the Government Reform and Oversight Committee has a reputation for being a consensus-oriented centrist.

As chairman of the Government Reform and Oversight Committee (formerly Government Operations), Clinger in the first two months of 1995 brought to the floor two bills high on the GOP agenda. One was designed to curb mandates that the federal government imposes on states and localities without providing the money to pay for them; the other was to grant the president a line-item veto of budget measures.

Representative Clinger supports unfunded mandates saying that unfunded mandates would "restore state and local governments to their true place as partners in our federal system." Democrats have criticized Clinger for not holding hearings on the issue before it passed the House.

Representative William F. Clinger (R-PA) 5TH



Born:	4/4/29, Warren
Education:	Johns Hopkins U., BA, U. of VA, LL.B.
Military:	Navy, 1951-1955
Family:	Married; four children
Religion:	Presbyterian
Pol. Career:	No previous office held
Elected:	1978
Residence:	Warren
Committees:	Government and Oversight, Chairman; Transportation and Infrastructure.

LEGISLATIVE INTERESTS

104TH Congress: Representative

Clinger has sponsored the Rural Hospital Survival Act of 1995 (H.R. 424); and, the Rural Health Professional Shortage Act of 1995 (H.R. 425). He has also sponsored a bill to revise and streamline the acquisition laws of the federal government, and for other purposes (H.R. 1038).

Representative Clinger has cosponsored the Personal Responsibility Act of 1995 (H.R. 4, Shaw (R-FL); the Health Care Fraud and Abuse Prevention Act of 1995 (H.R. 2326, Schiff (R-NM); the Basic Health Care Reform Act of 1995 (H.R. 1234, Thomas (R-CA); the Safety and Health Improvement and Regulatory Reform Act of 1995 (H.R. 1834, Ballenger (R-NC); and, the Health Information Modernization and Security Act (H.R. 1766, Hobson (R-OH).

He has also cosponsored a bill to allow the secretary of Health and Human Services to reimburse the Military Health Services System for care provided to Medicare-eligible military retirees and their spouses in the Military Health Services System (H.R. 580, Hefley (R-CO)).

GROUP RATINGS

YEAR	ACLU	COPE	ACU	NTLC
1994	16	33	95	88
1993	--	18	80	--

12/4/95

BACKGROUND INFORMATION

April, 1996

Contact: HHS Press Office
(202) 690-6343

PREVENTING TEENAGE PREGNANCY

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

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

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

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

- Awarded 15 grants totalling \$4.2 million to innovative and comprehensive demonstration programs to prevent early teen sexual activity and reduce teen pregnancies. These programs emphasize and encourage abstinence.
- Launched the CDC Teen Pregnancy Prevention Program by awarding 13 grants totalling \$6.5 million over two years to community-wide coalitions. The grants will help support local efforts to reduce teen pregnancy.
- Completed "Beginning Too Soon: Adolescent Sexual Behavior, Pregnancy, and Parenthood," a two-volume comprehensive review of the most recent literature on teen sexual behavior, pregnancy and parenthood and the effectiveness of teen pregnancy prevention programs.

HHS PROGRAMS:

- The Adolescent Family Life Program awarded \$4.2 million for 15 demonstration and research projects that encourage abstinence as the best way to prevent adolescent pregnancy and encourage the involvement of parents in discussions with their children of issues about human sexuality. The program also supports research on the causes and consequences of adolescent sexual behavior, pregnancy and childbearing.
- Community Coalition Partnership Programs for the Prevention of Teen Pregnancy is a new demonstration program that will provide \$6.5 million over two years to enable 13 communities to develop plans for implementing and evaluating community-wide interventions that are innovative, comprehensive, and sustainable.
- Health education in schools supports the efforts of every state and territorial education agency to implement school health programs to help prevent the spread of HIV and sexually transmitted diseases (STDs). Assistance is also given to 13 states to build an infrastructure for school health programs to help prevent unhealthy risk behaviors. Efforts are targeted at preventing early sexual activity, STDs, HIV, drug and alcohol abuse, tobacco use, and injuries, and emphasis is placed on the importance of healthy diets and adequate physical activity.
- Healthy Schools, Healthy Communities established 27 new school-based health centers in 20 states and the District of Columbia to serve the health and education needs of children and youth at high risk for poor health, teenage pregnancy, and other problems.
- Title X of the Public Health Service Act provides reproductive health and family planning services to more than 4 million persons each year. Nearly one-third of Title X clients are adolescents. Improving outreach and services to adolescents is a priority of the program.
- Health Care and Promotion under Medicaid provides Medicaid-eligible adolescents under age 21 with access to a comprehensive range of preventive, primary, and specialty services within its Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program. In conjunction with the Maternal and Child Health Bureau, new guidelines from the Bright Futures project, which stress the importance of family and community support for positive health and social behaviors, including adolescent pregnancy prevention, are being disseminated to state Medicaid and Maternal and Child Health programs.

- Federal/State Partnerships, including the *Maternal and Child Health Services Block Grant* and the *Social Services Block Grant* (authorized by Titles V and XX of the Social Security Act, respectively), include support for adolescent pregnancy prevention programs, state adolescent health coordinators, state prenatal care hotlines, family planning, school health, and other prevention services. The *Community Services Block Grant* enables local community agencies to provide low-income populations, including youth at risk, with job counseling, summer youth employment, GED instruction, crisis hotlines, information and referral to health care, and other services. The *Preventive Health and Health Services Block Grant* (under Title XIX of the Public Health Service Act) provides resources to 49 States for services to the general population, including health education, risk reduction and public health nursing.
- Youth programs including Runaway and Homeless Youth Programs, the High Risk Youth Program, Community Schools, National Youth Sports, and Youth Violence Prevention Programs, address a wide range of risk factors related to teenage pregnancy.
- Healthy Start has demonstration projects in 22 communities nationwide to reduce infant mortality in the highest-risk areas and to improve the health and well-being of women, infants, and their families. Among a broad array of services provided, thousands of teenagers participate in prevention programs exclusively designed for adolescents that encourage healthy lifestyles, youth empowerment, sexual responsibility, conflict resolution, goal setting, and the enhancement of self-esteem.
- Empowerment Zones and Enterprise Communities in 105 rural and urban areas across the country have been awarded grants to stimulate economic and human development and to coordinate and expand support services. As they implement their strategic plans, some sites are including a focus on teenage pregnancy prevention and youth development.
- Community and migrant health centers, including family and neighborhood health centers, operate in 1600 sites and provide primary and specialized health and related services to medically underserved adolescents. Some centers include special hours or clinics for adolescent patients.

- Indian Health Service provides a full range of medical services for American Indians and Alaska Natives. IHS has a special emphasis on youth substance abuse, child abuse and women's health care, and provides services directed at prevention of teenage pregnancy.
- Drug treatment and prevention programs include services to prevent first-time and repeat births among teenagers. Sixty-five residential substance abuse treatment programs for pregnant and postpartum women, as well as women with dependent children, receive support to provide family planning, education, and counseling services. In addition, 13 grant demonstration projects offer interventions and outreach to female adolescents ages 12-20 who are at risk for alcohol, tobacco, and other drug use; physical and sexual abuse; and pregnancy. Additional grants will be awarded in September, 1995. Finally, a two-year public information campaign will reach out to adolescent girls ages 9-14, and to their families and social networks, to educate them about the risks and consequences of drug, alcohol, and tobacco use.
- Resources centers and clearinghouses at both the state and national level provide information and technical assistance to state and community-based health, social service, and youth-serving agencies. Toll-free hotlines also provide guidance on family and youth services, STDs, AIDS, and other issues.
- Research, surveillance, demonstrations, and evaluations are conducted on an ongoing basis to gather and provide information and technical assistance on the magnitude, causes, and prevention of teenage pregnancy and on programs and approaches that work.

