The teen birth rate has gone down three years in a row.

For Facts

- Advocates For Youth
- CDC

Many Voters Will Split Their Tickets, Zimmer Says

By NEIL MacFARQUHAR

BLOOMFIELD, N.J., Oct. 27 — Representative Richard A. Zimmer, the Republican candidate for the United States Senate, distanced himself from the flagging presidential candidacy of Bob Dole today and his campaign shrugged off a series of endorsements for the Democrats from the editorial pages of newspapers in some of New Jersey's largest cities.

Speaking at several rallies in Essex County intended to help get out the vote for Republican candidates, Mr. Zimmer said he hoped Mr. Dole would win but that New Jersey voters would not automatically link him with the former Kansas Senator. "The voters are going to make up their minds on the candidates for each office," he said, "based on the qualifications of the candidate for that office."

While his Democratic opponent, Robert G. Torricelli, was in the southern part of the state, appearing at a rally with the First Lady, Hillary Rodham Clinton, Mr. Zimmer said it would not be unusual if New Jersey voters picked Bill Clinton for President and himself for senator. "It has been clear in our recent history that New Jerseyans are inveterate ticket splitters," he said, "and more often than not they have voted differently for President than for senator."

Polls in New Jersey have repeatedly shown President Clinton with a comfortable lead over his Republican opponent, but the two men seeking to replace Senator Bill Bradley, a Democrat, are running even in one of the country's nastiest, most expensive campaigns.

"The voters are sophisticated enough to understand who I am and what my qualifications are, distinct from those running elsewhere on the ticket," Mr. Zimmer said after an appearance at a "Hot Dog Rally" along with Representative William J. Martini, who is fighting to keep his Eighth District seat in a tight race against William J. Pascrell Jr., the Mayor of Paterson.

Gov. Christine Todd Whitman had been scheduled to address the rally in the Essex Manor banquet hall, but was at home with what appeared to be a pinched nerve in her back, said her husband, John, who delivered a speech in her place. Both Mr. Whitman and Mr. Zimmer stressed that the Republicans had to get out the vote for their candidates because Mr. Clinton and his wife would abandon moderate positions they adopted only to win re-election.

"We cannot afford to have four more years of Bill and Hillary Clinton unconstrained by the threat of a re-election campaign, free to do what they want to do to change America in their image," Mr. Zimmer said. "This is a frightening prospect, and I am hopeful in the last week or so of this election campaign Americans will come to understand it."

The editorial pages of some of the state's largest newspapers today endorsed Mr. Clinton for re-election, along with Mr. Zimmer's opponent, Mr. Torricelli. The general tenor of the editorial-page endorsements for Mr. Torricelli from The Newark Star-Ledger and The Asbury Park Press, as well as an earlier editorial-page endorsement from The Trenton Times, was that Mr. Torricelli had greater vision for New Jersey issues.

Andrea Hofelich, Mr. Zimmer's spokeswoman, said she did not think voters would chose on the basis of endorsements alone. She also pointed out that Mr. Zimmer garnered some endorsements today, including ones from the editorial pages of The Home News and Tribune, which covers Middlesex County, and The Daily Record in affluent Morris County.

The New York Times

MONDAY, OCTOBER 28, 1996

In His Own Words

RICHARD A. ZIMMER

Speaking at a rally for Republican candidates in Essex County, N.J.:

"I think we need Northeastern Republicans in the majority caucus to insure that the Republican Party is truly a national party and that there is a voice within the Republican caucus in the Senate for pro-choice views, pro-environment views and for the interests of our region. That is why it is important that although Northeastern Republicans will surely be a minority in the Republican ranks in the Senate, that we continue to have a strong and effective voice. I am hopeful that Bill Weld will be elected, and Susan Collins from Maine, so that we can continue that tradition. I think that is in the interest of New Jerseyans, to have that voice within the Republican caucus rather than to elect one more liberal Democrat."

Idaho County Finds Way to Chastise Pregnant Teen-Agers: They Go to Court

By JAMES BROOKE

EMMETT, Idaho, Oct. 24 — Seven months' pregnant and 17 years old, Amanda Smisek received a court summons last spring charging her with a crime she had never learned about in high school: fornication.

"My mom went down to the library and looked it up in the dictionary," Miss Smisek said this morning after bottle-feeding her newborn son, Tyler. "Nobody ever told us it was illegal for two people of the same age to do that."

As communities around the nation search for ways to curb teen-age pregnancies, some have opted for more sex education in high schools, some for easier access to contraceptives, and some for stiffer enforcement of statutory rape laws. Orange County, in Southern California, is promoting a modern brand of shotgun marriage in which some adult fathers face marriage or jail.

Here in Gem County, Douglas R. Varie, the county's Prosecuting Attorney, last spring dusted off the state's 1921 law prohibiting fornication, or, as the statute defines it, sex between unmarried people of the opposite sex.

"Children having children impose a heavy burden on society," Mr. Varie, a 33-year-old elected official, wrote in an open letter of explanation to residents here. "It's a sad thing for a child to only know his or her natural father as someone who had a good time with his mother in the back seat of a car."

Pushing communities to action is concern that the United States has the highest teen-age pregnancy rate of almost all major industrialized nations, according to the Planned Parenthood Federation of America. About 12 percent of all births in the United States are to teen-age girls. Most of the fathers are over 18.

This national problem is no stranger to Gem County, a blue-collar corner of sagebrush, cherry orchards, cattle ranches, a lumber mill and a drag strip in western Idaho, just over a mountain pass from Boise. Gem County's rate of 84 pregnancies per 1,000 teen-agers is slightly lower than the national average, but about 50 percent higher than Idaho's average.

As part of an effort to restore social opprobrium to teen-age pregnancy, Miss Smisek became the first of about 10 pregnant teen-age girls who have been charged with fornication, along with their boyfriends, after the prosecutor was alerted to the pregnancies by teachers, family members or social workers.

The teen-age girls and their boyfriends usually pleaded guilty. Miss Smisek opted for a trial before a Juvenile Court judge, and her lawyer argued, unsuccessfully, that the statute was being selectively applied.

> A 1921 anti-fornication law is applied to young unwed parents.

At the first prosecution, of Miss Smisek, protests erupted, with pickets on the courthouse lawn. At a protest over Miss Smisek's sentencing, in May, one woman held a sign reading, "She's pregnant, why make her criminal?"

In response, Mr. Varie noted that juvenile records were automatically sealed when a convicted teen-ager turned 18. The sentences for Miss Smisek and her 16-year-old boyfriend, Chris Lay, did not call for jail time or fines; they are designed to channel the teen-agers into responsible parenthood. Placed on probation for three years, the couple are required to attend parenting classes together, to complete their high school educations, to stay employed and to stay off drugs, alcohol and cigarettes. Violations of probation are dealt with through counseling rather than jail.

Juanita Goslin, a longtime friend of the Smisek family and a participant in the protest, fumed today: "What makes me mad is that old law states 'anyone' — it doesn't state 'teen-agers.' That's discrimination."

That objection is echoed in Boise, the state capital 35 miles southeast of here, by Jack Van Valkenburgh, executive director of the American Civil Liberties Union of Idaho.

"To the extent that the prosecutions are targeting teen-agers, and the law applies to everybody, it is selective prosecution, and it denies equal protection of the law," he said. "We just don't think that it is appropriate for the heavy hand of government to get involved in consensual behavior."

Unmoved, the county prosecutor responds: "To those who say that prohibiting teen-age sexual activity is too much of an intrusion on the personal freedoms of juveniles, consider how we limit the freedoms of minors already."

In Idaho, he said, young people under the age of 18 cannot buy cigarettes, buy alcohol or marry without parental consent. Youths cannot drive a car until they are 14, or drop out of school until they are 16.

The prosecutor's supporters here say he is trying to restore a lost sense of shame that went with teen-age pregnancy out of wedlock.

"We have higher standards than some of your faster metropolitan areas," said Mark D. John, the county sheriff, warily eyeing a visitor from Denver. A part-time rancher whose belt buckle is shaped like a miniature pistol, the sheriff said that no girls had become pregnant when he went to high school near here in the 1950's.

But down at Emmett's igloo-shaped high school, the impact of the anti-fornication campaign seems mixed.

Duane Horning, the principal, spent most of his afternoon today meeting with parents about revising the school's sex education course.

"Students weren't aware of the laws regarding sexual behavior, and a lot of parents weren't either," the principal said, speaking in his office, which is decorated with John Wayne posters. The fornication prosecutions, he added, "got a lot of publicity, but I don't think they are discouraging kids from having sex."

Similar views were voiced by a knot of cheerleaders as they waited to board a bus with the school team, the Huskies.

"Forn-if-cation?" Becky Harris, a 17-year-old junior, repeated quizzically. "What's that?"

Kathleen Green, another junior, clued her in, then added: "I don't see any lesson out of it. People are going to do it, no matter what."

Miss Green, whose sister got pregnant while in high school, added: "Just leave them alone. If they want to be moms, that's their choice."

Trina Wade, a 15-year-old sophomore, complained that the law was being enforced only in Gem County.

"It's not fair — if you live here, you get charged," she said. "If you live a few miles away, in another town, you won't be charged."

About half of Idaho high school seniors have had sex at least once, according to the results of a statewide survey conducted last year. In a separate poll of Boise High School students conducted last month, 79 percent said they wanted an improved sex education program.

"We have the highest teen pregnancy rate in the developed world because we don't educate our teens," said Jeanette Germain, a spokeswoman for Planned Parenthood of Idaho. "We don't provide health services."

Ms. Germain opposes the fornication prosecutions, but she said she had noticed one concrete result: More families are driving from Emmett with their teen-age children to attend sex education classes at Planned Parenthood in Boise.

It seems unlikely that Idaho, or the rest of the nation, will see a wave of fornication prosecutions. Fornication laws remain on the books in only one-third of the states. With controversy surrounding the Gem County prosecutions, other Idaho counties have resisted following its lead.

But Gem County shows little sign of backing away from its experiment.

Miss Smisek, now an aide in a nursing home here, said a 17-year-old co-worker had got a summons last week to explain to police why she was pregnant and unmarried.

And Emmett's silent majority appears to be sympathetic to the prosecutor and the sheriff, who are running for re-election. Despite enormous debate over the policy when it started six months ago, the fornication prosecutions have not become a campaign issue, local residents say. Mr. Varie is assured of victory next month: he is running unopposed.

Charitable Giving Rises to $23.5 Billion in U.S.

WASHINGTON, Oct. 27 (AP) — Americans donated $23.5 billion to charities last year, giving most generously to the Salvation Army, the American Red Cross and Catholic Charities U.S.A., according to an annual survey released today.

Donations were up 5 percent, compared with 1994. The study was done by The Chronicle of Philanthropy, which surveyed the 400 nonprofit organizations receiving the most private money. The 1994 increase in donations was 6.3 percent.

The list includes about $1 out of every $6 donated to nonprofit groups.

Although donations to the Salvation Army dropped by 11.3 percent, that organization topped the list for the fourth-consecutive year, with collections of $644.3 million.

The American Red Cross, second for three years, raised $456.6 million, a 7.9 percent drop from 1994.

A 25 percent increase in gifts to Catholic Charities U.S.A. brought that group to No. 3 from No. 7 on the list; it raised $419.4 million last year.

Over all, donations to human-service groups were down by 5.3 percent.

The survey found other changes:

¶Community foundations, which raise and distribute money in a single geographic area, saw the biggest gain in donations: 93 percent.

¶Donations were up 25.4 percent for museums and libraries, 17.5 percent for education groups, 17.4 percent for public broadcasting and 16.5 percent for arts organizations.

¶The sharpest decrease in donations, 8.2 percent, was seen by public-affairs groups.

¶The 400 top charities include 138 colleges and universities, 45 United Way organizations, 34 international groups, 21 human-service groups, 24 religious organizations, 21 health charities and 21 medical centers.

Rounding out the top 10 charities, in order, were the American Cancer Society; Second Harvest, a nation network of food banks; the Un Jewish Appeal; Harvard Unive Boys and Girls Clubs of Am the Y.W.C.A. of the U.S.A., American Heart Associati

The New York Times
MONDAY, OCTOBER 28, 1996

Child Trends, Inc.

4301 Connecticut Avenue, N. W., Suite 100
Washington, DC 20008
Phone: (202) 362-5580
Fax: (202) 362-5533
E-Mail: 73252.3431@compuserve.com

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4301 Connecticut Avenue, N.W., Suite 100, Washington, DC 20008

Phone (202) 362-5580
Fax (202) 362-5533

FOR RELEASE TUES., OCT. 29, 1996

CONTACT: Carol Emig
Cheryl Oakes
(202) 362-5580

DROP IN TEEN BIRTH RATE NATIONALLY REFLECTS CHANGES IN MOST STATES

New Data Show That Declining Teen Birth Rates Are Not Limited to Certain States or Regions

Washington, D.C. -- Teen birth rates dropped in 46 states between 1991 and 1994, according to new data released by Child Trends, Inc., a nonprofit, nonpartisan research firm that focuses on children and families. Declining teen birth rates in so many states suggest that the four-year decrease in the teen birth rate nationally reflects broad, society-wide changes rather than changes limited to one part of the country or to one group of teens. (See the table at the end of this release for a state-by-state listing of 1994 teen birth rates.)

Twelve states had substantial decreases in their teen birth rates of about 10 percent or more between 1991 and 1994. They are: Alaska (15 percent decrease), Idaho (13 percent decrease), Maine (18 percent decrease), Michigan (12 percent decrease), Montana (13 percent decrease), Ohio (10 percent decrease), South Dakota (10 percent decrease), Utah (10 percent decrease), Vermont (15 percent decrease), Washington (11 percent decrease), Wisconsin (11 percent decrease), and Wyoming (11 percent decrease).

The four states whose teen birth rates did not decrease between 1991 and 1994 -- Connecticut, Nebraska, New York, and Rhode Island -- all have teen birth rates below the 1995 national rate of 56.9 births per 1,000 women ages 15-19. Teen birth rates for each state are only available through 1994.

The new state-by-state data are presented in *Facts At a Glance*, an annual summary of data and research on teen pregnancy published by Child Trends. This information supplements data released recently for the nation as a whole by the National Center for Health Statistics. The national data indicate that the U.S. teen birth rate fell in 1995 for the fourth year in a row -- the first sustained downturn in the teen birth rate in a decade. Child Trends' state-by-state analysis provides additional information to policy makers and researchers seeking to identify the factors that contribute to a decrease in births to teens.

"State-by-state data over several years strongly suggest that the changes that are contributing to the decline in teen birth rates are happening on a broad societal level," said Kristin A. Moore, Ph.D., Executive Director of Child Trends, Inc. "Between 1986 and 1991, the teen birth rate increased in every state; since then, it has decreased in almost every state."

Moore added that significant additional data on teen sexual activity should be available in the next several months and may help answer the question of whether declining teen birth rates are driven by a decline in the percentage of sexually active teens.

The October 1996 issue of *Facts At a Glance* presents the latest national, state, and city-level data on teen pregnancy and summarizes recent research findings on teen pregnancy. Highlights include:

Births to Unmarried Teens. 76 percent of teen births in 1994 occurred outside of marriage. In 1960, 15 percent of births to teen mothers took place outside of marriage. Since then, the percentage has steadily increased. In 1994, 67 percent of births to white teens, 70 percent of births to Hispanic teens, and 96 percent of births to black teens were nonmarital births.

Hispanic Teen Birth Rate Bucks the National Trend. The Hispanic teen birth rate rose slightly in 1994 and now matches the black teen birth rate of 108 births per 1,000 females ages 15-19. The black rate, however, has dropped every year from 1991 to 1994. The white rate of 40 births per 1,000 females ages 15 to 19 was the same in 1993 and 1994.

Serious Consequences for the Children of Teen Mothers. *Facts At a Glance* includes a brief summary of recent research sponsored by the Robin Hood Foundation comparing children whose mothers were 17 or younger with children whose mothers were 20-21 when they gave birth. The children born to teen mothers tend to

- have lower cognitive test scores and more difficulty in school;
- have poorer health yet receive less health care;
- have less stimulating and supportive home environments;
- have higher levels of incarceration; and
- have higher rates of adolescent childbearing themselves.

These patterns are found even when researchers take account of background differences that distinguish adolescents who become mothers.

Sexual Abuse and Teen Pregnancy. Sexual abuse increases the risk of early pregnancy. Between 1986 and 1993, the estimated number of sexually abused children increased by 83 percent, from 119,200 to 217,700, according to the National Incidence Study of Child Abuse.

Teen Childbearing and High School Drop Out. Analyses by Child Trends of the National Educational Longitudinal Study find that 62 percent of young women who had a high school birth dropped out of high school at some point. 25 percent dropped out prior to the pregnancy, and 37 percent dropped out after the pregnancy. 38 percent of women who had a high school birth did not drop out at any time.

States With the Highest Teen Birth Rates. Mississippi had the highest teen birth rate in 1994 -- 83 births per 1,000 females ages 15 to 19. The states with the next highest teen birth rates are Arizona (79), Texas (78), New Mexico (77), and Arkansas (76). The national teen birth rate in 1994 was 58.9; in 1995, it was 56.9. (For purposes of state rankings, ChildTrends counts the District of Columbia as a city.) Table 1 of *Facts At a Glance* presents the numbers of births to teen mothers for each state; Table 2 presents the teen birth rate for each state, as does the table at the end of this release.

