

Teen Pregnancy

Youth Development/After School/
Violence

PHOTOCOPY
PRESERVATION

Teen Pregnancy
yes

THE WHITE HOUSE
WASHINGTON

file

January 25, 1995.

MEMORANDUM FOR: HILLARY RODHAM CLINTON
MELANNE VERVEER

FROM:

BILL GALSTON ^{W49}

SUBJECT:

NATIONAL CAMPAIGN AGAINST TEEN PREGNANCY

Attached you will find a one-pager on the National Campaign against Teen Pregnancy. As you will see, the core idea is a combination of public-sector actions and a voluntary-sector leadership mobilization.

Also attached is a memorandum that went to the President last month concerning the form of the voluntary-sector activity. The President has signed off on the idea of a 501c(3) along the lines of the Partnership for a Drug-free America. The idea is that when this organization is constituted with an appropriate leadership structure and mandate, the President would meet with the leaders and publicly bless its efforts.

We are not leaving this to chance. Jody Greenstone, who is in the private sector as of today, has agreed to volunteer her services full time to recruit nationally visible leaders for this new organization. The President has been consulted about this arrangement and has approved it.

Jody intends to consult widely inside and outside the administration in the next few days to develop a core leadership list. She plans to touch base with you immediately. To make sure the President is comfortable with the evolving plans, it would be useful for him to meet at some point in the next couple of weeks with the half dozen people who are likely to play key roles in this new organization.

Clearly, the new Surgeon General will be actively involved in coordinating the public-sector side of our teen pregnancy efforts. In addition, Secretary Shalala is reaching out to some heads of major foundations who may be interested in supporting the 501c(3).

To prepare for this initiative, I conducted a review of the best scholarship on teen pregnancy and an inventory of the most effective programs that have been implemented in communities over the past decade. I have attached one-page summaries of my findings.

TALKING POINTS: THE NATIONAL CAMPAIGN AGAINST TEEN PREGNANCY

"Tonight, I call on parents and leaders all across this country to join together in a National Campaign against Teen Pregnancy -- to make a difference. We can do this, and we must."

President Bill Clinton
State of the Union Address
January 24, 1995

In his State of the Union Address, President Clinton called for a National Campaign against Teen Pregnancy. This campaign has three key components.

1. **Tougher child support enforcement.** The President said that if parents aren't honoring their child support obligations, we should "suspend drivers' licenses, track them across state lines, make them work off what they owe." This program will benefit children and custodial parents. But knowing that they can't just walk away from their responsibilities will also make young people think twice before fathering a child or becoming pregnant out of wedlock.

2. **Anti-teen pregnancy programs in schools and communities.** Last year, the President sent Congress a plan to "target schools all over this country with anti-pregnancy programs that work." The key components of this plan are:

- o a National Clearinghouse on Teen Pregnancy to assemble, assess, and disseminate information on plans that work and are already in place in schools and communities;

- o federal support to implement effective anti-teen pregnancy plans in up to 1000 middle and high schools around the country.

3. **Leadership that goes beyond government.** The president stated that "Government can only do so much." He called for parents and leaders across the country to join together in a national mobilization. National voluntary organizations such as Partnership for a Drug-free America are one model for this kind of effort. The President stands ready to cooperate with organized voluntary-sector efforts to fight teen pregnancy.

In the context of this effort, the President placed special emphasis on the positive role of religious leaders and institutions: "These people who lead our houses of worship can ignite their congregations to carry their faith into action; can reach out to all of our children, . . . to those who have been savaged by the breakdown of all we hold dear." He also stressed the central role of parents: "It takes every parent to teach children the difference between right and wrong."

THE WHITE HOUSE
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THE PRESIDENT HAS SEEN

July 8, 1994

MEMORANDUM FOR THE PRESIDENT

FROM: BILL GALSTON *WAG*
BRUCE REED *BR*
GENE SPERLING *GS*
PAUL DIMOND *PD*

SUBJECT: TEEN PREGNANCY PREVENTION CAMPAIGN--
A Private, Non-Profit Entity to Assist in Mobilizing Private Sector

CC: ALEXIS HERMAN
CAROL RASCO
BOB RUBIN

Background. As a major component of the Welfare Reform proposal, you announced the need for a national campaign to prevent teen pregnancy. You noted that this is an American challenge -- one that can be met only if families, businesses, churches, youth groups and civic organizations, and peers join together in a parallel effort with your legislative proposals and Presidential leadership to provide a guiding hand to youth in communities all across the country. Due to the substantial press coverage, many prominent leaders of business, churches, youth and civic groups, foundations, entertainment, sports and the media have expressed a willingness to support a privately funded, non-profit organization ("private entity") to assist in mobilizing such a concerted national campaign.