WELFARE REFORM: REACHING THE NEXT GENERATION

Because estimates indicate that over half the mothers who receive Aid to Families with Dependent Children were teenagers when they had their first child, preventing teenage pregnancy is a critical part of the Clinton Administration's approach to welfare reform. To prevent welfare dependency, teenagers must get the message that staying in school, postponing sexual activity, and preparing to work are the right things to do. As President Clinton has said, "Nobody should get pregnant or father a child who isn't prepared to raise the child, love the child, and take responsibility for the child's future."

In his welfare reform legislation introduced last year, President Clinton presented a comprehensive approach to teenage pregnancy prevention. The welfare reform bill passed by the Senate in September 1995 includes the strong teen parent and child support enforcement provisions the Administration has called for from the start:

- * **Making Teen Parents Responsible.** Under the President's approach, the message to teen parents is clear: stay at home and remain in school. The Senate has adopted the President's proposal requiring custodial parents to live at home with an adult family member in order to qualify for assistance. States would also receive grants to establish "Second Chance" homes, or adult-supervised group homes, as alternative living situations to help teen parents break the cycle of welfare dependency. In addition, teenage parents would be required to remain in school and work or train for work after graduating from high school.
- * **Strengthening Child Support Enforcement.** Both houses of Congress have adopted President Clinton's comprehensive child support enforcement plan in their welfare reform legislation. This plan includes: streamlined efforts to name the father in every case; employer reporting in new hires to catch deadbeats who move from job to job; uniform interstate child support laws; computerized state-wide collections to speed up payments; and tough new penalties, like drivers' license revocation, for parents who fail to pay. These five measures would increase child support collections, move thousands of families off the welfare rolls, and send the strongest possible message to young men and women that they should not have children until they are prepared to care for them.

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THE NATIONAL CAMPAIGN TO PREVENT TEEN PREGNANCY

2100 M STREET, N.W., SUITE 500, WASHINGTON, D.C. 20037

CAMPAIGN UPDATE March 1996

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

Board established and officers elected:

On February 22, the Campaign's founding board met for the first time. It took the legal steps required to establish the Campaign as a new 501(c)(3) organization incorporated in the District of Columbia. Bylaws were adopted and basic Board management procedures were established. A press conference was held following this first Board meeting to announce the Campaign's formation and to clarify its status as an independent, non-governmental entity in the private sector.

The Board elected former New Jersey Governor Tom Kean as its founding chairman and Isabel Sawhill as its President, an office that also places her as chair of the Campaign's Executive Committee. A nominating committee was formally established to assist in adding additional Board members in the future. Attached to this memo is a roster of the Board.

Task force chairs elected:

The Board also elected chairs for the four task forces set up as the "working arms" of the Campaign: William Galston will lead the group addressing the role of religion and public values in teen pregnancy; Barbara Huberman will lead the group responsible for stimulating more action at the state and local levels to prevent teen pregnancy; Jody Greenstone Miller will head the media task force; and Kristin Moore will lead the task force on effective programs and research.

Staff appointed:

The Board also appointed Sarah Brown as Director of the National Campaign. She in turn is recruiting additional staff to support the Campaign's activities.

Fundraising:

Raising funds to support at least the first three years of the Campaign's operations is the current top priority. The goal for this first cycle is approximately \$4.5 million over three years; additional funds will be needed to support a full media campaign and to allow the Campaign to offer seed monies to states to form grassroots coalitions. Serious discussions are underway with several foundations and individual philanthropists. Based on those discussions, we expect to have about 70 percent of our initial funding goal achieved by May 1.

Future plans:

Immediate plans include at least the following:

- recruiting members for the four task forces noted above, convening each before the summer, and developing a specific calendar of activities for at least the first 18 to 24 months.
- organizing a Campaign launch event in the late spring or early summer to include a meeting with the President, who remains interested and supportive of our efforts.
- reaching out aggressively to many groups and individuals with a deep interest in preventing teen pregnancy, with careful attention to including a wide variety of perspectives.
- continuing to raise needed funds and to recruit key staff.