States With the Lowest Teen Birth Rates. New Hampshire had the lowest teen birth rate -- 30 births per 1,000 females ages 15 to 19 in 1994. The states with the next lowest teen birth rates are Vermont (33), Minnesota (34), North Dakota (35), and Maine (36). Table 1 of *Facts At a Glance* presents the numbers of births to teen mothers for each state; Table 2 presents the teen birth rates for each state, as does the table at the end of this release.

Percentage of Teen Births in the Nation's Largest Cities. Among the 100 largest cities in the U.S., St. Louis, Missouri had the highest percentage of all births to teen mothers in 1994 -- 25 percent of all births in St. Louis that year were to teenage mothers. New Orleans, with 24 percent of all births to teen mothers, was second. Table 3 of *Facts At a Glance* presents teen birth data for the nation's 100 largest cities.

Child Trends, Inc., established in 1979, is a nonprofit, nonpartisan research firm that focuses on children and families. Its primary goal is to improve the quality, scope, and use of research and statistical information concerning American's children and their families. *Facts At a Glance* has been published since 1983 with the support of the Charles Stewart Mott Foundation.

A copy of the October 1996 issue is attached. Additional copies or further information is available from Child Trends at (202) 362-5580.

#

TEEN BIRTH RATES BY STATE
(BIRTHS PER 1,000 TEEN MOTHERS AGES 15-19)
1991, 1994

State	1991	1994
Alabama	74	72
Alaska	65	55
Arizona	80	79
Arkansas	80	76
California	74	71
Colorado	58	54
Connecticut	40	40
Delaware	61	60
Florida	68	64
Georgia	76	72
Hawaii	59	54
Idaho	54	47
Illinois	65	63
Indiana	61	58
Iowa	43	40
Kansas	55	54
Kentucky	69	65
Louisiana	76	75
Maine	44	36
Maryland	54	50
Massachusetts	38	37
Michigan	59	52
Minnesota	37	34
Mississippi	86	83
Missouri	65	59
Montana	47	41
Nebraska	42	43
Nevada	75	74
New Hampshire	33	30
New Jersey	41	39
New Mexico	80	77
New York	46	46
North Carolina	70	66
North Dakota	36	35
Ohio	61	55
Oklahoma	72	66
Oregon	55	51
Pennsylvania	47	44
Rhode Island	45	48
South Carolina	73	67
South Dakota	48	43
Tennessee	75	71
Texas	79	78
Utah	48	43
Vermont	39	33
Virginia	53	51
Washington	54	48
West Virginia	58	54
Wisconsin	44	39
Wyoming	54	48

Note: For purposes of state rankings, Child Trends counts the District of Columbia as a city. Teen birth rates for the 100 largest cities in the U.S. (including the District of Columbia) are found in Table 3 of *Facts At a Glance*.

Source: *Facts At a Glance*, October 1996, published by Child Trends, Inc., Washington, D.C.

CHILD TRENDS, INC.
4301 Connecticut Avenue, N.W., Suite 100, Washington, DC 20008

Phone (202) 362-5580
Fax (202) 362-5533

October, 1996

TO: Individuals and Organizations Concerned About Teenage Pregnancy and Childbearing

FROM: Kristin A. Moore, Ph.D.

SUBJECT: Release of *Facts at a Glance*, reporting final 1994 and preliminary 1995 data on teen fertility in the United States

Final data for 1994 and preliminary data for 1995 indicate a continuing decline in rates of teenage childbearing. While small, these declines represent a reversal of the substantial increase that occurred between 1986 and 1991, when the teen birth rate rose by a quarter. From a high of 62.1 births per thousand females aged 15-19 in 1991, the rate has declined to 56.9 in 1995. This represents an eight percent decline.

Data for states are available through 1994. During the late 1980s, the teen birth rate rose in every state. Since 1991, the rate has declined in 46 states. In eight states the birth rate is less than 40 births per 1,000 females aged 15-19, substantially lower than the 1994 national birth rate of 58.9. These states include Maine (36), Massachusetts (37), Minnesota (34), New Hampshire (30), New Jersey (39), North Dakota (35), Vermont (33), and Wisconsin (39). However, even these rates are higher than rates in other Western industrialized nations, which ranged in the early 1990s from 4 in Japan to 15 in Norway to 32 in Great Britain.

This past year, a new private non-profit organization was founded to provide national leadership on the issue of teenage childbearing. This organization, The National Campaign to Prevent Teen Pregnancy, is making a long-term, science-based commitment to working to reduce teen pregnancy by, first, delaying sexual activity and, second, encouraging contraception among those teens who do have sex. I have agreed to head the Task Force on Effective Programs and Research. The National Campaign to Prevent Teen Pregnancy is located at 2100 M Street, N.W., Suite 500, Washington, D.C. 20037, phone (202) 857-8655 and fax (202) 331-7735.

 References for data cited are available upon request. For further information about Child Trends, visit our evolving Web page at www.childtrends.org

If this fact sheet has reached an inappropriate office or person, please forward it to the appropriate person. If you would like to add someone to our mailing list, or if you would like to have an address corrected or removed, please write or fax us with the correct information.

This informational effort is funded by the Charles Stewart Mott Foundation of Flint, Michigan.

FACTS AT A GLANCE

October 1996

TEEN BIRTH RATE. Preliminary data for 1995 indicate that the teen birth rate has declined slightly but steadily for four years. The teen birth rate reached its lowest point in more than half a century in 1986. Between 1986 and 1991, the teen birth rate rose by one-fourth, peaking at 62.1 in 1991. Since then, the rate has declined by 8 percent, to 56.9 in 1995. Data by age of teens are currently only available through 1994.

Teen Birth Rate (Births per 1,000 Females Aged 15-19)

All Females Ages:	1960	1970	1980	1986	1990	1991	1992	1993	1994	1995
15-19	89.1	68.3	53.0	50.2	59.9	62.1	60.7	59.6	58.9	56.9
15-17	--	38.8	32.5	30.5	37.5	38.7	37.8	37.8	37.6	--
18-19	--	114.7	82.1	79.6	88.6	94.4	94.5	92.1	91.5	--

NUMBER OF BIRTHS TO TEENS. Although the teen birth rate has decreased, the number of births to teens increased in 1994, reflecting an increase in the overall U.S. teenage population. This increase was concentrated among younger teens. The number of births to adolescents 18 and 19 was virtually unchanged from 1993 to 1994. The decline in the teen birth rate in 1995 led to a decline in the number of teen births in 1995.

Number of Births to Females Under Age 20

Ages:	1960	1970	1980	1986	1990	1991	1992	1993	1994	
Under 15	6,780	11,752	10,169	10,176	11,657	12,014	12,220	12,554	12,901	12,318
15-17	182,408	223,590	198,222	168,572	183,327	188,226	187,549	190,535	195,169	--
18-19	404,558	421,118	353,939	293,333	338,499	331,351	317,866	310,558	310,319	--
Under 20	593,746	656,460	562,330	472,081	533,483	531,591	517,635	513,647	518,389	513,062

NONMARITAL BIRTHS. Among teens who have births, the proportion of births that occur outside of marriage continued to increase, rising to 76% in 1994.

Percent of Births that Were Nonmarital

	1960	1970	1980	1986	1990	1991	1992	1993	1994
Mothers Under Age 20	15	30	48	61	68	69	71	72	76%
Mothers Aged 20-24	5	9	19	29	37	39	41	42	45%

In 1994, 33 percent of all births in the U.S. were to unmarried women. However, nonmarital childbearing is no longer concentrated among teens. Of the 1.3 million nonmarital births in the U.S. in 1994, 31 percent were to unmarried mothers under age 20, compared to 35 percent among unmarried women ages 20-24, 18 percent among those 25-29, and 16 percent among unmarried women age 30 or older.

CONSEQUENCES OF ADOLESCENT CHILDBEARING FOR THE OFFSPRING. Several research studies initiated by the Robin Hood Foundation indicate that the children of adolescent parents face substantial disadvantages. Compared with children whose mothers were 20-21 when they were born, children whose mothers were 17 or younger when they were born tend to have lower cognitive scores and more difficulty in school; have poorer health yet receive less health care; have less stimulating and supportive home environments; have higher rates of incarceration; and have higher rates of adolescent childbearing. These patterns are found even when researchers take account of background differences that distinguish adolescents who become mothers.

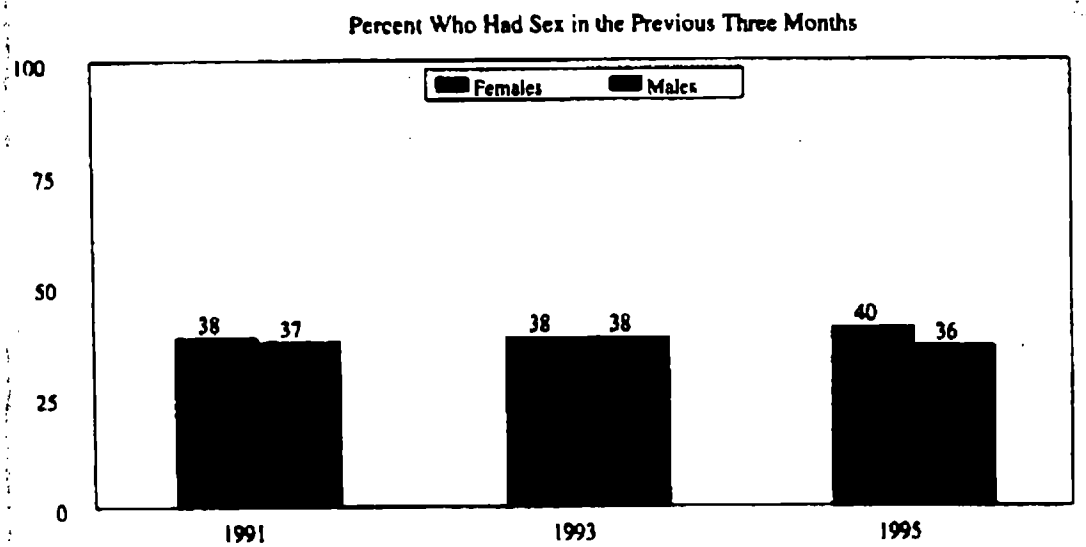
BIRTH RATES BY RACE/ETHNICITY. In 1994, the teen birth rate dropped slightly among non-Hispanic blacks, but stayed the same among non-Hispanic white teens and rose slightly for Hispanic teens. The birth rate for Hispanic teens and black teens is now the same.

Teen Birth Rate (Births Per 1,000 Females Aged 15-19) by Race/Ethnicity

Race/Ethnicity:	1980	1986	1990	1991	1992	1993	1994
Hispanics	82	80	100	107	107	107	108
Non-Hispanic Blacks	105	104	116	118	116	111	108
Non-Hispanic Whites	41	36	43	43	42	40	40

Note: 1980 data on Hispanic ethnicity are reported for 22 states, accounting for 90% of Hispanic births; 1986 data are for 23 states and DC; 1989 data are for 47 states and DC; 1990 data are for 48 states and DC; 1991 and 1992 data are for 49 states and DC; 1993 and 1994 data are for all states and DC.

SEXUAL ACTIVITY. During the first half of this decade, major changes in the proportion of adolescents who had sex in the last three months are not apparent, according to data from the Youth Risk Behavior Survey for students in grades 9-12.



SEXUAL ABUSE. Sexual abuse elevates the risk of adolescent pregnancy. Between 1986 and 1993, the estimated number of sexually abused children increased 83%, from 119,200 to 217,700, according to the National Incidence Study of Child Abuse.

PREGNANCY AND ABORTION. Estimates available for the early 1990s suggest that the pregnancy rate peaked in 1990 and 1991 at 115 pregnancies per 1,000 females age 15-19. The pregnancy rate declined to 111 in 1992. The abortion rate, which stayed in the low 40s throughout the 1980s also declined in the early 1990s, from 40 abortions per 1,000 females age 15-19 in 1990, to 38 in 1991 and 36 in 1992.

HIGH SCHOOL DROPOUT. Among young women who had a high school age birth (a birth within four years of eighth grade), the majority (62%) had dropped out at some point, according to analyses of the National Educational Longitudi Study. A sizeable percentage of women (25%) dropped out prior to pregnancy, suggesting that they were already disengaged from school before they became pregnant. An additional 37 percent dropped out after the pregnancy, while only 38 percent did not drop out at any time.

The percentage of teenage mothers who dropped out varies by race/ethnicity. For example, Hispanic teenage mothers were far more likely to drop out at any point (71%) than whites (64%) or blacks (54%).

	Total	Hispanics	Non-Hispanic Blacks	Non-Hispanic Whites
Did not drop out	38%	29%	46%	36%
Dropped out prior to pregnancy	25%	39%	10%	29%
Dropped out after pregnancy	37%	32%	44%	35%

Table 1: BIRTHS TO MOTHERS UNDER AGE 20 IN 1994

	NUMBER OF BIRTHS TO MOTHERS AGED:				BIRTHS TO MOTHERS UNDER AGE 20:			PERCENT OF TEEN BIRTHS TO UNMARRIED MOTHERS:		
				Total	Non-Hispanic			Non-Hispanic		
	Under 15	15-17	18-19	Under 20	White	Black	Hispanic	White	Black	Hispanic
ALABAMA	338	4,597	6,402	11,336	5,476	5,722	87	44%	96%	48%
ALASKA	19	426	784	1,229	856	78	72	69%	83%	78%
ARIZONA	248	4,127	6,462	10,835	3,850	530	5,194	72%	92%	82%
ARKANSAS	177	2,693	4,204	6,974	4,288	2,473	144	47%	96%	59%
CALIFORNIA	1689	26,423	41,909	70,021	15,807	7,883	42,656	66%	88%	71%
COLORADO	127	2,517	4,009	6,653	3,426	589	2,467	68%	90%	77%
CONNECTICUT	98	1,652	2,124	3,874	1,344	953	1,314	84%	95%	87%
DELAWARE	55	682	740	1,377	803	637	121	84%	99%	78%
DISTRICT OF COLUMBIA	86	682	865	1,632	24	1,483	113	92%	98%	84%
FLORIDA	760	10,145	15,290	26,195	11,488	10,098	4,324	68%	96%	68%
GEORGIA	598	7,105	10,232	17,935	7,817	9,359	631	53%	96%	40%
HAWAII	41	696	1,321	2,058	283	49	437	42%	85%	88%
IDAHO	41	788	1,460	2,289	1,796	10	404	56%	80%	61%
ILLINOIS	843	9,590	14,441	24,874	8,802	10,604	5,085	76%	98%	69%
INDIANA	224	4,240	7,499	11,963	8,946	2,467	470	73%	98%	77%
IOWA	96	1,403	2,588	4,047	3,456	306	208	79%	96%	64%
KANSAS	66	1,848	3,093	4,807	3,367	760	535	66%	94%	73%
KENTUCKY	202	3,306	5,613	9,121	7,658	1,364	65	53%	95%	65%
LOUISIANA	408	5,200	7,433	13,041	4,848	7,866	208	69%	96%	74%
MAINE	16	464	1,005	1,475	1,394	10	16	81%	80%	63%
MARYLAND	264	2,913	4,419	7,596	2,816	4,264	352	76%	96%	81%
MASSACHUSETTS	155	2,432	3,983	6,570	3,341	1,082	1,947	89%	96%	88%
MICHIGAN	397	6,303	10,760	17,460	9,724	6,528	921	81%	98%	79%
MINNESOTA	102	1,896	3,440	5,438	3,662	847	338	85%	98%	74%
MISSISSIPPI	370	3,739	5,158	9,267	3,242	5,937	28	48%	97%	64%
MISSOURI	225	3,872	6,712	10,809	7,329	3,164	209	67%	98%	71%
MONTANA	18	438	882	1,338	933	5	43	68%	60%	83%
NEBRASKA	47	851	1,658	2,556	1,769	336	265	77%	96%	72%
NEVADA	55	1,214	1,920	3,189	1,669	451	925	64%	94%	86%
NEW HAMPSHIRE	10	311	740	1,061	908	10	31	83%	100%	77%
NEW JERSEY	284	3,700	5,845	9,829	2,548	4,223	2,761	81%	97%	83%
NEW MEXICO	124	1,988	2,853	4,965	1,104	110	3,076	69%	95%	81%
NEW YORK	582	10,054	16,675	26,311	9,107	8,504	8,063	74%	96%	87%
NORTH CAROLINA	449	5,981	9,243	15,673	7,833	6,809	527	58%	97%	54%
NORTH DAKOTA	7	218	578	803	596	8	17	74%	38%	59%
OHIO	480	7,698	13,125	21,303	14,488	6,037	616	76%	98%	86%
OKLAHOMA	152	2,856	4,815	7,822	5,042	1,224	440	64%	95%	62%
OREGON	117	1,904	3,336	5,357	3,995	257	870	75%	96%	84%
PENNSYLVANIA	436	6,373	10,103	16,914	9,721	5,370	1,575	83%	98%	86%
RHODE ISLAND	38	568	821	1,427	708	232	327	89%	98%	81%
SOUTH CAROLINA	269	3,506	5,079	8,854	3,859	4,847	95	57%	96%	80%
SOUTH DAKOTA	11	392	800	1,203	792	7	28	74%	43%	61%
TENNESSEE	357	4,547	7,803	12,707	8,015	4,476	136	53%	97%	54%
TEXAS	1390	20,680	30,791	52,861	15,811	9,569	26,971	57%	92%	66%
UTAH	48	1,433	2,610	4,091	3,329	36	626	54%	86%	70%
VERMONT	11	187	430	628	570	5	1	80%	100%	100%
VIRGINIA	249	3,798	6,672	10,719	5,817	4,427	569	61%	96%	72%
WASHINGTON	151	3,039	5,428	8,618	5,634	555	1,526	73%	90%	86%
WEST VIRGINIA	47	1,320	2,354	3,721	3,511	196	11	62%	94%	64%
WISCONSIN	161	2,489	4,387	7,037	4,132	1,961	526	81%	98%	79%
WYOMING	13	296	625	934	777	6	108	84%	40%	78%
U.S. TOTAL	12,901	195,169	310,319	518,389	236,569	144,272	118,379	67%	96%	70%