Recommendation. With the full support of the Welfare Reform Working Group, including the National Service Corporation, we recommend that you bless such a welcome response to your call once such a private entity is properly formed as set forth below.

Form of Private Entity. Pursuant to our consultation with the White House Counsel's office (memorandum attached), we strongly support the recommendation of the Working Group that this entity take the form of a privately funded, non-profit corporation with an independent board of directors modelled after the Lawyers' Committee for Civil Rights under Law or the Partnership for a Drug-Free America, rather than a federal advisory commission modelled after the President's Council on Physical Fitness with a board appointed by the President and funding from appropriations. The greater flexibility, independence and proven effectiveness of the independent private entity model better meets the need for mobilizing the media and all parts of the private sector in communities all across the country than the more cumbersome and restrictive federal advisory committee model.

Mission of Private Entity. Such a private entity can assist in leading a teen pregnancy prevention campaign, focussed on youth ages 10-18, by: (1) proposing national youth goals to complement the National Education Goals, starting with teen pregnancy prevention; (2) leading an on-going campaign in the media, schools, churches, and youth centers to inform youth of the real risks and severe damage to life chances of teen pregnancy, violence, and dropping out of school and the real opportunities and rewards for learning, advancing from school to work and college, and supporting your own family; and (3) engaging all segments of the private sector in sustained, local efforts to establish on-going partnerships with youth by providing continuing coaching, mentoring, parent-youth and peer-group participation in community service, learning, recreation, apprenticeship, internship, and work opportunities.

Next Steps. To proceed to recognize such a private entity, it is important that we exercise care in contacting persons who have expressed an interest in assisting in leading a national campaign against teen pregnancy.

The first step is to explore how a small group of independent volunteers -- a steering committee if you will -- wishes to form, define, and govern such a private entity. A second step is exploring whether there should be honorary chairs: for example, can one or more former First Families serve in such a capacity? Finally, assuming the private entity forms in a manner and pursuant to a mission that will help to answer your call on the private sector, you may recognize the directors of the newly formed entity at an appropriate ceremony in the White House, much as President Kennedy did in 1963 in recognizing the formation of the Lawyers' Committee.

We recommend that Alexis Herman lead these exploratory discussions, assisted by DPC and NEC staff, with the advice of the White House Counsel. We believe that the necessary preparatory work can be completed so that you can recognize such a newly formed private entity within 45 days.

☒ APPROVE
☐ DISAPPROVE
☐ DISCUSS FURTHER

THE WHITE HOUSE

WASHINGTON

June 14, 1994

MEMORANDUM FOR PAUL DIMOND

SPECIAL ASSISTANT TO THE PRESIDENT
FOR ECONOMIC POLICY

FROM:

STEPHEN NEUWIRTH 
ASSOCIATE COUNSEL TO THE PRESIDENTKATHLEEN M. WHALEN 
ASSISTANT COUNSEL TO THE PRESIDENT

SUBJECT:

Teen Pregnancy Prevention Private Sector
Initiative

We understand that the President will be introducing his welfare reform proposal and will be addressing, among other things, teen pregnancy prevention. This memorandum sets forth two options for private sector involvement in an initiative to prevent teen pregnancy.

This memorandum concludes with suggestions for the type of Presidential statement that would be appropriate depending on the option selected.

Option One: Presidential Council

The President may establish by Executive Order, or ask Congress to establish by statute, a committee of private citizens to render advice to the President on, and participate in, efforts to reduce teen pregnancy.

Because the council would be composed of private sector individuals, and would be rendering advice to the government, it would be subject to the Federal Advisory Committee Act (FACA). The Act requires, among other things, advance notice of meetings, public meetings, and public availability of documents. Unless Congress specifically granted the council gift acceptance authority, the council would not be entitled to accept gifts.