Staying in touch:

We plan to send out brief progress notes often and, in addition, encourage each of you to be in touch with us with your ideas, names of people to involve, suggested candidates for the staff, or other items of interest. We can be reached through the letterhead address. The key contact is Sarah Brown, the campaign's director (Internet address: ssbrown@ui.urban.org)

Attachments: Board Roster
One page summary of the Campaign

THE NATIONAL CAMPAIGN TO PREVENT TEEN PREGNANCY

2100 M STREET, N.W., SUITE 500, WASHINGTON, D.C. 20037

SUMMARY

Mission: To prevent teen pregnancy by supporting values and stimulating actions that are consistent with a pregnancy-free adolescence.

Goal: To reduce the teenage pregnancy rate by one-third by the year 2005.

What the Campaign will do:

- take a clear stand against teenage pregnancy and attract the interest of more national leaders and organizations in this issue;
- enlist the help of the media to reduce teen pregnancy;
- support and stimulate state and local action to reduce teen pregnancy;
- foster a national discussion about how religion, culture, and public values influence both teen pregnancy and responses to it; and
- strengthen the knowledge base for effective programming

Organization and leadership: This is a totally private (nongovernmental) and nonpartisan effort being led by a distinguished Board; work is conducted through four task forces and a small staff. A new 501(c)(3) organization has been established and funding is being sought to accomplish its objectives. The Board has elected The Hon. Thomas Kean, former governor of New Jersey, as its Founding Chairman. Dr. Isabel Sawhill serves as the Campaign's President and Sarah Brown as its Director.

Origins and history: The initiative 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." A follow-up meeting was held at the White House with a group of private citizens in October to discuss what might be done. Following that meeting, a serious private-sector planning effort was initiated around the ideas generated at the meeting. In his 1996 State of the Union address, the President once more talked about the seriousness of the issue and mentioned the current private-sector initiative as one very positive response.

Current status: A detailed prospectus for the overall Campaign was reviewed by the Board at its first meeting in February. The Campaign is now in the process of establishing a new organization, hiring a staff, and working with others to achieve its objectives.

For further information: To get on the mailing list of the new organization, or if you have other questions, please write to Sarah Brown, The National Campaign to Prevent Teen Pregnancy, 2100 M Street, N.W., Suite 500, Washington, D.C. 20037.

THE NATIONAL CAMPAIGN TO PREVENT TEEN PREGNANCY

2100 M STREET, N.W., SUITE 500, WASHINGTON, D.C. 20037

BOARD MEMBERS (As of February 22, 1996)

Chairman

Thomas Kean, former Governor of New Jersey and President, Drew University

President

Isabel V. Sawhill, Senior Fellow, Arjay Miller Chair, Urban Institute

Charlotte L. Beers, Chairman and Chief Executive Officer, Ogilvy and Mather

William Galston, School of Public Affairs, University of Maryland

Katharine Graham, Chairman of the Executive Committee, The Washington Post Company

Whoopi Goldberg, actress

Dr. David Hamburg, President, Carnegie Corporation of New York

Irving B. Harris, Chairman, The Harris Foundation

Barbara Huberman, Director of Training, Advocates for Youth

Nancy Kassebaum, U.S. Senator

Dr. C. Everett Koop, former Surgeon General

Judy McGrath, President, MTV

Jody Miller, Senior Vice President for Operations, Americast

Kristin Moore, Executive Director, Child Trends

Hugh Price, President, National Urban League, Incorporated

Warren B. Rudman, former U.S. Senator, Paul, Weiss, Rifkind, Wharton & Garrison

Andrew J. Young, former Ambassador to the U.N. and Co-Chairman, Atlanta Committee for the Olympic Games

Campaign Director

Sarah Brown, former Senior Study Director, Institute of Medicine