Source/Notes: Unpublished and specially tabulated data from the National Center for Health Statistics, Department of Health and Human Services; forthcoming in Vital Statistics of the United States, 1994, Vol. 1, Natality. Nonmarital births are inferred for California, Connecticut, Michigan, Nevada, and New York from information on the ce

TABLE 2: BIRTH RATES FOR TEENS 15-19 IN 1970, 1980, 1985, 1990-1994, AND TEENS 15-17 AND 18-19 IN 1994; PERCENT 2ND OR LATER BIRTHS AMONG BIRTHS TO 15-19 YEAR OLDS IN 1994; AND PERCENT OF ALL FIRST BIRTHS IN A STATE THAT OCCURRED TO A TEEN MOTHER

	Birth Rates (Births per 1,000) to Teen Mothers Aged 15-19								Birth Rates (Births per 1,000) Age 15-17	Age 18-19	Percent of Teen Births That are 2nd or Later Births	Of All First Births in State, Percent to Teen Mothers
	1970	1980	1985	1990	1991	1992	1993	1994	1994	1994	1994	1994
ALABAMA	89	68	64	71	74	73	71	72	51	103	22%	33%
ALASKA	87	64	56	65	65	63	57	55	32	90	20%	24%
ARIZONA	77	68	67	76	80	81	80	79	50	124	22%	31%
ARKANSAS	91	75	73	80	80	76	74	76	49	117	23%	36%
CALIFORNIA	65	53	53	71	74	74	73	71	46	111	22%	26%
COLORADO	64	50	48	55	58	58	55	54	34	88	19%	23%
CONNECTICUT	43	31	31	39	40	39	39	40	29	58	19%	16%
DELAWARE	72	51	51	55	61	60	60	60	45	83	21%	24%
DISTRICT OF COLUMBIA	110	62	72	93	116	117	129	115	88	151	32%	30%
FLORIDA	85	69	66	69	69	66	65	64	42	98	23%	25%
GEORGIA	98	72	68	76	76	75	73	72	49	107	24%	28%
HAWAII	60	51	48	61	59	54	53	54	32	84	18%	20%
IDAHO	65	60	47	51	54	52	51	47	27	76	18%	29%
ILLINOIS	66	56	61	63	65	64	63	63	41	97	25%	28%
INDIANA	73	58	52	59	61	59	59	58	35	92	20%	28%
IOWA	52	43	35	41	43	41	41	40	23	67	17%	23%
KANSAS	61	57	52	58	55	56	56	54	30	90	21%	26%
KENTUCKY	86	72	63	68	69	65	64	65	40	102	20%	31%
LOUISIANA	85	76	72	74	76	76	76	75	51	110	25%	35%
MAINE	85	47	42	43	44	40	37	36	18	63	17%	20%
MARYLAND	66	43	46	53	54	51	50	50	33	77	22%	19%
MASSACHUSETTS	38	26	29	35	38	38	38	37	24	57	20%	15%
MICHIGAN	66	46	43	59	59	57	53	52	32	84	22%	25%
MINNESOTA	42	35	31	36	37	36	35	34	20	58	19%	17%
MISSISSIPPI	102	84	76	81	86	84	83	83	58	120	25%	39%
MISSOURI	71	58	54	63	65	63	60	59	35	96	22%	26%
MONTANA	58	49	44	48	47	46	46	41	22	72	16%	20%
NEBRASKA	52	45	40	42	42	41	41	43	24	71	19%	23%
NEVADA	90	59	56	73	76	71	73	74	47	118	21%	28%
NEW HAMPSHIRE	56	34	32	33	33	31	31	30	15	55	16%	14%
NEW JERSEY	48	35	34	41	41	39	38	39	26	61	20%	15%
NEW MEXICO	77	72	73	78	80	80	81	77	52	118	20%	35%
NEW YORK	49	35	38	44	46	45	46	46	30	70	21%	18%
NORTH CAROLINA	86	58	57	68	70	70	67	66	44	100	21%	27%
NORTH DAKOTA	43	42	36	36	38	37	37	35	16	66	15%	19%
OHIO	63	53	50	58	61	58	57	55	34	87	21%	27%
OKLAHOMA	81	76	69	67	72	70	69	68	41	105	21%	32%
OREGON	56	51	43	55	55	53	51	51	30	84	19%	26%
PENNSYLVANIA	52	41	40	46	47	46	44	44	28	68	22%	21%
RHODE ISLAND	45	33	36	44	46	48	50	46	32	72	21%	20%
SOUTH CAROLINA	89	66	63	71	73	71	66	67	46	97	21%	31%
SOUTH DAKOTA	50	53	46	47	48	48	44	43	23	74	17%	26%
TENNESSEE	87	64	61	72	76	72	70	71	43	114	23%	30%
TEXAS	84	74	72	78	79	78	78	78	52	116	23%	30%
UTAH	54	65	50	49	48	48	44	43	26	70	16%	24%
VERMONT	53	40	36	34	39	36	35	33	17	59	17%	17%
VIRGINIA	72	48	48	53	53	52	50	51	31	79	19%	21%
WASHINGTON	56	47	45	53	54	51	50	48	29	79	18%	22%
WEST VIRGINIA	72	58	54	57	56	56	56	54	33	87	18%	31%
WISCONSIN	44	40	39	43	44	42	41	39	23	64	22%	21%
WYOMING	89	79	59	56	54	49	50	48	25	86	17%	30%
U.S. TOTAL	68	53	51	60	62	61	60	59	38	92	22%	28%

Sources/Notes: The 1985-1993 rates are calculated by Child Trends. Denominators use the latest revised data from the U.S. Bureau of the Census, Population Estimates Branch. These revisions affect birth rates in some states. Population denominators for D.C. and less populated states are small and therefore some instability in rates can occur. Birth data and rates for 1970, 1980, and 1990 are published by the National Center for Health Statistics, Department of Health and Human Services. The 1970 rate represents the average for 1969-1971. Birth rates for 1994 are forthcoming in Ventura, S.J., Clarke, S.C., and Mathews, T.J. (1996), Recent declines in teenage birth rates in the United States: [illegible] by state, [illegible] 1994, National Center for Health Statistics.

TABLE 3. BIRTHS TO TEENAGE MOTHERS IN THE 100 LARGEST U.S. CITIES IN 1994

City	BIRTHS TO TEENS			Of All Births for City, % to Mothers Under Age 20	NUMBER OF BIRTHS TO TEENS UNDER AGE 20		BIRTHS TO UNMARRIED TEEN MOTHERS			Of all Births to Mothers Under Age 20 Percent Nonmarital
	Total Under 20	17 and Younger	Ages 18-19		White	Black	Total Under 20	17 and Younger	Ages 18-19	
AKRON, OH	668	286	402	19%	313	366	628	276	352	91%
ALBUQUERQUE, NM	1,191	504	687	15%	1,082	44	1,002	460	542	84%
ANAHEIM, CA	863	338	525	12%	809	28	585	256	329	88%
ANCHORAGE, AK	489	185	304	10%	324	57	380	168	212	78%
ARLINGTON, TX	505	196	309	10%	408	75	332	155	177	66%
ATLANTA, GA	1,722	851	871	20%	142	1,571	1,606	819	787	93%
AURORA, CO	474	189	285	11%	310	142	385	177	208	81%
AUSTIN, TX	1,348	572	774	14%	1,044	280	876	444	432	65%
BAKERSFIELD, CA	1,355	546	809	18%	1,178	164	1,060	481	599	80%
BALTIMORE, MD	2,555	1,294	1,261	22%	390	2,152	2,414	1,238	1,176	94%
BATON ROUGE, LA	820	356	464	17%	167	648	736	337	399	90%
BIRMINGHAM, AL	960	472	488	23%	93	867	887	452	435	92%
BOSTON, MA	1,012	420	592	12%	395	586	943	403	540	93%
BUFFALO, NY	976	451	525	17%	418	544	688	427	461	91%
CHARLOTTE, NC	859	416	443	12%	254	592	792	398	394	91%
CHICAGO, IL	10,797	4,952	5,845	19%	3,738	6,985	9,646	4,643	5,003	89%
CINCINNATI, OH	1,149	527	622	19%	330	817	1,081	519	562	94%
CLEVELAND, OH	2,000	914	1,086	20%	662	1,329	1,898	893	1,003	95%
COLORADO SPRINGS, CO	776	251	524	12%	641	104	477	212	265	62%
COLUMBUS, GA	594	260	334	21%	191	399	495	231	264	83%
COLUMBUS, OH	1,705	657	1,048	16%	880	794	1,469	619	850	86%
CORPUS CHRISTI, TX	904	401	503	19%	847	48	653	319	334	72%
DALLAS, TX	3,808	1,664	2,152	18%	2,227	1,545	2,887	1,382	1,505	79%
DAYTON, OH	627	273	354	21%	247	380	567	264	303	90%
DENVER, CO	1,373	620	753	16%	1,058	281	1,113	561	552	81%
DES MOINES, IA	448	176	272	13%	359	78	385	169	216	86%
DETROIT, MI	4,261	1,812	2,439	22%	442	3,764	4,078	1,777	2,301	96%
EL PASO, TX	2,350	947	1,403	17%	2,261	57	1,297	602	695	55%
FORT WAYNE, IN	560	227	333	15%	322	234	491	220	271	88%
FORT WORTH, TX	1,603	687	916	18%	1,052	521	1,020	502	518	64%
FREMONT, CA	173	61	112	5%	132	16	114	45	69	66%
FRESNO, CA	1,845	817	1,028	18%	1,314	202	1,232	570	662	67%
GARLAND, TX	484	194	270	14%	371	84	334	160	174	72%
GLENDALE, CA	139	57	82	5%	131	0	93	43	50	67%
GRAND RAPIDS, MI	633	281	352	15%	326	300	576	269	307	91%
GREENSBORO, NC	326	132	194	12%	89	223	291	125	166	89%
HIALEAH, FL	287	133	154	11%	276	11	201	101	100	70%
HONOLULU, HI	384	124	260	7%	88	17	301	118	183	78%
HOUSTON, TX	6,453	2,825	3,628	16%	4,148	2,224	4,366	2,095	2,271	88%
HUNTINGTON BEACH, CA	167	55	112	6%	158	5	88	32	56	53%
INDIANAPOLIS, IN	2,082	820	1,232	16%	1,168	893	1,811	774	1,037	88%
JACKSON, MS	747	345	402	23%	79	666	668	333	356	92%
JACKSONVILLE, FL	1,646	665	981	15%	777	836	1,319	597	722	80%
JERSEY CITY, NJ	667	299	368	18%	230	415	614	282	332	92%
KANSAS CITY, MO	1,122	490	632	17%	425	683	1,019	470	549	91%
KNOXVILLE, TN	421	161	260	17%	273	146	315	132	183	75%
LAS VEGAS, NV	1,182	471	711	13%	886	260	871	396	475	74%
LEXINGTON-FAYETTE, KY	429	172	257	13%	247	181	345	152	193	80%
LINCOLN, NE	269	91	178	9%	227	28	218	81	137	81%
LITTLE ROCK, AR	468	187	281	16%	96	372	422	176	246	90%
LONG BEACH, CA	1,305	515	790	13%	847	342	958	410	548	73%
LOS ANGELES, CA	9,961	4,083	5,878	14%	8,343	1,488	7,725	3,339	4,386	78%
LOUISVILLE, KY	1,240	570	670	20%	816	815	1,101	539	562	89%
LUBBOCK, TX	654	272	382	20%	561	89	396	192	204	61%
MADISON, WI	201	79	122	6%	97	80	171	74	97	85%
MEMPHIS, TN	2,555	1,131	1,424	22%	364	2,174	2,336	1,086	1,250	91%
MESA, AZ	784	299	485	13%	730	24	590	264	326	75%

(continued)

TABLE 3. BIRTHS TO TEENAGE MOTHERS IN THE 100 LARGEST U.S. CITIES IN 1994 (continued)

City	BIRTHS TO TEENS			Of All Births for City, % to Mothers Under Age 20	NUMBER OF BIRTHS TO TEENS UNDER AGE 20		BIRTHS TO UNMARRIED TEEN MOTHERS			Of all Births to Mothers Under Age 20, Percent Nonmarital
	Total Under 20	17 and Younger	Ages 18-19		White	Black	Total Under 20	17 and Younger	Ages 18-19	
MIAMI, FL	2,360	1,101	1,259	18%	955	1,396	2,017	1,013	1,004	85%
MILWAUKEE, WI	2,409	1,091	1,318	21%	701	1,620	2,249	1,058	1,191	93%
MINNEAPOLIS, MN	869	393	476	14%	272	420	801	370	431	93%
MOBILE, AL	707	314	393	19%	178	525	599	290	309	85%
MODESTO, CA	864	271	393	17%	562	31	485	212	283	70%
MONTGOMERY, AL	597	278	319	18%	105	489	529	267	262	89%
NASHVL.-DAVIDSON, TN	1,256	524	732	16%	628	617	1,040	469	571	83%
NEWARK, NJ	1,137	537	600	20%	335	800	1,063	514	549	93%
NEW ORLEANS, LA	2,063	943	1,120	24%	107	1,938	1,971	928	1,043	96%
NEWPORT NEWS, VA	540	182	358	13%	235	292	387	164	223	72%
NEW YORK, NY	14,147	5,917	8,230	11%	7,668	6,269	12,709	5,609	7,100	90%
NORFOLK, VA	799	309	490	17%	280	511	599	281	318	75%
OAKLAND, CA	969	412	557	14%	282	606	737	328	409	76%
OKLAHOMA CITY, OK	1,242	496	746	17%	761	409	917	410	507	74%
OMAHA, NE	750	302	448	14%	443	291	658	286	372	88%
ORLANDO, FL	1,054	429	625	17%	542	502	866	388	478	82%
PHILADELPHIA, PA	4,733	2,248	2,486	18%	1,427	3,216	4,530	2,209	2,321	96%
PHOENIX, AZ	3,577	1,471	2,106	17%	3,072	347	3,012	1,337	1,675	84%
PITTSBURGH, PA	739	345	394	16%	226	508	706	342	364	96%
PORTLAND, OR	931	389	542	13%	646	215	775	358	417	83%
RALEIGH, NC	359	139	220	10%	109	245	297	132	165	83%
RICHMOND, VA	552	246	306	19%	53	497	524	243	281	96%
RIVERSIDE, CA	877	343	534	14%	762	92	637	279	358	73%
ROCHESTER, NY	902	408	494	16%	341	549	837	396	441	93%
SACRAMENTO, CA	1,803	771	1,032	16%	1,021	467	1,255	583	672	70%
ST LOUIS, MO	1,683	773	910	26%	284	1,388	1,620	766	854	96%
ST PAUL, MN	677	281	396	14%	319	187	568	262	306	84%
ST PETERSBURG, FL	547	233	314	16%	231	308	476	218	257	87%
SAN ANTONIO, TX	3,703	1,683	2,020	17%	3,370	314	2,444	1,249	1,195	69%
SAN BERNARDINO, CA	883	435	448	16%	665	183	742	379	363	84%
SAN DIEGO, CA	2,346	890	1,456	11%	1,872	426	1,552	659	893	66%
SAN FRANCISCO, CA	686	280	406	8%	347	255	500	223	277	73%
SAN JOSE, CA	1,775	737	1,038	11%	1,508	98	1,265	576	689	71%
SANTA ANA, CA	1,447	560	887	15%	1,406	11	945	413	532	65%
SEATTLE, WA	590	244	346	8%	293	182	499	227	272	85%
SHREVEPORT, LA	676	318	358	21%	138	532	594	303	291	88%
SPOKANE, WA	448	161	285	13%	416	11	340	140	200	78%
STOCKTON, CA	1,018	446	572	18%	619	182	727	343	384	71%
TACOMA, WA	408	156	252	15%	276	90	345	142	203	85%
TAMPA, FL	1,309	573	736	18%	609	684	1,093	517	576	83%
TOLEDO, OH	1,012	393	619	18%	575	430	935	376	559	92%
TUCSON, AZ	1,414	557	857	16%	543	88	1,133	516	617	80%
TULSA, OK	975	398	577	16%	1,289	326	721	344	377	74%
VIRGINIA BEACH, VA	685	228	457	10%	452	215	490	198	292	72%
WASHINGTON, DC	1,632	767	865	16%	45	1,550	1,580	753	827	97%
WICHITA, KS	866	338	528	14%	614	222	657	289	368	76%
WORCESTER, MA	361	156	206	15%	301	44	327	147	180	91%
YONKERS, NY	281	111	170	10%	175	101	246	103	143	88%

Source/Notes: Unpublished data provided by Stephanie Ventura of the National Center for Health Statistics, Department of Health and Human Services; forthcoming in Vital Statistics of the United States, 1994, Vol. 1, Natality. Nonmarital births are inferred for California, Connecticut, Michigan, Nevada, and New York from information on the birth certificate.