In addition, members of the council could be considered special government employees depending on the method of selection and scope of duties. Individuals appointed to the council to represent views of outside organizations or a particular industry or sector would not be considered special government employees. Persons selected for their individual expertise but not as representatives of a particular organization, industry or sector would be considered special government employees.

We understand that, as presently contemplated, such a council would include a number of individuals who would be representatives of particular industries or sectors (e.g., educators, public health officials, or social workers), but that not all members would necessarily represent a sector. Some would be selected for their name recognition or because of personal interest in the subjects to be addressed. Such individuals would be considered special government employees.

Special government employees are subject to the Federal conflict of interest statutes and financial disclosure reporting requirements. Prominent, visible individuals are often unwilling to complete financial disclosure reports or comply with conflict statutes.

This option is restrictive and complex. Funding would be limited. Compliance with the conflict statutes and the financial disclosure reporting requirements could be burdensome and an obstacle to service for many otherwise qualified private sector individuals.

Option Two: Private Sector Initiative

Individuals outside the government could establish a private sector initiative directed at reducing or eliminating teen pregnancy. The group would not be subject to the FACA. It also would not be restricted from raising money from private sources, from seeking and obtaining Federal grants, or from spending the funds it obtains as it deems appropriate. The members of the private sector initiative would not be special government employees and would not be subject to Federal conflict of interest statutes or the financial disclosure requirements.

While the President may propose such a private sector initiative, the initiative must indeed be private. Individuals rather than government employees would need to initiate, and exercise complete control over the affairs of such an entity.

Suggestions Regarding Statements

If Option One is selected, it would be appropriate for the President to announce that he is planning to create -- or to ask Congress to create -- a council to address the issue of teen pregnancy prevention.

If Option Two is selected, it would be appropriate for the President to encourage the private sector to become actively involved in efforts to prevent teen pregnancy. The President could publicly ask that a private entity be created to sponsor such efforts. If appropriate, the President could identify individuals who have indicated a willingness to lead a private sector initiative.

FACT SHEET ON BIRTHS TO OUT-OF-WEDLOCK TEEN PARENTS

The surge in births out of wedlock to teen parents is an urgent problem.

o During the past three decades, births out of wedlock to teen parents have quadrupled, from 92,000 in 1960 to 368,000 last year. In this same period, non-marital births to teens age 15 to 19 have risen from 15 percent of all births in this cohort to 69 percent of all such births.

o In just five years, 1986 to 1991, the overall rate of births to teens increased by 24 percent. The U.S. rate of births to teens aged 15 to 19 is now twice as high as that of any other industrialized nation, and five to ten times as high as in most European countries.

o Almost 80 percent of the children born to unmarried teenage high school dropouts live in poverty. In contrast, the poverty rate is only 8 percent for children of young people who defer childbearing until they are graduated from high school, twenty years old, and married.

o Even after correcting for income differences, the children born to unmarried teenage parents experience higher rates of educational and emotional problems, are more likely to commit crimes, and are less likely to be employed. In addition, the children born to unmarried teen parents are more likely to become unmarried teen parents in turn.

o Cases headed by unwed mothers accounted for about four-fifths of the growth of 1.1 million families in the welfare rolls over the past ten years.

o More than three-quarters of teen mothers will be on AFDC at some point during the five years following the birth of their child.

o 40 percent of families headed by never-married mothers remain on AFDC for more than 10 years.

o The annual cost to taxpayers to assist families begun by teenagers is now about \$34 billion.

PROMISING PROGRAMS TO FIGHT TEEN PREGNANCY

Postponing Sexual Involvement

- o Implemented in Atlanta public schools since 1983 by the Grady Memorial Hospital.
- o By the end of the 9th grade, one third fewer of the youth who participated in the program had begun having sex that had nonparticipants.
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- o Implemented in four cities under the sponsorship of Girls Incorporated (formerly Girls Clubs of America).
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- o Implemented in Baltimore schools under the leadership of the Johns Hopkins School of Medicine.
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- o Program participants showed a significant decline in pregnancy rates over the full 28 months of the program, versus a significant increase for nonparticipants during the same period.

These summaries and data are drawn from Brant C. Miller et al., Preventing Adolescent Pregnancy: Model Programs and Evaluations (Sage Publications, 1992).