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Compiled by: Kristin A. Moore, Ph.D., Angela Romano, and Cheryl Oakes
Child Trends, Inc., 4301 Connecticut Ave., NW, Suite 100, Washington, DC 20008 Fax 202/362-5533

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Jeff Lancashire, 301-436-7551
Sandra Smith, 301-436-7551
<paoquery@nch10a.em.cdc.

VITAL STATISTICS REPORT SHOWS BROAD GAINS IN THE NATION'S HEALTH

HHS Secretary Donna Shalala today released annual preliminary vital statistics findings for 1995, showing broad gains in national health indicators.

According to the report, the U.S. last year achieved:

- an historic low infant mortality rate;
- continued increase in the number of women obtaining early pre-natal care;
- the first decline in the birth rate for unmarried women in almost 20 years;
- continued decline in the teen birth rate;
- a dramatic decline in homicide deaths;
- a leveling in the HIV/AIDS death rate, for the first time since the epidemic took hold;
- a decline in the number of cesarean section births; and
- continued increase in life expectancy.

"Today we have good news about America's health," President Clinton said. "I'm particularly pleased to see that the teen birth rate has declined for the fourth straight year, and the out-of-wedlock birth rate has decreased for the first time in

- MORE -

nearly two decades. Preventing teen pregnancies has been one of my top priorities since taking office, and we must all work together to ensure these trends continue."

"These are welcome findings, and they indicate that we are moving in the right direction in improving health for Americans," Secretary Shalala said. "We still have challenges in every category, but we are making significant progress, and we should press ahead toward the goal of better health for all Americans."

The report, "Births and Deaths for 1995," prepared by the National Center for Health Statistics, part of HHS' Centers for Disease Control and Prevention, contains the latest preliminary U.S. natality and mortality statistics. Highlights include:

--The infant mortality rate reached a record low of 7.5 infant deaths per 1,000 live births in 1995, a 6 percent reduction from the previous year. Declines occurred among neonatal infants (infants under 28 days old) as well as postneonatal infants (28 days through 11 months), and among both white and black infants.

--The proportion of mothers beginning care in the first trimester (81 percent) continued to rise for the sixth consecutive year.

--The birth rate for unmarried women dropped 4 percent from 46.9 births per 1,000 unmarried women aged 15-44 years in 1994 to 44.9 in 1995. This is the first decline in nearly two decades. The number of nonmarital births also declined three percent in 1995 to approximately 1,248,000,

and the proportion of births to unmarried mothers fell two percent to an estimated 32 percent in 1995. The proportions for white (25.3 percent) and black births (69.5 percent) were about one percent lower than in 1994, while the proportion for Hispanic women (40.8 percent) was five percent lower than in 1994.

--The teen birth rate dropped an estimated 3 percent from 1994 to 1995 (56.9 per 1,000 women aged 15-19) and 8 percent from 1991 (62.1) to 1995. Declines were recorded for white, American Indian, Asian or Pacific Islander, and Hispanic teens; the rate for black teens dropped 9 percent from 1994 to 1995 and 17 percent from 1991 to 1995.

--Preliminary age-adjusted homicide rates fell sharply in 1995, by an estimated 15 percent, accounting for the largest decline among leading causes of death between 1994 and 1995. Mortality from firearms also declined between 1994 and 1995.

--For the first time, HIV/AIDS death rates did not increase from the previous year. The age-adjusted death rate from HIV infection was 15.4 deaths per 100,000 population in 1995, the same rate as in 1994. Despite the plateau in mortality rates from HIV/AIDS, however, the number of deaths from the disease rose from 42,114 in 1994 to approximately 42,500 in 1995, the highest total ever reported.

--The cesarian section rate declined for the sixth consecutive year (20.8 percent of live births in 1995.

--Estimated life expectancy in 1995 matched the record high of 75.8 years attained in 1992, and was slightly above the estimate of 75.7 years of 1994. Although racial disparities still exist, life expectancy for both white and black males (73.4 and 65.4, respectively) and black females (74.0) was higher in 1995 than in previous years. For white females, life expectancy was unchanged at 79.6 years from the previous year, and slightly below the record high of 79.8 reached in 1992.

Preliminary vital statistics data are issued annually each fall. However, Secretary Shalala said, today's report

represents the results of a new initiative to improve the timeliness and quality of vital statistics in the U.S.

These preliminary data are based on up to 90 percent of all birth and death records reported to the states. In the past, "provisional" annual data on deaths were based on a ten percent sample of records. And this is the first time that detailed birth data have been available on a preliminary basis.

"We're putting a system into place that effectively addresses the growing public demand for faster and more accurate health information," Secretary Shalala said. "We are now on a schedule to provide near-final vital statistics at least a year earlier than we used to be able to do."

The report is available from the National Center for Health Statistics, 6525 Belcrest Rd., Hyattsville, MD 20782 or by e-mail at paoquery@nch10a.em.cdc.gov.

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'Babies having babies' trend on declin

By Cheryl Wetzstein
THE WASHINGTON TIMES

The teen birthrate has dropped for most of the country for the fourth year in a row, signaling a societal trend, a Washington research group says in a report released today.

Recent state-by-state data "strongly suggest that the changes that are contributing to the decline in teen birthrates are happening on a broad societal level," said Kristin A. Moore, executive director of Child Trends Inc., a nonprofit group that tracks data on children and families.

"Between 1986 and 1991, the teen birthrate increased in every state; since then, it has decreased in almost every state," she said.

Of the 46 states that saw their birthrates decline since 1991, 12 states saw drops of about 10 percent or more, Child Trends said in its new Facts at a Glance report, which uses data from the federal National Center for Health Statistics, states and major cities.

The District, which has had the nation's highest teen birthrate for years and in 1993 had an unprecedented rate of 129 births per 1,000 teens, saw a drop to 115 births per 1,000 teens in 1994, the organization said.

New York and Connecticut saw no change in their teen birthrates, and Nebraska and Rhode Island saw their birthrates increase.

Births to teen mothers reached a historical peak in 1957, with 96.3 births per 1,000 girls aged 15 to 19.

The rate fell to a low point in 1986, with 50.2 births per 1,000 teens, but then climbed to its most recent peak of 62.1 births per 1,000 teens in 1991.

Since 1991, the birthrate has dipped each year, and preliminary data for 1995 show that the downward trend for teen births is continuing — the 1995 rate is 56.9 per 1,000 teens.

Researchers have not determined why the birthrates are dropping. Activists, however, are eager to point to many causes: Some say teens use contraceptives more regularly and effectively; others say teens are responding to the myriad school- and church-related abstinence programs.

Child Trends said forthcoming data on teen sexual activity will likely help answer questions about why teen birthrates are declining.

Child Trends cautioned that though overall teen birthrates are dropping, the percent of births occurring to unmarried teens is still climbing — as is the unwed-birth rate of women in their 20s.

In 1960, 15 percent of births to teens were outside of wedlock. Since then, the percentage of unwed teen births has steadily increased, reaching 76 percent in 1994.

The rate of births to unwed women aged 20 to 24 has also skyrocketed, from 5 percent in 1960 to 45 percent in 1994.

Compared to children raised by two parents, children raised by single parents are at risk for school and health problems, poverty, involvement in crime and drugs, and teen childbearing.

More than 50 percent of all new welfare cases are due to births to unmarried women.

TEEN BIRTHRATES FALL AGAIN

Teen birthrates were lower in 1994 than they were in 1991 in 46 states and the District of Columbia, according to the nonprofit research group Child Trends.
Births per 1,000 teen mothers, ages 15-19 in:

State	1991	1994	% change
Alabama	74	72	– 2.7
Alaska	65	55	–15.3
Arizona	80	79	– 1.2
Arkansas	80	76	– 5.0
California	74	71	– 4.0
Colorado	58	54	– 6.8
Connecticut	40	40	0
Delaware	61	60	– 1.6
District of Columbia	116	115	– 0.8
Florida	68	64	– 5.8
Georgia	76	72	– 5.2
Hawaii	59	54	– 8.4
Idaho	54	47	–12.9
Illinois	65	63	– 3.0
Indiana	61	58	– 4.9
Iowa	43	40	– 6.9
Kansas	55	54	– 1.8
Kentucky	69	65	– 5.7
Louisiana	76	75	– 1.3
Maine	44	36	–18.1
Maryland	54	50	– 7.4
Massachusetts	38	37	– 2.6
Michigan	59	52	–11.8
Minnesota	37	34	– 8.1
Mississippi	86	83	– 3.4
Missouri	65	59	– 9.2
Montana	47	41	–12.7
Nebraska	42	43	+ 2.3
Nevada	75	74	– 1.3
New Hampshire	33	30	– 9.0
New Jersey	41	39	– 4.8
New Mexico	80	77	– 3.7
New York	46	46	0
North Carolina	70	66	– 5.7
North Dakota	36	35	– 2.7
Ohio	61	55	– 9.8
Oklahoma	72	66	– 8.3
Oregon	55	51	– 7.2
Pennsylvania	47	44	– 6.3
Rhode Island	45	48	+ 6.6
South Carolina	73	67	– 8.2
South Dakota	48	43	–10.4
Tennessee	75	71	– 5.3
Texas	79	78	– 1.2
Utah	48	43	–10.4
Vermont	39	33	–15.3
Virginia	53	51	– 3.7
Washington	54	48	–11.1
West Virginia	58	54	– 6.8
Wisconsin	44	39	–11.3
Wyoming	54	48	–11.1
National average	**62.1**	**58.9**	**– 5.1**

The Washington Times

The Washington Times
TUESDAY, OCTOBER 29, 1996

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After delay, FBI turns over documents

New citizens' past crimes listed

By Ruth Larson
THE WASHINGTON TIMES

The Justice Department yesterday agreed to allow the FBI to give Congress 52 boxes of criminal records on newly naturalized citizens after intense, daylong efforts to prevent their release.

Justice Department spokeswoman Carole Florman said the delay was caused by "concern about the use of the files" and fears that people could be identified, even though names and Social Security numbers were deleted from the documents.

Rep. Bill Zeliff, New Hampshire Republican, refused to accept new conditions and insisted on delivery as promised.

FBI Director Louis J. Freeh said Friday that Attorney General Janet Reno had authorized him to turn over the records, which were subpoenaed last week by a House Government Reform and Oversight subcommittee probing abuses of the citizenship process.

But shortly before the truck was scheduled to deliver the boxes to Capitol Hill yesterday afternoon, Deputy Attorney General Jamie Gorelick balked at the deal.

The boxes were delivered to the Rayburn House Office Building in the evening.

They are thought to contain 38,246 criminal records found by the FBI last week in its initial review of an Immigration and Naturalization Service computer tape of recent citizenship applicants.

"He feels it's absolutely wrong to prevent the public from learning what it absolutely has a right to know," said a member of Mr. Zeliff's staff.

A congressional investigator said of Mrs. Gorelick's tactics, "This is just outrageous, for her to be weighing in at the last minute."

He added: "They're scared to death that the rap sheets are going to get out. In every major city — in Chicago, say — they're afraid they're going to have to put out fires on all the murderers they let in."

Rosemary Jenks, director of policy analysis for the Center for Immigration Studies, said: "It's ridiculous. The INS is still trying to stonewall this investigation, when the evidence is clear that criminals were naturalized."

For months, INS employees have expressed concerns about criminal immigrants. In May, an INS employee wrote: "I suggest we keep the current [file] six months, or we'll be naturalizing ax murderers . . . and Nazi war criminals."

Miss Jenks said, "It's interesting that the No. 2 official in the Justice Department was also implicated in the political pressure that came from the White House."

Mrs. Gorelick's name turns up several times in internal White House memos. For example, Doug Farbrother, a staffer in Vice President Al Gore's office, wrote in March about Mrs. Gorelick and INS Deputy Commissioner Chris Sales: "I favor drastic measures. I am meeting with Jamie G and Chris S Friday at 1:30. If I don't get what we need, I will call for heavy artillery."

A subsequent memo outlined the results of that meeting and noted, "Jamie said she would deliver by Tuesday."

The number of convicted criminals granted citizenship has become a hot issue in recent days. Republican Govs. Pete Wilson of California, George W. Bush of Texas, Christine Todd Whitman of New Jersey, Jim Edgar of Illinois and David Beasley of South Carolina have demanded that Miss Reno disclose the number of criminals naturalized.

The FBI has not reviewed a second INS computer tape but estimated that as many as 100,000 of the more than 1 million new citizens have criminal records.

INS Commissioner Doris Meissner defended her agency's screening procedures. "INS deports criminal aliens; we do not naturalize them," she said. "INS is removing criminal aliens from the country at record levels," more than 100,000 the past three years.

Mr. Zeliff also has subpoenaed INS documents on possible criminal aliens. Mrs. Meissner has not said when those records will be turned over, only that the INS has "initiated the necessary process to produce the full range of information requested" in Mr. Zeliff's Sept. 17 and Oct. 16 letters.

Mrs. Meissner said the INS has just completed work on a rule change, begun in 1994, enabling the agency to dramatically speed up the process for revoking citizenship "in the small number of cases in which it has been inappropriately granted."

"Swift action in this limited number of cases should not sully, as the recent misinterpretation of our Citizenship USA program does, the reputations of more than one million new American citizens," she wrote.

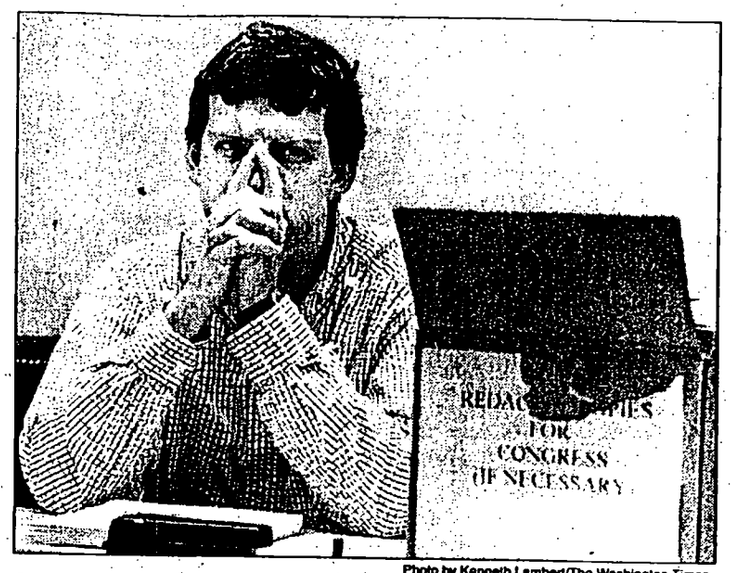

Photo by Kenneth Lambert/The Washington Times

Congressional staffer John Knepper spends the night of his 26th birthday going through the criminal records delivered to a House panel.

> ***"They're scared to death that the rap sheets are going to get out."***
>
> *— Congressional investigator*


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Facts in Brief

Teen Sex And Pregnancy

SEXUAL ACTIVITY

- Most adolescents begin having intercourse in their mid-to-late teens, about 8 years before they marry.
- 56% of young women and 73% of young men today have had intercourse by age 18, compared with 35% of young women and 55% of young men in the early 1970s.
- While the likelihood of having intercourse increases steadily with age, 1 in 5 teens do not have intercourse during their teenage years.
- 7 in 10 women who had sex before age 14, and 6 in 10 of those who had sex before age 15, report having had sex involuntarily.
- Among sexually active 15–17-year-old women, 55% have had 2 or more partners and 13% have had at least 6.