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FROM:

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BRUCE REED *BR*
GENE SPERLING *GS*
PAUL DIMOND *PD*

SUBJECT:

TEEN PREGNANCY PREVENTION CAMPAIGN--
A Private, Non-Profit Entity to Assist in Mobilizing Private Sector

CC:

ALEXIS HERMAN
CAROL RASCO
BOB RUBIN

Background. As a major component of the Welfare Reform proposal, you announced the need for a national campaign to prevent teen pregnancy. You noted that this is an American challenge -- one that can be met only if families, businesses, churches, youth groups and civic organizations, and peers join together in a parallel effort with your legislative proposals and Presidential leadership to provide a guiding hand to youth in communities all across the country. Due to the substantial press coverage, many prominent leaders of business, churches, youth and civic groups, foundations, entertainment, sports and the media have expressed a willingness to support a privately funded, non-profit organization ("private entity") to assist in mobilizing such a concerted national campaign.

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FROM: STEPHEN NEUWIRTH *SN*
ASSOCIATE COUNSEL TO THE PRESIDENT

KATHLEEN M. WHALEN *KMW*
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January 25, 1995

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MELANNE VERVEER

FROM: BILL GALSTON ^{W49}

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To prepare for this initiative, I conducted a review of the best scholarship on teen pregnancy and an inventory of the most effective programs that have been implemented in communities over the past decade. I have attached one-page summaries of my findings.

TO: Hillary
FROM: Melanne

Please call Arvone Fraser to thank her for her work heading up the women's commission and ask if she would like to serve as a part of the official delegation to Beijing because of her human rights expertise.

612-379-9451

*file teen
preg'cy*

June 27, 1995

Dear PPI Friend:

Teen mothers have figured prominently in the welfare reform debate now stalled in the Senate. One source of tension among Republicans has been the efforts of conservatives to punish teen mothers by cutting off their welfare benefits.

In the enclosed paper, "Second-Chance Homes: Breaking the Cycle of Teen Pregnancy," Kathleen Sylvester argues that the conservatives' punitive solutions "are based on false premises," while liberals too often defend a welfare system that "makes no moral judgment about life choices that are detrimental to children—a system that relies more on condoms and sex education than on community values to deter pregnancy."

In the enclosed paper, Sylvester, PPI vice president for domestic policy, offers a piece of the solution, a proposal called "second-chance homes," community-based, nonbureaucratic group residences that offer young women and their children structure and stability. The concept is being promoted by Senate Minority Leader Tom Daschle and Sen. Kent Conrad in their efforts to combat teen pregnancy as part of welfare reform legislation.

At a recent PPI forum to unveil the proposal, Sen. Barbara Mikulski said of the idea, "It is specific, it is immediate, it is realizable, it's achievable, it's practical, it's sustainable, and it's terrific."

We hope you'll think so too.

Sincerely,



Chuck Alston
Communications Director

SECOND-CHANCE HOMES

Breaking the Cycle of Teen Pregnancy

Kathleen Sylvester

For many Americans, teenage welfare mothers symbolize the tragedy of our nation's failed welfare policy and the unraveling of our nation's social fabric.

Growing numbers of poor and uneducated young women—often still children themselves—are using public support to bear and raise children outside of marriage. These young women are a constant reminder of government's inability to address a fundamental social problem. More importantly, they are producing a new generation of poor and fatherless children who will begin life with disadvantages from which they may never recover.

More than one million teenagers become pregnant every year; half will give birth and most will not marry. Their children are likely to grow up poor, poorly nurtured, and—because they are raised in virtual isolation from the rest of society—unsocialized. These children are at high risk of dropping out of school, getting into trouble with the law, abusing drugs, joining gangs, having children of their own out of wedlock, and becoming dependent on welfare.

These young people will pay a high price for our nation's inability to help their mothers: And society, too, will pay a high price. The problem is urgent. There are now nine million children living in welfare families. As those nine million children reach adolescence, many are "scripted" to repeat the lives of their parents. We must intervene and break the cycle before those children, too, become parents too soon and create a new generation of disadvantage.

The current public debate over teen mothers offers Congress and the nation an opportunity to try to break the cycle with the help of communities. The debate offers an opportunity to move beyond the punitive solutions offered by conservatives and the defense of a failed welfare system offered by liberals. The debate offers an opportunity to seek an alternative that can help teen mothers change their lives and—more importantly—the lives of their children.