CONTRACEPTIVE USE

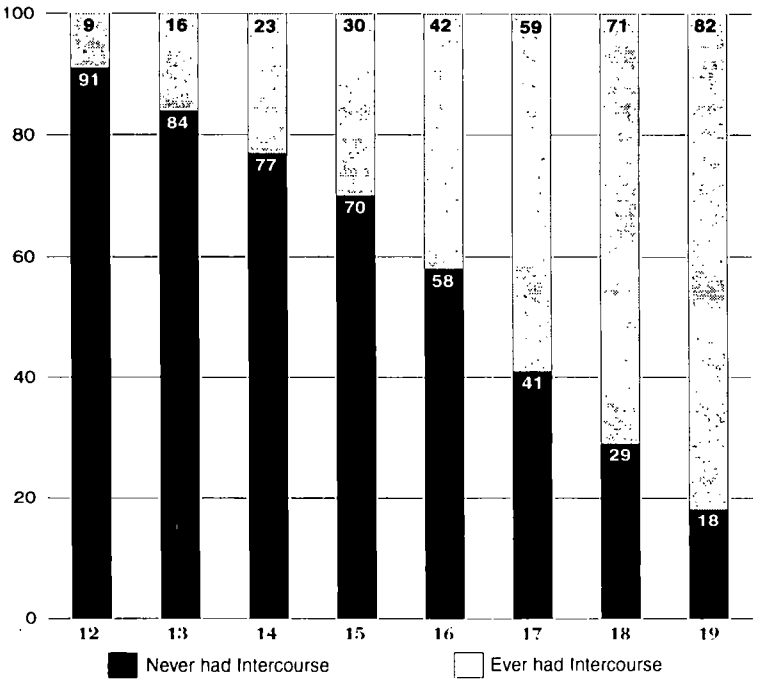
- A sexually active teenager who doesn't use contraception has a 90% chance of pregnancy within one year.
- 2/3 of teens use some method of contraception—usually a condom—the first time they have sex.
- Teenage women's contraceptive use at first intercourse rose from 48% to 65% during the 1980s, almost entirely because of a doubling in condom use (from 23% to 48%).
- At least 7 in 10 teenage women and their partners currently use a contraceptive method.
- 1/4 of the 1.7 million teens who use the pill also use condoms.
- Single teens who use contraceptives are less likely to become pregnant than are single women in their early 20s who practice contraception.

SEXUALLY TRANSMITTED DISEASES (STDs)

- Every year 3 million teens—about 1 in 4 sexually experienced teens—acquire an STD.
- In a single act of unprotected sex with an infected partner, a teenage woman has a 1% risk of acquiring HIV, a 30% risk of getting genital herpes and a 50% chance of contracting gonorrhea.
- Chlamydia is more common among teens than among older men and women; in some settings, 10–29% of sexually active teenage women and 10% of teenage men tested for STDs have been found to have chlamydia.
- Teens have higher rates of gonorrhea than do sexually active men and women aged 20–44.
- In some studies, up to 15% of sexually active teenage women have been found to be infected with the human papillomavirus (HPV), many with a strain of the virus linked to cervical cancer.
- Teenage women have a higher hospitalization rate than older women for acute pelvic inflammatory disease (PID), which is most often caused by untreated gonorrhea or chlamydia. PID can lead to infertility and ectopic pregnancy.

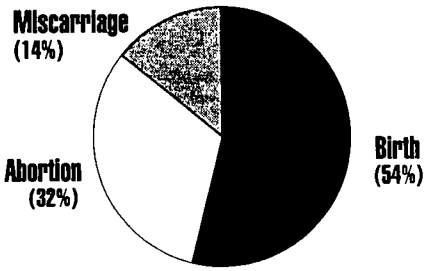
Sex is rare among very young teenagers, but common in the later teenage years.

% of 12–19-year-olds, 1988



The Alan Guttmacher Institute
New York and Washington

Teen Pregnancy Outcomes



More than half (54%) of the almost 1 million teenage pregnancies each year (960,000 in 1992) end in births (most of which are unplanned).

TEEN PREGNANCY

- Each year, almost one million teenage women—11% of all women aged 15–19 and 20% of those who have had sexual intercourse—become pregnant.
- 85% of teen pregnancies are unplanned, accounting for about 1/4 of all accidental pregnancies annually.
- 6 in 10 teen pregnancies occur among 18–19 year-olds.
- Teen pregnancy rates are much higher in the United States than in many other developed countries—twice as high as in England and Wales or Canada, and nine times as high as in the Netherlands or Japan.
- Among sexually experienced teens, about 8% of 14-year-olds, 18% of 15–17-year-olds and 22% of 18–19-year-olds become pregnant each year.

CHILDBEARING

- 13% of all U.S. births are to teens.
- The fathers of babies born to teenage mothers are likely to be older than the women: Half of the fathers of babies born to women aged 15–17 are 20 years of age or older. About 1 in 5 of all teenage mothers had a partner six or more years older.
- 76% of births to teens occur outside of marriage.
- Teens now account for only 31% of all nonmarital births, down from 50% in 1970.
- 1/4 of teenage mothers have a second child within 2 years of their first.

TEEN MOTHERS AND THEIR CHILDREN

- Teens who give birth are much more likely to come from poor or low-income families (83%) than are teens who have abortions (61%) or teens in general (38%).
- In 1993, 3.8 million mothers aged 15–44 received welfare or Aid to Families with Dependent Children (AFDC); 55% of these women became mothers when they were teenagers. Only 5% were currently teenage mothers, and 83% of these—159,000—were aged 18–19; young teens, those aged 15–17 accounted for 32,000 of all mothers receiving AFDC.
- 7 in 10 teen mothers complete high school, but they are less likely than women who delay childbearing to go on to college.
- In part because most teen mothers come from disadvantaged backgrounds, 28% of them are poor in their 20s and early 30s; only 7% of women who first give birth after adolescence are poor at those ages.
- 1/3 of pregnant teens receive inadequate prenatal care; babies born to young mothers are more likely to be low birth weight, to have childhood health problems and to be hospitalized than are those born to older mothers.

ABORTION

- Nearly 4 in 10 teen pregnancies (excluding miscarriages) end in abortion. There were about 308,000 abortions among teens in 1992.
- Since 1980, abortion rates among sexually experienced teens have declined steadily, because fewer teens are becoming pregnant, and in recent years, fewer pregnant teens have chosen to have an abortion.
- The reasons most often given by teens for choosing to have an abortion are concern about how having a baby would change their lives, feeling that they are not mature enough to have a child and having financial problems.
- 25 states currently have mandatory parental involvement laws in effect for a minor seeking an abortion: AL, AR, DE, GA, IN, KS, KY, LA, MD, MA, MI, MN, MS, MO, NE, NC, ND, OH, PA, RI, SC, UT, WV, WI and WY.
- 61% of minors who have abortions do so with at least one parent's knowledge; 45% of parents are told by their daughter. The great majority of parents support their daughter's decision to have an abortion.

SOURCES OF DATA

The data in this fact sheet are the most current available. Most of the data are from research conducted by The Alan Guttmacher Institute (AGI) and /or published in the peer-reviewed journal *Family Planning Perspectives* and the 1994 AGI report *Sex and America's Teenagers*. Additional sources include the Centers for Disease Control and Prevention and the National Center for Health Statistics.

The Alan Guttmacher Institute

New York and Washington

A Not-for-Profit Corporation for Reproductive Health Research, Policy Analysis and Public Education

120 Wall Street
New York, NY 10005
Telephone: 212 248-1111
Fax: 212 248-1951
info@agi-usa.org

1120 Connecticut Ave. NW
Suite 460
Washington, DC 20036
Telephone: 202 296-4012
Fax: 202 223-5756
policyinfo@agi-usa.org

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FACTS in BRIEF

The Alan Guttmacher Institute
New York and Washington

A Not-for-Profit Corporation
for Reproductive Health
Research, Policy Analysis
and Public Education

120 Wall Street
New York, NY 10005
Telephone: 212 248-1111
FAX: 212 248-1951

1120 Connecticut Avenue, NW, Suite 460
Washington, DC 20036
Telephone: 202 296-4012
FAX: 202 223-5756

Pregnancy and Birth in the United States

BIRTHS

- In 1990, there were more than 6 million pregnancies, of which 4,158,212 resulted in births and the rest in abortions and miscarriages. 7% of women aged 15–44 give birth each year.
- 41% of all births in 1990 were first babies.
- At any one time, 10% of sexually active women are pregnant, postpartum or attempting to become pregnant; half have had a first birth by age 26 and half have had the number of children they want by age 30.
- On average, women today have 2 children.
- Most births are to married women (72%) and are planned (60%).
- 98% of single women who give birth keep their child.
- Half of all births to poor women are unplanned.
- 13% of all births are to teenagers, 73% of these births are unplanned; ⅔ of births to teenagers are to those unmarried.
- Birthrates (births per 1,000 women) are highest among women aged 20–29, married women and nonwhite women.
- Birthrates for women aged 15–17 in 1990 (36.5 per 1,000) were 23% higher than in 1986 (30.5 per 1,000) and the highest since 1973.
- Birthrates for women aged 30-44 in 1990 were the highest since the early 1970s.

LOW BIRTH WEIGHT AND PREMATURITY

- Most newborns are healthy; however, 1 in 5 in 1985 were born with a health problem.
- 7% of newborns are of low birth weight (LBW is defined as less than 5.5 lbs.); 10% are born preterm or before 37 weeks of pregnancy. LBW and preterm births rose in the late 1980s.
- Women who do not obtain adequate prenatal care have twice the risk of having a LBW or preterm baby.
- The proportion of LBW babies born to black women (13%) is more than double that of whites (6%) and is higher among Hispanics (6%) and Native Americans (6%); it is lowest among Asians (5%).*
- Preterm births are higher among blacks (18%), Native Americans (12%) and Hispanics (11%) than among whites (9%) and Asians (7%).*
- Large variations exist in levels of LBW, preterm delivery and infant mortality among counties within some states.
- States with the highest levels of LBW births include Ga., La., Miss. and S.C., and the District of Columbia; states with the lowest levels include Alaska, Maine, Minn., N.H. and N. Dak.

INFANT AND MATERNAL MORTALITY

- The infant mortality rate (deaths of infants under age 1 per 1,000 births) was half as high in 1989 (9.8) as in 1970 (20); still, 1% of infants die before their first birthday.
- The infant mortality rate among black babies, however, is more than twice that of white babies (18 compared with 8 per 1,000).
- Nearly 20 countries report lower infant mortality rates than does the United States; lower rates are due in part to higher rates of participation in prenatal care.
- Infant mortality rates are highest in the District of Columbia (22) and in Ala., Ga., Miss., N.C. and S.C. (11.9 to 12.6) and lowest in Mass., Maine, Minn., N.H. and Vt. (7.4 to 8.0).
- The maternal mortality rate (number of deaths to women from complications of pregnancy and childbirth per 100,000 live births) dropped from 9.2 in 1980 to 7.9 in 1989.
- The maternal mortality rate among black women (18.4) is double that of Hispanic women (9.2) and more than triple that of white women (5.6).

ACCESS TO PRENATAL CARE*

- Pregnancy and childbirth are relatively safe, but 6 in 10 mothers experience some health problems—half of which are major.
- 16% of women who give birth receive inadequate prenatal care—they begin care in the fifth month of pregnancy or later, or they begin early but make less than half the number of visits recommended by the American College of Obstetricians and Gynecologists.
- Only ¾ of women who gave birth in 1989 obtained prenatal care in the first 3 months of pregnancy; ¼ did not obtain care until the second trimester of pregnancy or later, or received no care at all.
- Between 1980 and 1989, the proportion of women initiating prenatal care in the last 3 months of pregnancy or receiving no prenatal care at all increased from 5% to 6.3%.
- ⅓ of teenage mothers receive inadequate care, a level about twice that of all mothers.

- ⅓ of unmarried women who give birth receive inadequate prenatal care, a rate 3 times that among married women.
- 32% of native American women, 27% of black women and 30% of Hispanic women obtain inadequate care, compared with 13% of white and Asian women.
- 8 states and the District of Columbia have 20% or more women receiving inadequate prenatal care (Ariz., Ark., Fla., N. Mex., Okla., S.C., Tex. and W. Va.); the District of Columbia (28%) and N. Mex. (27%) have the highest proportions of pregnant women receiving inadequate care.
- Barriers to prenatal care include lack of, or inadequate, public and private insurance coverage, lack of coordination between health and social services for low-income women, and inhospitable conditions at some prenatal care sites. Other obstacles include the lack of knowledge, and the attitudes, fears and lifestyles among some pregnant women.

PROVISION OF MATERNITY CARE*

- 76% of all prenatal visits are to private physicians; 14% take place in hospitals and 10% in nonhospital clinics.
- Although low-income women are less likely than other women to go to private practitioners for prenatal care, private physicians are still the most common source of care for these women (40%). Hospital clinics provide care to 29% and health departments serve 23%; 8% of women obtain care from other sources.
- For uninsured women, health departments are the main source of care (49%); 23% of these women are served by doctors' offices and 22% by hospital clinics; 6% rely on other sources.
- More than 42,000 of all obstetricians-gynecologists (OB/GYNs) (83%) and general practice or family physicians (29%) provide obstetric care.
- At most, 5,400 clinic sites are involved in the delivery of prenatal care to poor women.
- 29% of hospitals are likely to provide prenatal care services because they handle at least 400 births annually, have an outpatient department and have an OB/GYN on staff.
- Community and migrant health services are highly concentrated and play a major role in the provision of prenatal care in only 6 states (Idaho, Nev., S. Dak., Vt., Wash. and W. Va.).
- No source of clinic-based prenatal care is apparent in 799 (26%) of all U.S. counties; 6% of all births occur to women who live in these counties.
- 99% of all births take place in a hospital; 1% take place at home, a birthing center, a clinic or a doctor's office. 95% of women are delivered by a physician, and 4% by a midwife.

FUNDING FOR MATERNITY CARE**

- Prior to major changes in Medicaid maternity care coverage instituted in the late 1980s, 1 in 4 women of reproductive age (more than 15 million) had no private or public maternity insurance coverage; and 27% of the uncompensated hospital care in 1985 was maternity care.
- In addition to Medicaid, prenatal care services for low-income women are provided through Maternal and Child Health block grants to the states, grants to community and migrant health centers and grants through the Indian Health Service.
- Medicaid paid for 17% of all deliveries in 1985; it paid for more than half the deliveries to unmarried women and more than ⅓ of those to teens.
- It is still too early to determine the extent to which federal and state prenatal care reforms (such as expanded Medicaid coverage for prenatal care and delivery) may have increased pregnant women's use of prenatal care and improved maternal and infant health.
- Each dollar spent on providing more adequate prenatal care for poor women could reduce total public expenditures by more than $3.00 for medical care to their infants in the first year of life.
- For every LBW birth averted by earlier or more consistent prenatal care, the United States saves up to $30,000 in infant hospitalizations and associated long-term health care costs.

SOURCES OF DATA

The data in this factsheet are from research conducted by The Alan Guttmacher Institute, and from the Centers for Disease Control and Prevention, the Institute of Medicine, the National Center for Health Statistics and/or were published in *Family Planning Perspectives*. All data are from the latest year available. Unless otherwise specified, data are from 1989 and refer to women aged 15–44; numbers may not add to totals because of rounding.

*1984–1986 data.
**1985 data.

FOR MORE INFORMATION FROM THE ALAN GUTTMACHER INSTITUTE:

Blessed Events and the Bottom Line: Financing Maternity Care in the United States, 1987, 64pp., $15.00.

The Financing of Maternity Care in the United States, 1987, 424 pp., $40.00.

Preventing Pregnancy, Protecting Health: A New Look at Birth Control Choices in the United States, 1991, 129 pp., $20.00.

Prenatal Care in the United States: A State and County Inventory, 1989, Volume I and II, 412 pp., $50.00.

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Family Planning Perspectives, 1-year subscription—6 issues: $38.00 for institutions, $28.00 for individuals.

State Reproductive Health Monitor: Legislative Proposals and Actions, 1-year subscriptions—4 issues: $120.00 for institutions, $100.00 for individuals.

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The Alan Guttmacher Institute
New York and Washington

A Not-for-Profit Corporation
for Reproductive Health
Research, Policy Analysis
and Public Education

120 Wall Street
New York, NY 10005
Telephone: 212 248-1111
FAX: 212 248-1951

1120 Connecticut Avenue, NW, Suite 460
Washington, DC 20036
Telephone: 202 296-4012
FAX: 202 223-5756

Teenage Reproductive Health in the United States

SEXUAL ACTIVITY

- Most teenagers begin having intercourse in their mid-to-late teens, about 8 years before they marry.
- 56% of women and 73% of men today have intercourse before age 18, compared to 35% and 55% in the early 1970s.
- Most very young teenagers have not had intercourse—84% of 13-year-olds, 77% of 14-year-olds and 70% of 15-year-olds.
- While the likelihood of having intercourse increases steadily with age, 1 in 5 teenagers do not have intercourse during their teenage years. 12% of 19-year-old women and 3% of 19-year-old men are married. Levels of sexual activity by race and ethnicity have narrowed in recent decades.
- Half of black women report having had intercourse by age 16.5—a year sooner than white and Hispanic women; and ½ of young black men say they have had sex by age 15, about 2 years sooner than Hispanic and white men.
- Teenagers in families with incomes below $20,000 have sex about 4–6 months sooner than those from higher income families.
- 7 in 10 women who had sex before age 14 and 6 in 10 of those who had sex before age 15 report having had sex involuntarily.
- ½ of sexually experienced teenage women wait almost 18 months between first intercourse and having sex with a second sexual partner; for another ¼, the gap is almost 2 years.
- Among sexually active 15–17-year old women, 55% have had 2 or more partners and 13% have had at least 6.

CONTRACEPTIVE USE

- A sexually active teenage woman using no contraceptive over one year has a 90% chance of becoming pregnant.
- ⅔ of teenagers use some method of contraception—usually a condom—the first time they have sex.
- Teenage women's contraceptive use at first intercourse rose from 48% to 65% during the 1980s, almost entirely because of a doubling in condom use (from 23% to 48%).
- Between 72% and 84% of teenage women and their partners use a contraceptive method on an ongoing basis. Black (77%) and Hispanic (65%) teenagers are somewhat less likely than white (81%) teenagers to use contraception; higher income teenagers (83%) are more likely than low-income (71%) or poor (78%) teenagers to use contraception.
- ¼ of the 1.7 million teenagers who use the pill, also use condoms.
- Single teenagers are less likely to become pregnant while using contraception than are single women in their early 20s.
- Higher income teenagers and those using the pill have the lowest accidental pregnancy rates.

SEXUALLY TRANSMITTED DISEASES (STDs)

- 3 million teenagers—about 1 in 4 sexually experienced teenagers—acquire an STD every year.
- In a single act of unprotected sex with an infected partner, she has a 1% risk of acquiring HIV, a 30% risk of getting genital herpes, and a 50% chance of contracting gonorrhea.
- Chlamydia is more common among teenagers than among older men and women; in some studies, 10%–29% of sexually active teenage women and 10% of teenage men tested in different settings for STDs have been found to have chlamydia.
- Teenagers have higher rates of gonorrhea than sexually active men and women aged 20–44.
- In some studies, up to 15% of sexually active teenage women have been found to be infected with HPV, many with a strain of the virus linked to cervical cancer.
- Infectious syphilis rates more than doubled among teenagers since the mid-1980s.
- Infertility, cancer and HIV infection can result from an STD. Teenage women have the highest rate of hospitalization for acute pelvic inflammatory disease, most often caused by untreated gonorrhea or chlamydia, which can lead to infertility and ectopic pregnancy.

TEENAGE PREGNANCY

- One million teenage women—12% of all women aged 15–19 (117 per 1,000) and 21% of those who have had sexual intercourse (207 per 1,000)—become pregnant each year.
- The pregnancy rate among sexually experienced teenagers dropped from 254 to 207 per 1,000 (19%) in the last two decades.
- 85% of teenage pregnancies are unplanned, accounting for about ¼ of all accidental pregnancies each year.
- ½ of the more than 1 million teenage pregnancies (1,040,000 in 1990) each year end in birth (most of which are unplanned); about ¼ in abortion (35%) and the rest in miscarriage (14%).
- 6 in 10 teenage pregnancies occur among 18–19-year-olds.
- Among sexually experienced teenagers, about 9% of 14-year-olds, 18% of 15-17-year-olds and 22% of 18-19-year olds become pregnant each year.
- Only 26% of the men involved in the pregnancies among women under age 18 are estimated to have been that young.
- Teenage pregnancy rates are much higher in the United

States than in many other developed countries—twice as high as in England and Wales, France and Canada; and 9 times as high as in the Netherlands or Japan.

CHILDBEARING

- Of all births to U.S. women, 12% are to teenagers.
- After a 15-year decline, teenage birthrates have risen from 98 in 1988 to 107 in 1990 per 1,000 sexually experienced teenage women.
- Birthrates have risen among teenagers of all races, but have been most pronounced among Hispanics.
- The rise in birthrates reflects a higher proportion of teenagers having intercourse, but also a higher proportion of pregnant teenagers giving birth rather than having abortions.
- Overall, about 1 in 5 fathers of babies born to adolescent women are not teenagers. Nearly ⅓ of the fathers of babies born to 15-year-old mothers are six or more years older.
- Adolescents now account for only 30% of all out-of-wedlock births, down from 50% in 1970.
- In 1991, about 368,000 unmarried teenagers gave birth. 7 in 10 births to teenagers occur outside marriage.
- The percentage of first births to teenagers that occur out of wedlock has increased dramatically since the early 1960s—from 33% to 81%.
- Births to black teenagers are more likely to be nonmarital (92%) than are births to whites (57%), largely because marriage among blacks is less common.
- 24% of teenage mothers have a second child within twenty-four months of their first.

TEENAGE MOTHERS AND THEIR CHILDREN

- 1 in 4 black women and 1 in 7 white women are already mothers at age 19.
- Teenagers who give birth are much more likely to come from poor or low-income families (83%) than are teenagers who have an abortions (61%) or teenagers in general (38%).
- Blacks and Hispanics, who are disproportionately poor or low-income, have a higher likelihood than whites of becoming adolescent mothers.
- Teenage mothers are more likely than older mothers to rely on public assistance to pay for having and raising a child.
- Over 70% of teenage mothers complete high school, but they are less likely than older mothers to both finish high school or go on to college.
- 31% of teenagers who become mothers before age 17 and 24% of those who are aged 18–19 when they first give birth have a second child within 2 years.
- Teenagers who give birth eventually have a median family income well above poverty, but only ½ the future family income of those who postpone their first birth until age 25 or older.
- 28% of women who become mothers as teenagers are poor in their 20s and early 30s; only 7% of women who first give birth after adolescence are poor at those ages.
- ⅓ of pregnant teenagers receive inadequate prenatal care; babies born to young mothers are more likely to be low birth weight, to have childhood health problems and to be hospitalized than are those born to older mothers.
- Poverty status is one of the strongest predictors of low birth weight, especially among teenage mothers.
- ½ of children under age 6 who were born to women younger than 18 live with only one parent, usually their mothers, compared with ¼ of those born to women in their early 20s.
- 75% of black children under age 6 born to teenagers live with a single parent, compared with 44% of Hispanic children and 37% of white children born to teenage mothers.

ABORTION

- 4 in 10 teenage pregnancies (excluding miscarriages) end in abortion. There were about 364,000 teenage abortions in 1990.
- About ¾ of higher income teenagers who accidentally become pregnant have abortions, compared with fewer than ½ of those from poor or low-income families.
- Pregnant teenagers whose parents have more education are more likely than those with less-educated parents to end their pregnancies in abortion.
- The teenage abortion rate among minorities is considerably higher than among whites (75 vs. 36 per 1,000 women aged 15–19), because they have more unintended pregnancies.
- Since 1980, abortion rates among sexually experienced teenage women have declined steadily, in the early 1980s because fewer teenagers have become pregnant and because fewer pregnant teenagers have chosen to have an abortion.
- The reasons most often given by teenagers for choosing to have an abortion are: concern about how having a baby would change their lives, feeling that they are not mature enough to have a child, and financial problems.
- 25 states currently have mandatory parental involvement laws in effect for a minor to obtain an abortion: AL, AR, GA, ID, IN, KS, LA, MA, MD, MI, MN, MO, MS, ND, NE, OH, PA, RI, SC, TN, UT, WI, WV and WY. The laws in all of these states except ID, MD and UT stipulate that a minor can seek a court order authorizing the procedure without parental knowledge; MD allows a physician to waive parental notification. CT requires counseling by a professional for minors under age 16; MA requires parental consent or counseling by a professional.
- In 46 states and the District of Columbia, mothers who are minors may legally place their child for adoption without involving their parents.
- 61% of minors have abortions with a parent's knowledge; 45% of parents are told by their daughter. The great majority of parents support their daughter's decision to have an abortion.

SOURCES OF DATA

Most of the data in this fact sheet are from research conducted by The Alan Guttmacher Institute (AGI) and/or published in the peer-reviewed journal, *Family Planning Perspectives* and the 1994 AGI's report, *Sex and Americas's Teenagers*. Additional sources include: Advocates for Youth, The Centers for Disease Control and Prevention and The National Center for Health Statistics.

FOR MORE INFORMATION FROM THE ALAN GUTTMACHER INSTITUTE

Readings on Teenage Pregnancy from Family Planning Perspectives, 1985–1989, 1989, 352 pp., 30.00.

Sex and America's Teenagers, 1994, 88 pp., $30.00. Slides #64, $120.00.

Teenage Pregnancy in Industrialized Countries, 1986, 310 pp., $30.00 clothbound, $15.00 paperbound (Yale University Press).

Family Planning Perspectives, 1-year subscription: $42.00 for institutions, $32.00 for individuals.

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1120 Connecticut Avenue, NW
Suite 460
Washington, DC 20036
Telephone: 202 296-4012
FAX: 202 223-5756

Lawmakers Grapple With Parents' Role in Teen Access to Reproductive Health Care

Legislation introduced recently in the U.S. House of Representatives seeks, among other things, "to preserve the common law tradition that allows parental choices to prevail in a health care decision for a child."[1] The measure would bar federal, state and local governments from interfering with or "usurp[ing] the right of a parent to direct the upbringing of the child."

Although the proposal seems eminently reasonable at first glance, in practice it would override longstanding efforts by both the states and Congress to reconcile the right of parents to guide and protect their minor children and minors' need and desire for confidentiality in certain situations. Perhaps no area better illustrates the difficulty of achieving this balance than decisions about medical care related to teenage sexual activity, substance abuse and mental health problems.

Establishing rules for patient consent to medical care has primarily been a state responsibility, and states have traditionally required doctors to obtain parental consent before treating a minor, on the presumption that before reaching majority (age 18 in all but four states) young people lack the experience and judgment to make fully informed decisions. Over the last 20-30 years, however, states have recognized that, in fact, many minors are capable of making informed decisions about medical care and that confidentiality can be essential to encouraging young people to address sensitive health concerns in a timely manner. As a result, many states have policies that permit minors to make their own decisions about reproductive health care and other sensitive medical services.

Similarly, Congress concluded more than a decade ago that while parental involvement is desirable and to be encouraged by federal law, confidential access to contraceptive services is crucial to helping teenagers avoid unintended pregnancies.

This Issues in Brief summarizes the current status of state laws affirming minors' ability to make their own decisions about contraceptive use, sexually transmitted disease treatment, prenatal care, and other sensitive medical services. Noting that many states have treated abortion differently from these services, it also summarizes state statutes that affirm minors' ability to make potentially life-altering decisions outside the health care arena without their parents' involvement. In addition, it reviews congressional efforts to balance the rights of parents and of minors on the issue of teenagers' access to contraceptive care.

The States and Medical Care for Minors

Although states have traditionally required parental consent before a minor receives medical treatment, there have long been exceptions to this rule. Many states, for example, authorize doctors to treat any minor involved in an emergency without first obtaining parental consent. In addition, states often consider a minor who is married, serving in the armed forces or living apart from his or her parents and self-supporting to be "emancipated"; in such cases, a minor has the right to act on his or her own behalf, including the right to consent to medical treatment.

Furthermore, while the constitutional rights of minors historically have been subject to more stringent limitation than the rights of adults, the U.S. Supreme Court ruled in 1967 that "constitutional rights do not mature and come into being magically only when one attains the state-defined age of majority."[2] In subsequent decisions, the Court held that minors have a constitutional right to privacy that includes the right to obtain contraceptives and the right to decide to terminate an unwanted pregnancy.

Spurred in part by these court rulings, states have given teenagers greater authority to make decisions for themselves. Some states, for example, have adopted the so-called mature minor rule, which allows a minor who is sufficiently

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Telephone: 202 296-4012
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Teenage Pregnancy and The Welfare Reform Debate

Teenage pregnancy and out-of-wedlock childbearing have become central issues in the debate over welfare reform. Paradoxically, they are frequently seen as both the cause of increased welfare costs and caseloads over the last 25 years, and the result of the welfare system itself.

Out-of-wedlock births among teenagers have increased dramatically in the last several decades and now account for almost 70% of all teenage births. Yet, trends in teenage sexual activity and childbearing reflect broader trends in sexual and reproductive behavior among women of all ages and income levels. Women age 20 and older, for example, account for more than three-quarters of the unintended pregnancies and abortions that occur each year in the United States. Moreover, despite the sharp increase in teenage out-of-wedlock births, the increase has been even greater among older women. As a result, teenagers account for a much smaller proportion of out-of-wedlock births today than they did in the 1970s.

Contrary to popular belief, only 5% of mothers on welfare are teenagers, and just 1%, or about 32,000, are under age 18. However, a large proportion of women who begin childbearing as teenagers eventually end up on welfare, and those who do tend to need assistance for a long period of time.

Clearly, therefore, ensuring teenagers access to services that can enable them to avoid unplanned pregnancies and unwanted births is essential to helping them avoid or escape poverty and welfare. Making voluntary family planning services and, as a backup, abortion easily accessible to adolescents has been demonstrated to be a cost-effective way to reduce unplanned childbearing and its consequences.

For the most part, however, current welfare reform proposals take a different approach. They rely on disincentives -- the threat of punitive measures down the line -- to discourage teenage childbearing.

These proposals appear to rest on two basic assumptions: that poor, unmarried teenagers deliberately get pregnant and have babies in order to collect welfare and set up their own households; and that a prohibition on benefits will, in and of itself, discourage out-of-wedlock births. Undoubtedly, some teenagers want to get pregnant and have a child. Research indicates, however, that the great majority of poor teenagers use contraceptives to prevent pregnancy, and that most births to poor adolescents are unintended. It also suggests that most women, including teenagers, would prefer to give birth within marriage. The reality is, however, that marriage is not a realistic or even desirable option for most poor adolescent women.

This Issues in Brief *examines teenage sexual and reproductive behavior, with special attention to key behavior differences among adolescents of varying income levels. It explores the extent to which teenage mothers depend on welfare and whether welfare recipients who gave birth as teenagers differ significantly on certain socioeconomic indicators from those who were not teenage mothers. It also considers whether current proposals to reduce teenage pregnancies and out-of-wedlock births among young women on or at risk of welfare are likely to achieve their stated goals.*

Teenagers and Sex

Initiation of sexual intercourse during the teenage years has become the norm in the U.S. While intercourse among very young teenagers is still relatively rare (and many of the youngest teenagers who have had sex report that they were forced to do so), more than eight in 10 adolescents have had intercourse by the time they turn 20. Because marriage in the teenage years is now so uncommon, most adolescent sexual activity occurs outside marriage.

As sex has become more common at younger ages, historic differences in sexual activity among teenagers of different races, income levels and religions

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Family Planning Services in the United States

WOMEN AT RISK OF UNINTENDED PREGNANCY (AGED 13–44)

- 62 million U.S. women are aged 13–44: 12 million (19%) are younger than 20, 20 million (32%) are 20–29 and 30 million (48%) are 30–44.
- 29 million women (47%) are currently married; 33 million (53%) have never married or are widowed, divorced or separated.
- 48 million women (77%) are non-Hispanic white or are of racial or ethnic groups other than black or hispanic, 8 million (13%) are non-Hispanic black and 6 million (10%) are Hispanic.
- 18 million women (29%) have family incomes under 185% of the poverty level (or $23,447 for a family of four).
- Half of women 13–44 (31 million) are at risk of unintended pregnancy—they are sexually active and believed to be fertile, and are not pregnant, postpartum or seeking pregnancy.
- Half of women at risk of unintended pregnancy (more than 15 million) are in need of subsidized family planning services; these include all teenagers at risk of unintended pregnancy and women aged 20–44 who are at risk and whose family income is less than 250% of the poverty level (or $31,685 for a family of four).
- 56% (3.6 million) of the 6.4 million pregnancies that occur among U.S. women each year are unplanned; 53% of unplanned pregnancies occur among the 10% of women at risk of unintended pregnancy but using no method of contraception.
- 8 in 10 pregnancies among women under 20 are unplanned, compared with 6 in 10 among 20–24-year-olds, 5 in 10 among 25–29-year-olds, 4 in 10 among 30–34-year-olds, 6 in 10 among 36–39-year-olds, and 8 in 10 among women 40 and older.
- Of the 3.6 million unintended pregnancies that occur each year, 44% end in induced abortion, 43% in birth and 13% in miscarriage.

CONTRACEPTIVE USE AND STERILIZATION

- 6 in 10 women aged 15–44 (35 million women) either use a reversible contraceptive method, have been sterilized or have partners who have been sterilized.
- Among those practicing contraception, 20 million women (58%) use reversible contraceptives—29% take oral contraceptives, 18% use condoms, 3% use the diaphragm, 3% rely on periodic abstinence, 1% have an IUD and 5% depend on other methods.
- Sterilization is the most popular method of birth control, relied upon by 14 million women, or 42% of method users. More than 10 million women have undergone contraceptive sterilization, and another 4 million rely on their partner's vasectomy to avoid unintended pregnancy.
- Of the 8.5 million women aged 15–19, 2.7 million, or 32%, use a contraceptive method; of these, 52% take oral contraceptives, 44% use condoms and 4% rely on other methods.