Conservative solutions, including such punitive steps as cutting off welfare to mothers under age 18, are based on false premises: that teen mothers are entirely in control of the circumstances that lead them to early childbearing, that their reasons for childbearing are in large part financial, and that sanctions alone are enough to influence their decisions.

Conservatives would needlessly risk the well-being of children. Ignoring the inadequacy of the foster care system, they would break up families with no alternative safety net in place. Ignoring the reality that the welfare system was designed to help

families whose fathers are absent, they would reform it by absenting mothers as well, substituting institutions such as orphanages for real parents.

Liberals now find themselves in the untenable position of defending a failed welfare system. They are defending a system that makes no moral judgment about life choices that are detrimental to children—a system that relies more on sex education and condoms than on community values to deter teen pregnancy. They are defending a system that by its offer of unconditional support for welfare recipients insulates those mothers—and the fathers of their children—from taking responsibility for their own actions. It insulates these parents from accountability to their families and communities as well.

The answer is not to cut off the welfare checks of teen mothers. Nor, for many young women, is the answer to continue their welfare support and send them back to the homes where they grew up. Instead, communities must "take in" these young mothers and their children.

The Progressive Policy Institute (PPI) offers a third alternative: an approach that invokes society's values, requires responsibility and reciprocity from welfare recipients, and engages communities in solving the problem.

To do that, our nation must revive an old institution—the maternity home—in a new form. With seed money and guidance from the federal government, communities could create a national network of "second-chance homes," a new version of the homes that once provided community support for unmarried mothers.

These second-chance homes would be group residences in which young teen mothers would live—under adult supervision—with their children, while meeting their social and personal obligations for receiving welfare support. These homes would offer a rare institutional opportunity for bringing together in one setting the three fundamental elements teen mothers need if they are to have a chance to succeed: nurturing and support, structure and discipline, and socialization.

Second-chance homes would offer teen mothers a positive family environment that gives them real opportunities to become good parents, finish school, and join the workforce. By providing nurturing and support, second-chance homes would allow teen mothers to establish emotional and familial bonds and find role models apart from their own troubled families. In these homes, help and support would go hand in hand with obligation and responsibility. Unless society finds a way to offer them an environment that provides the socialization that many of these young women lacked in their first homes, they are unlikely to succeed in meeting the obligations society now places on them.

Finally, such homes would help ensure that the welfare system meets one of its most important responsibilities: removing vulnerable children from dangerous environments. Many teen mothers were themselves left too long in dysfunctional homes. They were abused and neglected; many were shuffled from foster home to foster home. Most have grown up poor and poorly nurtured.

The sad legacy of such childhoods is that many of these young mothers have great difficulty developing parenting skills; some are emotionally incapable of bonding with their own children. Others are so damaged by abuse and neglect that they are

dangerous to their children because they repeat these patterns. And a small percentage of these mothers are so damaged that they will never be able to learn to put the needs of their children ahead of their own needs.

On any given day in this country, nearly a half million children are in foster care or other temporary care because their biological parents are unable to care for them properly. Federal law specifies that foster care should last no longer than 18 months, with a decision about parental competence to be made within that period so that a child is available for adoption. The reality, however, is that courts postpone final decisions about parents' rights and leave children to languish in temporary care. In Illinois, for example, the median time spent in *first* foster care placement is approximately 13 months for white children, 18 months for Latino children, and 51 months for African-American children.

Too many children spend years of their young lives waiting. These children wait for a mother who needs to kick a drug habit, or to outgrow an attachment to an abusive boyfriend—or simply to grow up.

For some of these children, the only solution is to terminate parental rights and place them in new—and permanent—homes. This means adoptive parents, not foster care. An unfortunate but necessary goal of second-chance homes would be to make assessments about the capabilities of these young women to be good parents. Second-chance homes must offer young mothers every opportunity to become good mothers. Most will achieve this goal; those who cannot must not be allowed to damage the lives of another generation of children.

Declaring a parent "unsafe" for a child and terminating parental rights is a serious and irrevocable step. The existence of these homes would make it possible to gather enough information to make such a grave decision a well-informed and wise one.

Getting Started: How the Policy Would Work

The federal government should set aside \$20 million a year for three years as seed money to create a national network of second-chance homes. These homes should be designed by community-based organizations for teen mothers under age 18 who need stable and supportive environments. Under strict adult supervision and with an array of social services available, teen mothers will stay in school or job training, learn parenting skills, and move toward self-sufficiency.