WHERE WOMEN OBTAIN CONTRACEPTIVE SERVICES

- A majority of users of reversible contraceptives obtain their method from private physicians or managed health care organizations; however, 1 in 3 users (primarily teenagers, minority women and low-income women) go to a family planning clinic.
- More than 1.4 million office visits to private, office-based obstetrician-gynecologists during 1989–1990 were for family planning services.
- Besides offering a source of free or low-cost care for low-income, uninsured women, family planning clinics provide a confidential alternative for teenagers and, in some cases, offer more educational and counseling services than may be available through private physicians.
- Family planning services are provided by different types of operating agencies: health departments, hospitals, Planned Parenthood affiliates and a variety of independent agencies.
- 2,614 agencies provided organized family planning services at more than 5,500 clinics nationwide in 1992.
- 1,433 local health departments operate 52% of all family planning clinics; 171 Planned Parenthood affiliates operate 15%; 259 hospitals operate 6%; and 751 other agencies operate 27% (one-fifth of these agencies are federally funded community or migrant health centers).
- Family planning clients routinely receive, on average, 8 of 13 common tests and examinations related to contraceptive services (pelvic examinations; breast examinations; Pap tests; blood pressure measurement; pregnancy testing; testing for gonorrhea, syphilis, chlamydia, herpes, diabetes and urinary tract infections; measurement of hematocrit and hemoglobin; and screening for cardiovascular problems or hypertension.)
- 82% of family planning providers offer testing for HIV to female clients, 70% provide postpartum care, 66% offer prenatal care and 71% administer well-baby care.
- 93% of family planning providers dispense condoms to male

clients, 86% treat sexually transmitted diseases (STDs), 84% conduct STD testing and 79% offer HIV testing.
- The large majority of family planning providers have special programs and policies for teenagers: 82% conduct outreach in schools and youth centers, 56% offer educational programs emphasizing postponement of sexual activity and 38% provide teenage parenting programs. In addition, 76% encourage counselors to spend extra time with teenage clients, mostly to provide counseling on issues related to STDs.

PUBLIC FUNDING FOR CONTRACEPTIVE SERVICES

- Public funding for family planning services for low-income and teenage women comes from several federal sources: Medicaid, Title X of the Public Health Service Act, and the Maternal and Child Health (MCH) and Social Services block grants. Additionally, most states contribute some of their own funds for these services.
- The federal and state governments spent $644 million on contraceptive services and supplies in FY 1992; federal funds accounted for $489 million (76%) of the total expenditure, and state sources accounted for $155 million (24%) of the total public funding.

Federal total:	**$489 million**	**76%**
Medicaid	$319 million	49%
Title X	$110 million	17%
Social Services block grant	$ 30 million	5%
MCH block grant	$ 30 million	5%
State total:	**$155 million**	**24%**
TOTAL:	**$644 million**	**100%**

- Of the 10 states with the largest number of women at risk of unintended pregnancy (Calif., Fla., Ga., Ill., Mich., N.J., N.Y., Ohio, Penn. and Tex.), 7 are among the 10 with the greatest total public expenditures for contraceptive services (Calif., Fla., Ga., Mich., N.Y., Ohio and Tex.).

TRENDS IN PUBLIC FUNDING

- Between 1980 and 1992, public funding for contraceptive services fell by 27%—from $350 million to $254 million, *when inflation is taken into account* (by converting 1992 expenditures into constant 1980 dollars). This decline occurred despite a 28% increase in total public expenditure for contraceptive services—from $504 million to $644 million—between 1990 and 1992.
- Medicaid expenditures for contraceptive services increased dramatically (68%) between 1990 and 1992, and were primarily responsible for the 28% rise in overall public spending during that time.
- Title X accounted for 44% of all expenditures on contraceptive services in 1980, but only 17% in 1992. After adjustment for inflation, Title X funding decreased by 72% between 1980 and 1992.
- In 1980, states contributed 15% of all public funding for services; in 1992, 24% of all funding came from the states. In 1992, 36 states used their own funds to provide contraceptive services.

COST-EFFECTIVENESS OF PUBLIC FUNDING

- Publicly funded contraceptive services assist women in averting up to 3.1 million unintended pregnancies (1.3 million births, 1.4 million abortions, and 400,000 miscarriages) each year.
- Without government support for family planning services, women who discontinue use or use less effective methods would average 1.2 million more unintended pregnancies annually than they currently have—at least 4 in 10 of which would end in abortion.
- An average of $4.40 in health and welfare costs ($3.30 in medical costs alone) is saved for each public dollar spent on family planning services.
- 1987 estimates show that $412 million in public expenditures on family planning services saved taxpayers $1.8 billion in the short term.
- In California alone, for every public dollar spent on contraceptive services, an average of $7.70 is saved in health and welfare costs by the prevention of an estimated 136,800 unintended pregnancies each year.

PRIVATE COVERAGE OF FAMILY PLANNING

- Half of typical fee-for-service insurance plans (59% of commercial companies and 36% of Blue Cross–Blue Shield plans) do not cover any reversible contraceptive method.
- Just 15% of fee-for-service plans (8% of companies and 24% of Blue Cross-Blue Shield plans) routinely cover all five of the most effective, reversible medical family planning methods—the hormonal implant, injectables, the IUD, oral contraceptives and the diaphragm.
- Counseling and risk assessment services are even less likely than methods to be covered in conventional fee-for-service plans; fewer than one-quarter of plans routinely cover contraceptive counseling (13% of commercial companies and 33% of Blue Cross-Blue Shield plans).
- 40% of HMOs typically cover all five reversible medical family planning methods, and nearly all cover contraceptive counseling.
- 7 in 10 typical fee-for-service insurance plans routinely cover abortion; 9 in 10 cover sterilization and maternity care.

SOURCES OF DATA

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International Family Planning Perspectives, 1-year subscription: $36.00 for institutions, $26.00 for individuals, free for individuals in developing countries.

Preventing Pregnancy, Protecting Health: A New Look at Birth Control Choices in the United States, 1991, 128 pp., $25.00.

State Reproductive Health Monitor: A Quarterly Review of Legislative Policy and Actions; 1-year subscription: $120.00 for institutions, $100.00 for individuals.

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Washington Memo, 1-year subscription: $45.00 for institutions, $35.00 for individuals.

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Abortion in the United States

INCIDENCE OF ABORTION

- More than 50% of the pregnancies among American women are unintended—½ of these are terminated by abortion.
- In 1992, there were 1.5 million abortions in the United States. From 1973 through 1992, more than 28 million legal abortions took place in the United States. Since 1967, when many states began liberalizing their abortion laws, almost 30 million legal abortions have been performed.
- Each year nearly 3 out of 100 women aged 15–44 have an abortion—46% have had at least one previous abortion and 53% have had a previous birth.
- The abortion rate—the number of abortions per 1,000 women aged 15–44—in 1975 was 22; in 1980, 29; in 1985, 28; and in 1992, 26.
- The United States has one of the highest abortion rates among developed countries; U.S. rates of abortion and unintended pregnancy are about 5 times those of the Netherlands.

WHO HAS ABORTIONS AND WHY?

- The majority of women obtaining abortions are young: 55% are under age 25, including about 21% who are teenagers; only 22% are aged 30 and older.
- 18–19-year-old women have the highest abortion rate—56 per 1,000 women.
- The proportion of pregnancies terminated by abortion is higher among unmarried women (51%), women aged 40 and older (34%), teenagers (38%) and nonwhite women (40%) than among all women (28%).
- Pregnant unmarried women are 6 times more likely than married women to have an abortion.
- Poor women are about 3 times more likely than women who are financially better off to have abortions. Nevertheless, 11% of abortions are obtained by women whose household incomes are $50,000 or more.
- While white women account for 63% of all abortions, the nonwhite abortion rate is more than twice the white rate (54 vs. 20 per 1,000).
- The abortion rate among Hispanic women is 43% higher than among non-Hispanic women.
- Women who report no religious affiliation have a higher rate of abortion than women who report some affiliation.
- Catholic women are about as likely to obtain an abortion as are all women nationally, while Protestants and Jews are less likely. Catholic women are 30% more likely than Protestants to have abortions.
- 1 in 6 abortion patients in 1987 described herself as a born-again or Evangelical Christian; they are half as likely as other women to obtain an abortion.
- 70% of women having an abortion say that they intend to have children in the future.
- On average, women report more than 3 reasons that lead them to choose abortion: ¾ say that having a baby would interfere with work, school or other responsibilities; about ⅔ say they cannot afford to have a child; and ½ say they do not want to be a single parent or have problems in their relationship with their husband or partner.
- Of women having abortions, 1% have been advised that the fetus has a defect and an additional 12% fear that the fetus may have been harmed by medications or other conditions.
- About 15,000 women have abortions each year because they become pregnant as a result of rape or incest.
- Most women who have an abortion after 15 weeks of pregnancy have had problems detecting their pregnancy, and almost ½ are delayed because of problems, usually financial, in arranging an abortion.

ABORTION AND TEENAGERS

- Among teenagers, 85% of pregnancies are unintended.
- Of the 1.5 million abortions obtained by U.S. women in 1991, 327,000 were obtained by teenagers.
- 38% of women who become pregnant as teenagers choose abortion, while 62% continue their pregnancies to term (excluding those who miscarry).
- Of teenagers having abortions, ¾ say they cannot afford to have a baby, and ⅔ think they are not mature enough.
- More than ¼ of unmarried teenagers under age 18 who get abortions have never used birth control. Of those who have, most used one of the less effective ones, such as the condom or withdrawal.
- Teenagers are more likely than older women to have abortions during the second 3 months of pregnancy, when health risks associated with abortion increase significantly.
- 61% of minors have abortions with a parent's knowledge; 45% of parents are told by their daughter. The younger the teenager, the more likely that her parents know. The great majority of parents support the decision to have an abortion.
- 26 states currently have mandatory parental involvement laws in effect for a minor to obtain an abortion: AL, AR, GA, IN, KS, KY, LA, MA, ME, MD, MI, MN, MO, MS, MT, ND, NE,

OH, PA, RI, SC, TN, UT, WI, WV and WY. The laws in all of these states except MD and UT stipulate that a minor can seek a court order authorizing the procedure without parental knowledge; MD allows a physician to waive parental notification. ME requires parental consent or counseling by a professional.

- In contrast, in 46 states and the District of Columbia, mothers who are minors may legally place their child for adoption without parental involvement.

WHEN DO WOMEN HAVE ABORTIONS?

- 89% of abortions take place in the first trimester of pregnancy.
- 52% of abortions each year take place at 8 weeks or less from the last time the woman menstruated (LMP); 26% at 9–10 weeks LMP; and 12% at 11–12 weeks LMP. 6% of abortions take place at 13–15 weeks LMP; 4% at 16–20 weeks LMP; and about 1% at 21 weeks LMP or more.
- About 600 or 0.04% of abortions take place after 26 weeks.
- One study found that of 78 reported abortions past 24 weeks of pregnancy, 75 were classified incorrectly and were actually in utero fetal deaths or occurred at earlier gestation, and two of the three correctly classified abortions were for anencephaly.

WHERE DO WOMEN HAVE ABORTIONS?

- 93% of abortions take place in clinics or doctors' offices.
- In 1993, the cost of a first-trimester nonhospital abortion ranged from $140 to over $1,700, and the average amount paid was $296.
- The number of abortion providers declined by 8% between 1988 and 1992 (from 2,582 to 2,380). The geographic distribution of services is markedly uneven: 84% of all U.S. counties lacked an abortion provider in 1992 yet these counties were home to 30% of all women aged 15–44.
- Less than 2% of all abortions take place outside of metropolitain areas.
- Only 48% of all abortion facilities provide services to women after the 12th week of pregnancy.
- The states with the highest abortion rates (according to the state in which the abortion occurred) in 1992 were: HI (46); NY (46); NV (44); CA (42) and DE (35). Like other large cities, the District of Columbia has a higher rate (138) than any state.
- The states with the lowest abortion occurrence rates in 1992 were: UT (9); WV (8); SD (7); ID (7) and WY (4).

ABORTION AND CONTRACEPTIVE USE

- 62 million U.S. women are aged 13–44; half are at risk unintended pregnancy—they are sexually active and believed to be fertile, and are not pregant, postpartum or seeking pregnancy.
- 56% (3.6 million) of the 6.4 million pregnancies that occur among U.S. women each year are unplanned; 53% of unplanned pregnancies occur among the 10% of women at risk of unintended pregnancy but using no method of contraception.
- Only 9% of women having abortions have never used a birth control method; nonuse is greatest among those who are young, unmarried, poor, black, Hispanic or less educated.

HOW SAFE IS ABORTION?

- The risk of complications with abortion is minimal—less than 1% of all abortion patients experience a major complication associated with the procedure, such as a serious pelvic infection, hemorrhage requiring a blood transfusion or unintended major surgery.
- There is no evidence of problems with later childbearing among women who have an early abortion performed by the most common method—vacuum aspiration.
- The risk of death associated with childbirth is about 10 times as high as that associated with abortion.
- The risk of death associated with abortion increases with the length of pregnancy, from 1 death for every 600,000 abortions at 8 weeks or less to 1 per 17,000 at 16–20 weeks and 1 per 6,000 at 21 or more weeks.
- The risk of death associated with abortion decreased more than fivefold from 1973 to 1987, with 3.4 deaths per 100,000 legal abortions in 1973 to 0.4 in 1987.

PUBLIC FUNDING AND ABORTION

- The U.S. Congress has barred the use of federal funds to pay for abortions for Medicaid-eligible women except when the woman's life would be endangered by a full-term pregnancy or in cases of rape or incest. However, 17 states (AK, CA, CT, HI, ID, IL, MA, MD, MN, MT, NJ, NM, NY, OR, VT, WA and WV) and DC use their own funds to pay for abortions for low-income women.
- In 1992, 13% of all abortions in the United States were paid for with public funds, virtually all of which were state funds.
- For every $1.00 spent by government to pay for abortions for poor women, about $4.00 is saved in public medical and welfare expenditures incurred as a result of the unintended birth.
- When public funds are unavailable, 20–35% of Medicaid-eligible women who want to have an abortion carry their unplanned pregnancy to term.
- An estimated 22% of the Medicaid-eligible women who had second-trimester abortions would have had first-trimester abortions if the lack of public funds had not resulted in delay in trying to raise funds.

FOR MORE INFORMATION FROM THE ALAN GUTTMACHER INSTITUTE:

Abortion and Women's Health: A Turning Point for America?, 1990, 74 pp., $15.00.

Abortion Factbook, 1992 Edition: Readings, Trends, and State and Local Data to 1988, 212 pp., $30.00.

Clandestine Abortion: A Latin American Reality (English, Spanish, or Portuguese), 1994, 32 pp. $15.00.

Family Planning Perspectives, 1-year subscription: $42.00 for institutions, $32.00 for individuals. Back issues available for $10.00.

Induced Abortion, A World Review: 1990 Supplement, 120 pp., $25.00.

Our Daughters' Decisions: The Conflict in State Law on Abortion and Other Issues, 1992, 35 pp., $8.00.

Preventing Pregnancy, Protecting Health: A New Look at Birth Control Choices in the United States, 1991, 129 pp., $25.00.

Sex and America's Teenagers, 1994, 88 pp. $30,00.

State Reproductive Health Monitor: Legislative Proposals and Actions, 1-year subscription: $120.00 for institutions, $100.00 for individuals.

Uneven and Unequal: Insurance Coverage and Reproductive Health Services, 1994, 38 pp., $15.00.

Washington Memo, 1-year subscription: $45.00 for institutions, $35.00 for individuals.

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ISSUES in BRIEF

The Alan Guttmacher Institute
New York and Washington

A Not-for-Profit Corporation
for Reproductive Health
Research, Policy Analysis
and Public Education

120 Wall Street
New York, NY 10005
Telephone: 212 248-1111
FAX: 212 248-1951

1120 Connecticut Avenue, NW
Suite 460
Washington, DC 20036
Telephone: 202 296-4012
FAX: 202 223-5756

The U.S. Family Planning Program Faces Challenges and Change

Although a woman's reproductive years span half of her lifetime, the typical American woman today wants only two children -- a goal that is unrealistic without the use of contraception. In 1990, approximately 30.5 million women were considered to be at risk of unintended pregnancy (that is, they were sexually active and fertile, but were neither pregnant nor desiring pregnancy); over 15 million were low-income women and teenagers in need of subsidized contraceptive services. The nation's organized family planning program was established to address their needs.

One in three women who made a family planning visit in 1988 -- the last year for which comprehensive data are available -- reported going to a publicly funded family planning clinic. These clinics complement the private health care system in several ways: They serve Medicaid-eligible women when other providers refuse to accept them; provide subsidized services to low-income women who are not eligible for Medicaid; offer more extensive counseling on contraceptive methods; provide confidential services for teenagers and other women who may not be able to discuss reproductive health issues with their regular physicians; and offer contraceptive supplies at a lower cost than is usually available elsewhere.

This Issues in Brief describes the current structure and funding of the national family planning program, and the reproductive health and other preventive services it provides. It examines the impact of the program on the prevention of unintended pregnancies, births and abortions as well as on the reduction of low birth weight and infant mortality. It also discusses the central role that Title X of the Public Health Service Act, the historic core of the federal effort, plays in determining the shape and substance of the national family planning service delivery system.

Overview

History. Studies conducted during the 1960s showed that rates of unwanted childbearing among low-income women were at least twice as high as those among the more affluent -- a phenomenon that could be traced in large part to inequalities in access to family planning services. By the end of the decade, a sizeable, bipartisan consensus had emerged favoring government support of voluntary family planning programs as a means of expanding economic development, alleviating poverty, avoiding welfare dependency and improving the health of women and their families.

In the meantime, Congress had amended a number of federal laws to allow family planning services to be provided under certain existing programs. In 1965, as part of the so-called War on Poverty, federal funds were made available for family planning through the Office of Economic Opportunity. In 1967, Title IV-A of the Social Security Act was amended to require state welfare agencies to offer and provide family planning services to women receiving public assistance.