Communities can qualify for funds by pledging financial and in-kind support for the homes. Participants should be allowed to use portions of their welfare or foster care payments, as well as federal nutrition and housing subsidies as program fees.

These homes should be carefully evaluated to determine their effects on teen mothers, the children of teen mothers, and younger teens who are not yet pregnant but at risk of becoming pregnant.

This new national network of second-chance homes would be created with three implementing devices:

1) *Leveraging the federal social welfare system.* A large portion of continuing support could be funded by fees paid from participants' welfare or foster care support. Current law should be amended to give states the option of allowing designated second-chance homes to cash out participants' food stamp coupons in order to create a flexible fund that home administrators can use for food budgets. Housing subsidies, too, could be cashed out and used by residents as part of the program fee they pay to a second-chance home. The maximum median benefit per month for a family of two in 1994, for example, was \$294. Monthly food stamp benefits, child care subsidies, and housing subsidies can bring the total typical monthly benefits for a family of two to more than \$900.

The Adoption Assistance and Child Welfare Act, Title IV-E, should be protected from being capped in a federal block grant. The foster care funding it now provides for some teen mothers or their children could be redirected to second-chance homes, or states could allocate some of the program's administrative funds to second-chance homes. Title IV-B child welfare funding could also be made available for these purposes.

The Department of Housing and Urban Development (HUD) could make property available for second-chance homes as it now does for 501(c)(3) nonprofit organizations. Under HUD's "Dollar-a-Year" program, providers of services to homeless persons can lease federally owned property for one dollar a year, with an option to purchase it. In addition, nonprofits can buy some property from HUD at a 10 percent-30 percent discount. Other federally owned property, such as closed military installations and properties held by the Resolution Trust Corporation, might be made available for these purposes as well.

Residents could also use Section 8 vouchers and certificates, available under the National Housing Act, or cash out conventional low-income public housing subsidies to pay for their share of a program fee in a second-chance home.

2) *Using limited federal funds for seed money and evaluation.* In creating a national network of these homes, the federal role could be limited to offering seed money and guidance about how existing models are structured and evaluating the effectiveness of the programs.

Federal dollars for start-up costs could be designated from the Title XX Social Services Block Grant or from Senator Nancy Kassebaum's proposed Youth Development Block Grant, which is designed to support prevention programs and programs that serve as catalysts for community support for families and children. Federal start-up funds, however, would go only to communities that pledge matching funds and in-kind contributions.

Most federal assistance for welfare now focuses on amelioration, with too little spending and emphasis on prevention. States or communities that promote second-chance homes and produce measurable results—such as reduced demand for foster care, reduced numbers of second pregnancies, and shorter spells of welfare dependence—should be allowed to retain a portion of the savings from reductions in projected welfare caseloads.

Thus, federal funds could provide seed money for more homes. As capacity in the system builds, teen mothers might use their welfare support as "vouchers" to choose homes that meet their needs.

3) Catalyzing community support: "Stone Soup." The model for these second-chance homes comes from a children's story—the story of stone soup. When a traveler came into a very poor village whose residents had little food, he went to the square in the center of the village and began to stir up a pot of stone soup. His pot contained only water and a large stone. As people gathered in curiosity, he suggested that with a little bit of salt, the soup might be better. A bystander offered some salt. Next, the traveler suggested a snip of parsley, and again, a villager came forward. After that, the traveler asked for potatoes, and then beans, and then carrots. Within a short time, he had convinced all of the poor villagers to share, and they had pooled their meager resources to create a fine meal.

Government's role is to provide the stone for the soup: to be a catalyst for gathering communities together to solve a problem that begins in those communities and affects those communities.

The goal is achievable. There are more than 250,000 organized religious congregations in this nation. There are 183,000 local governments. There are tens of thousands of colleges, YMCAs, and neighborhood clinics; women's groups such as the Junior League and Big Sisters; Rotary Clubs and fraternal organizations; senior citizens' groups and youth groups. The members of this "community" must join government and supply the element now missing in attempts to help teen mothers and their children: connection to community and community standards.

While the costs for many of the programs cited in this paper run as high as \$50,000 a year for mother and child, many of the most effective programs cost far less because they are supported by their communities. Albuquerque's Teen Parent Residence (TPR), which costs just \$67,500 for services to 14 teen mothers for one year, operates in a cluster of HUD-subsidized low-income apartment units. The mothers pay below-market rent for the apartments they share and the state picks up the cost of an apartment for the resident "house mother," a night-duty nurse, and professional counseling services. Everything else comes from the community.

Families from local church congregations invite the young mothers and children home for Sunday dinner. A local family clinic provides "development assessments" of the babies so their mothers can learn what to do to help them progress. The U.S. Department of Agriculture's Cooperative Extension Service offers nutrition classes and child development counseling; the Rotary Club paid the salary of a consulting psychologist for a year; the local university's dental school offers free dental services. A local Presbyterian church puts on an annual Mother's Day picnic; the Civitan youth group offers babysitting services; another youth group collects cans and bottles for recycling and donates the proceeds to the TPR program. Stores such as Kmart and Wal-Mart offer huge discounts on their products, and often throw in extra groceries and diapers. The manager of the local Cort Furniture store gave the residents a discount on furniture, then loaned them one of his own trucks and a driver to pick up other

furniture that had been donated to furnish their apartments. And the Albuquerque Hispano Chamber of Commerce not only donates money to the program, it hires its graduates.

Barbara Otto, New Mexico's director of Teen Family Services, says that these donations and contributions are rarely one-time benevolent gestures. TPR has become a part of the community; supporters and volunteers continually renew their support.

At Catholic Charities' Casa Maria in San Diego, five obstetrician/gynecologists volunteer their time to serve the health care needs of the home; two social work masters' students counsel the residents; foster grandparents come in every morning to help the mothers and children begin their day; and volunteers help with group meetings and nightly educational classes.

The Bridgeway program is a private, nonprofit organization in Denver. Director Rich Haas keeps it going by cobbling together donations from individuals and businesses and small foundations to create an annual \$235,000 budget for three residences, operated for \$600 a month per mother and child. Programs and classes at Bridgeway are run by experts who donate their skills and volunteers who donate their time and goodwill. Despite its small budget, Bridgeway reports impressive statistics on adoption rates, high school graduation rates, and reduced second pregnancies.

Second-chance homes will begin to remedy one of the unintended consequences of the New Deal. When government became the primary safety net for fatherless families, the importance of community values and community institutions was diminished and the notion of reciprocal responsibility disappeared.

The parallel development has been equally destructive. When government assumed primary responsibility for women and children in the welfare system, communities were relieved of responsibility to care for their own citizens. Indeed, many communities no longer consider welfare recipients to be citizens. They live in a separate society; they are defined by their deficits rather than their capacities. For too long now, government has been a wedge between communities and individuals, providing each excuses to ignore their obligations to the other.

A Limited Experiment

Initially, these homes should be designed to serve teen mothers under age 18. The current debate has frequently focused specifically on policies for welfare mothers under age 18. Conservatives have used this focus to fuel public outrage at a welfare system that appears to condone irresponsible decisions by very young girls. It is nevertheless appropriate to focus on these young women. Teen mothers under age 18 are the most likely of all welfare recipients to become long-term recipients. Nearly half of long-term welfare recipients are women who gave birth before age 17.

PPI suggests another reason to focus on these mothers in particular. The existence of these homes and the requirement for many teen mothers to live in them would send a very strong message to younger teens—those not yet pregnant. The message would be simple: Society no longer offers unconditional, open-ended financial support for young women who bear children out of wedlock. Government will help unmarried

mothers, but only if they meet mutual obligations: learning to be good parents, finishing school, and joining the workforce.

There is a pragmatic reason as well to focus on mothers under age 18. In 1993, the U.S. Department of Health and Human Services (HHS) reported that there were just under 296,000 unmarried teen mothers on welfare. The large majority, however, were 18- and 19-year-olds; there were just over 67,000 welfare mothers under age 18. We should begin our efforts to help this group of young mothers because they need the most help, because their number is small, and the "community" with the potential to take them in is large.

PPI does not propose these homes as a guaranteed solution to the problem of teen pregnancy, but rather as a promising idea. The prototypes for these homes scattered across the country have produced some notable results: fewer second pregnancies, dramatically increased school completion rates for mothers, reduced incidence of child abuse, better maternal and child health, higher employment rates, and reduced welfare dependency.