Then, in 1970, with broad bipartisan support, legislation establishing Title X of the Public Health Service Act was enacted and signed into law by President Richard Nixon, creating for the first time a comprehensive federal program devoted entirely to the provision of family planning services on a national basis. In his Message on Population Growth and the American Future, delivered the preceding year, President Nixon declared that "no American woman should be denied access to family planning assistance because of her economic condition. I believe, therefore, that we should establish as a national goal the provision of family planning services...to all who want but cannot afford them."

Following the enactment of Title X, public expenditures for family planning grew rapidly in the early 1970s, as the clinics Title X helped to create became established across the country. By fiscal year 1983, $340 million in public -- federal and state -- funds were being

Births to Unmarried Women		
All Races		
Year	Number	Percentage of all Births
1960	224,300	5.3
1965	291,200	7.7
1970	398,700	10.7
1975	447,900	14.2
1980	665,747	18.4
1985	828,174	22.0
1989	1,094,169	27.1
1990	1,165,384	28.0

Source: National Center for Health Statistics.

Teenage Pregnancy,
Birth & Abortion Rates

Analysis:: The Number of unmarried teenagers getting pregnant has nearly doubled in the past two decades. Rare in the early 1960s, by the late 1980s nearly one unmarried teenage girl in ten got pregnant. According to the American Enterprise Institute, teenage sexual activity will result in nearly one million pregnancies anually, leading to 406,000 abortions, 134,000 miscarriages and 409,000 live births. About three million teens will get a sexually transmitted disease.*

Year	Pregnancy (per thousand)	Abortion (per thousand)	Birth (per thousand)
1960	NA	NA	15.3
1965	NA	NA	16.7
1970	NA	NA	22.4
1972	49.4	19.9	22.8
1975	63.1	32.1	23.9
1980	78.3	43.4	27.6
1985	89.6	45.9	31.6
1988	93.0	44.4	36.8
1990	99.2	43.8	42.5

Source: National Center for Health Statistics, The Alan Guttmacher Institute, Centers for Disease

Control.

* Douglas Besharov with Karen Gardiner, "Teen Sex," The American Enterprise, January/February 1993.

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Source: National Center for Health Statistics.

Reported Cases of Child Abuse

Analysis:: Although there is controversy surrounding the number of reported child abuse cases,* the number of children abused in the U.S. has increased dramatically in the past two decades. Some of the reasons for the dramatic increase are: substance abuse, the additional stress of single parenthood, and low-income status.**

Year	Reported Cases	Rate (per 10,000)
1960	NA	NA
1965	NA	NA
1970	NA	NA
1976	669,000	101
1980	1,154,000	181
1985	1,928,000	306
1990	2,537,000	390
1991	2,694,000	420

Source: American Humane Association;
National Committee for the Prevention of Child Abuse.

* Dr. Richard Gardner, clinical professor of child psychology at Columbia University, writes that there is now a "child abuse establishment" made up of social workers, psychologists, and law enforcement officials that actually encourages false charges of child abuse.

** Charmine Yoest, ed., "Free to Be Family: Helping Mothers and Fathers Meet the Needs of the Next Generation of American Children," Family Research Council.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
ASSISTANT SECRETARY FOR PLANNING AND EVALUATION

PHONE: (202)690-8794 FAX: (202)690-6518

Date: October 2, 1995

From: Lisa A. Gilmore
Division: ASPE
City & State: D.C.
Office Number: (202)690-6035
Fax Number: (202)690-6562

To: Debbie Fine and Janet Abrams
Division: DPC
City & State: DC
Office Number: (202)456-5572
Fax Number: (202)456-7028

Number of Pages + cover 3

REMARKS: Teen pregnancy fact sheet for President's briefing book. I'm about to start on revising the HHS program fact sheet.

THE FACTS ABOUT TEENAGE PREGNANCY

Teen pregnancy is one of our most serious social problems.

- Pregnancy rates and birth rates among women under age 20 are considerably higher in the U.S. than in other developed countries, despite similar patterns of sexual activity.
- Almost 70 percent of American high school seniors have been sexually active by their eighteenth birthday.
- Every year, about one million American teenagers become pregnant -- that's about 11% of women ages 15-19.
- From 1991 to 1992, the majority of states saw a decline in teen pregnancy rates for 15 to 19 year olds.
- And teen birth rates slowed as well. After rising steadily since 1986, they fell 4 percent from 1991 to 1993.
- However, as the teenage population grows, teen births are expected to increase. Even if the teen birth rate remains constant, births would jump 30% by the year 2010.
- A recent survey indicates that at least half the babies born to teenage women ages 15 to 17 are fathered by adult men ages 20 or older.
- Teens account for less than one in three out-of-wedlock births, but 72 percent of births to teens are nonmarital.
- Over 80 percent of teen pregnancies are unintended, although unintended pregnancy is high among all women.

Teen pregnancy and childbearing have consequences for all of us.

- Children born to teens are more likely to die in their first year of life, to have lower cognitive achievement, to repeat a grade in school, to be victims of abuse and neglect, and to become teen parents themselves.
- Eighty percent of children born to unwed teenage mothers who have not completed high school live in poverty.

- More than three-fourths of all unmarried teen mothers will be on Aid to Families with Dependent Children (AFDC) at some point during the five years following their child's birth.

- And teenage parents--male and female--have a much tougher time getting the education and skills they need to work and be productive members of society. #'s ?

Comprehensive approaches offer the most promising solutions[1].

- There is no single solution or "magic bullet" to prevent teen pregnancy.

- Among the primary factors associated with teenage sexual activity and parenthood are low socioeconomic status, failure in school, risky behaviors, and insufficient family strengths.

- Although there have been numerous teen pregnancy intervention programs, most are small, ad hoc, and short-term projects, and few have been rigorously evaluated.

- It appears, however, that programs emphasizing only one component, e.g., abstinence or sex education only, are less effective in reducing teen pregnancy or sexual activity than comprehensive programs that combine several approaches.

- For example, comprehensive programs which use a specific and narrow message, combined with contraceptive information and other skill building activities have resulted in a slight delay in sexual initiation and modest gains in contraceptive use.

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[1]Based on findings from "Beginning Too Soon: Adolescent Sexual Behavior, Pregnancy and Parenthood," a report by Child Trends, Inc., June 1995, prepared for and funded by the Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, under Contract No. HHS-100-92-0015, DO-08.

TEEN PREGNANCY FACTS

How large is the teen pregnancy problem?

* Before the end of their teenage years, 43 percent of U.S. teenage girls become pregnant once.

* Of the 1 million teens who become pregnant each year, about half give birth, about 35 percent choose abortion and the remainder miscarry.

* About 72 percent teen mothers are unmarried--a rate that has doubled in one generation.

* In 1991, 95 percent of Atlanta's teen mothers were unmarried; the rate was 88 percent in Baltimore, 90 percent in Cleveland, 71 percent in Oklahoma City.

What are the trends?

Teen birth rates rose one fourth from 1986 to 1991. That's because sexual activity increased and abortion dropped. The birth rates dropped slightly in 1992 and 1993. But it was among older teens. We don't know why.

* Abortion rates are dropping among teens but still account for 25 pecent of abortions. Less stigma? Less access? Better birth control?

* Getting younger: By age 18, 61 percent of males and

58 percent of females have had sex.

* Two-thirds use some form of birth control.

* Less likely to use birth control: About 3/4 of teens waited an average of 23 months after first sex before visiting clinics.

* Eight year gap.

What part does teen pregnancy play in welfare dependency?

* Fewer than 8 percent of welfare mothers are teens.

W'hy should we care about this small percentage?

* Because these youngest mothers are the ones most likely to get "stuck" in the welfare system:

* Child Trends, Inc. reports that 43 percent of long-term AFDC recipients were 17 years old or younger at the time of their first birth.

* The Congressional Budget Office reports that 77 percent of unmarried adolescent mothers are welfare recipients within five years of the birth of their first child.

* The federal government spends $34 billion a year on aid to families begun by teenagers.

What do we know about teen mothers?

* Many come from homes strained by poverty and dysfunction.

* They have been poorly nurtured.

* Many have been subjected to neglect or physical violence. And a number of studies suggest that many teen mothers have histories of early sexual abuse.

* A 1992 report of a Washington state study of 535 teen mothers revealed that the first pregnancies of 62 percent of the participants were preceded by experiences of molestation, rape, or attempted rape. The mean age of their offenders was 27.4 years.

* A 1986 study of 445 teen mothers in Chicago reported that 60 percent claimed they had been forced into an unwanted sexual experience, with a mean age for the first incidence of abuse being 11½.

* 51 percent of female rape victims were under age 18, more than twice their representation in the nation's population.

Such exploitation leaves young women significantly more vulnerable to the long-term effects that include:

psychiatric illness, depression, suicidal tendencies, repeated victimization, and difficulty in protecting their own children from abuse.

* High-risk behaviors:
-- drug and alcohol abuse
--delinquent and criminal behavior
--and early sexual activity.

Many of these young women are particularly vulnerable to the attentions of older men

What do we know about the fathers of their babies?

There is very little data available about the characteristics and life histories of these fathers. But data about their ages--about their ages relative to the ages of the teen mothers--is beginning to define a clear pattern.

* The National Center for Health Statistics reported that based on 1991 data, almost 70 percent of babies born to teenage mothers were fathered by men 20 years of age or older.

* AGI:
--Among 15 to 17-year-old teen mothers, 51 percent had children by men age 20
-- Among all teen mothers, 66 percent had babies by fathers age 20 and older.

* A 1990 study of births to California teens highlighted this trend: *the younger the adolescent mother, the greater the age gap with her male partner.* For example, among mothers ages 11-12, the average age

of the fathers was nearly 10 years older.

Is this a significant cause of teen pregnancy?

But this issue must be considered in context. First, two thirds of teen pregnancies are to teens who are 18 and 19--legal adults. And about one-third of teen mothers--generally the older teens--are married. Teen pregnancy is the result of many factors.

Then why should we pay attention to this phenomenon?

Because sexual exploitation is the root cause of some teen pregnancies, especially among the youngest teen mothers.

* Among sexually experienced teens, 9 percent of 14 year-olds, and 18 percent of 15-17 year olds experience a pregnancy each year.

* And *births to the youngest teens are rising sharply.* only three percent of all adolescent pregnancies and abortions occurred in the population of girls younger than 15 years.

* In the late 1980s, this group registered a 26 percent increase in the birth rate because the abortion rate declined even as the pregnancy rate remained stable.

* On average, adolescents reach menarche and develop sexually mature physical characteristics two years before they are able to conceive. Thus the rising birth

rate among the very youngest teens may be an indication of increasing sexual exploitation of young girls generally.

Health Consequences:

* Three million a year contracts an STD

* One quarter of all HIV infections occur in young people between 13 and 20.
CDC reports that 2,000 cases of HIV in 13-19 but 18,000 in 20-24

Pregnancy:

* Teens ages 17 and under have higher risk of pregnancy related complications

* Maternal mortality rates as as much as 60 percent greater than for women in their 20s.

* Teens are twice as likely to receive no or very late prenatal care.

* Babies are likely to be born of premature, low birthweight, and require hosptializtion in wtih first five years of life.

What else do we know about their children?

*Few unmarried teens place their children for

adoption. 2-3 percent

* Children in single-parent households score worse on measures of health, education, and emotional and behavioral adjustment.

* Children who grow up in single-parent households are at much greater risk of drug and alcohol abuse, mental illness, suicide, poor educational performance and criminality

* Mothers under age 20 were vastly overrepresented in a sample of 5,000 families reported for both abuse and neglect

* One study found 30 percent of teen mothers abused or neglected their children. -- figure three times their representation in the population.

* A 1992 study sponsored by the National Institute of Justice found that childhood abuse increased the odds of future delinquency and adult criminality overall by 40 percent.

* link between physical abuse in childhood and adult violence has long been established, this suggests that neglect victims also are more likely to develop later violent behavior

Stories:

* use of birth control, attitudes about birth control

* teens not choosing abortion
* community attitudes about access to services

* AIDS/HIV and STDs in teens
* older men younger girls
* health and mental health consequences for children
* sex abuse as contributing factor to high risk behaviors

THE FACTS ABOUT TEENAGE PREGNANCY

A National Epidemic

- Every year, about 1 million American teenagers become pregnant -- that's about 11% of women ages 15–19. Recent news has been somewhat positive: From 1991 to 1992, the majority of states saw a decline in teen pregnancy rates for 15–19 year-olds.

- From the 1950s through the early 1980s, the rate of births to teens decreased steadily. However, in 1986, that trend reversed, and over the period 1986–91, the rate grew by 24%. From 1991 to 1993, the rate declined by 4%.

- As the teenage population grows, teen births are expected to increase. Even if the teen birth rate remains constant, the number of births is expected to jump 30% by the year 2010.

Trend towards out-of-wedlock childbearing

- In 1960, only 15% of teenage mothers were unmarried. Today, 72% are unmarried.

International Comparisons

- The U.S. rate of births to teens is now twice as high as in the United Kingdom and six times as high as in France, Italy, and Denmark.

Role of Adult Males

- A recent survey indicates that at least half the babies born to teenage women ages 15–17 are fathered by adult men ages 20 or older.

Costs to the Children

- Children born to teens are more likely to die in their first year of life, to have lower cognitive achievement, to repeat a grade in school, to be victims of abuse and neglect, and to become teen parents themselves.

- 80% of children born to unwed teenage mothers who have not completed high school live in poverty. In contrast, of those children born to 20 year-old married parents who are high school graduates, only 8% live in poverty.

Costs to Society

- More than three-fourths of all unmarried teen mothers will be on welfare (Aid to Families and Dependent Children) at some point during the 5 years following the birth of their child.

HHS FACT SHEET

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

September 1995

Contact: HHS Press Office
(202) 690-6343

PREVENTING TEENAGE PREGNANCY

Overview: *Each year, approximately one million pregnancies occur among American teenagers. As President Clinton said in his State of the Union address, "We've got to ask our community leaders and all kinds of organizations to help us stop our most serious social problem: the epidemic of teen pregnancies and births where there is no marriage."*

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.

The Administration's strategy is reflected in all of HHS' activities. This month, for example, HHS has:

- *Awarded 15 grants totalling $4.2 million dollars to comprehensive demonstration programs aimed at preventing early teen sexual activity and reducing teen pregnancies. These programs feature innovative ways to emphasize and encourage abstinence.*

- *Launched the Community Coalition Partnership Program for the Prevention of Teen Pregnancy by awarding 13 grants totalling $6.5 million over two years. The grants will help support community-wide coalitions in their efforts to reduce teen pregnancy.*

- *Completed a comprehensive and exhaustive review of the most recent literature on adolescent sexual behavior, pregnancy, and parenthood and on 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, the Youth Gang and Drug Prevention Program, 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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CDC
CENTERS FOR DISEASE CONTROL AND PREVENTION

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MORBIDITY AND MORTALITY WEEKLY REPORT

State-Specific Pregnancy and Birth Rates Among Teenagers — United States, 1991–1992

Pregnancy and childbearing rates for teenagers remain high in the United States despite well-documented associated adverse health, social, and economic consequences for many of these teenagers and their children. In 1990, approximately 835,000 (10%) teenagers aged 15–19 years became pregnant and either gave birth or had an abortion (CDC, unpublished data, 1995); an estimated 95% of such pregnancies are unintended (*1*). This report presents estimates of pregnancy rates among women aged ≤19 years for each state and the District of Columbia (DC) by age group, pregnancy rates for women aged 15–19 years by race, and birth rates for women aged 15–19 years by race and by Hispanic ethnicity for 1991–1992, and compares pregnancy rates for 1991 and 1992.

The numbers of pregnancies for 1991 and 1992 were estimated as the sum of live births and legal induced abortions among women aged ≤19 years (data were analyzed for women aged <15, 15–17, 18–19, and 15–19 years); estimates of spontaneous abortions and stillbirths were not included. Births were reported by state of residence; because abortion data by residence were not available for all states, abortions were reported by state of occurrence.* Denominators for rate calculations were obtained from intercensal population estimates provided by the U.S. Bureau of the Census (*2*). Rates for 15–19-year-olds were calculated as the number of pregnancies, abortions, or births per 1000 women aged 15–17, 18–19, and 15–19 years. Because almost all pregnancies (97% of births and 94% of abortions) among girls aged <15 years occur among those aged 13–14 years (*3*; CDC, unpublished data, 1993), the number of girls aged 13–14 years was used as the denominator when calculating rates for the <15-year age group. For each state included in rate calculations, the number of women who had abortions for whom age or race information was missing and the number who gave birth for whom ethnicity information was missing were included in age, race, or ethnicity categories based on the known distributions for abortions or births in that

*For 47 reporting areas, data were provided from the central health agency (state health departments and the health departments of DC, upstate New York, and New York City). Data from upstate New York and New York City were combined to produce totals for the state. For the other five states, data were provided from hospitals and other medical facilities. The word "state" in this report refers to both states and DC except where DC is mentioned explicitly. Wisconsin and DC reported age for those who had abortions among residents only.

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MORBIDITY AND MORTALITY WEEKLY REPORT

CDC Surveillance Summaries

Special Focus: Surveillance for Reproductive Health

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service
Centers for Disease Control
and Prevention (CDC)
Atlanta, Georgia 30333