These results, however, are self-reported, anecdotal, and short-term. None has been tracked carefully enough to determine whether these results are valid in the long-term. And none has been evaluated sufficiently to demonstrate their effects on the children of teen mothers.

Reviving an Old Idea

Maternity homes are by no means a new concept. As early as the 19th century, white, middle-class, evangelically oriented Protestant women with experience as missionaries or teachers volunteered in these privately owned homes. African-American women founded maternity homes in their own communities as well, including New York City's Katy Ferguson Home, Boston's Harriet Tubman House, and Chicago's Phyllis Wheatley House. National organizations such as the Florence Crittenton Mission and the Salvation Army provided shelter and aid to young women in trouble. In 1863, Abraham Lincoln signed a charter establishing St. Ann's Infant and Maternity Home, a home for orphans and "unprotected females during their confinement in childbirth," on Pennsylvania Avenue just a few blocks from the White House.

Initially, most homes were loosely defined as "rescue homes," providing shelter for prostitutes, alcoholics, and drug addicts as well as unmarried mothers. In order to gain credibility for their efforts, these rescue-home workers developed relationships with the judicial system; women were often sentenced to stay at Florence Crittenton or Salvation Army homes as an alternative to jail or reform school. Life in the homes was strictly supervised. In most cases, a mother could not receive visitors other than female relatives, she could not leave the grounds unchaperoned, and both her incoming and outgoing mail was censored.

Between 1910 and 1920, however, maternity care replaced redemption of prostitutes as the primary function of rescue homes, largely because prostitutes proved difficult to recruit and often left after a short period of time. Young pregnant women were more likely to actually need the rescue homes, and the homes shifted their focus

entirely to unmarried mothers. Most homes restricted their residents to mothers under age 25 with one child, and they remained largely racially segregated.

While a few maternity homes achieved a degree of racial and socioeconomic diversity, most homes served young women whose families were unable or unwilling to support them. Rehabilitation and redemption were the primary goals, while refuge from potentially abusive families was a secondary function. The homes sought to transform young, helpless women into productive members of society and to give them and their children a future.

Until the mid-1910s, maternity homes focused on marriage as a main goal. At first, homes encouraged young mothers to marry the fathers of their children, but by the early 20th century, most homes abandoned that practice. Still, the early maternity homes recognized the positive influence of motherhood on otherwise "wayward" women, and the commitment to keep mothers and children together became a sacred maternity-home policy. Both Crittenton and Salvation Army homes required residents to sign contracts in which they promised to keep their babies.

Abandoning marriage as a primary goal forced maternity homes to take on the task of employment training. Domestic work was the occupation with the most appeal, since it served young mothers' practical needs. The households in which the women worked assumed many of the supervisory functions of the maternity home, providing stable income and allowing them to keep their children with them.

By the late 1910s, old-fashioned benevolence gave way to the increasingly professional field of social work. In an effort to prove their legitimacy as scientific social experts, social workers attempted to abolish traditional charitable endeavors. Not surprisingly, maternity homes, with their focus on domesticity, proved too stereotypically feminine to survive the attacks of prominent social work leaders.

As social workers took on illegitimacy as their domain, the assumptions behind the problem of unwed motherhood changed dramatically. Instead of perceiving the problem as one of personal defects, the new school of thought attributed poverty and unwed motherhood to social inequities.

The social insurance movement of the New Deal officially transferred welfare functions from the private to the public sector. Not surprisingly, the clash between private charities and mothers' pension advocates was intense. The new ideology stressed the superiority of the home to the institution. The New Deal mothers' pensions were intended to support mainly widows and orphans but quickly extended to benefit the small population of unwed mothers as well. Ironically, both maternity home advocates and mothers' pensions advocates sought the same goal: to keep mothers and children together. The former exerted their efforts on personal defects, while the latter concentrated on equalizing economic and social differences.

During the 1940s, the majority of unwed mothers relinquished their children for adoption, and child welfare services began focusing on prenatal services only. Again, the pendulum swung, and by the 1970s the majority of pregnant teenagers were giving birth and keeping their children. But because most maternity homes had been phased out, young women no longer had such refuges available.

A handful of these homes, however, exist today. Lincoln's St. Ann's has never closed its doors. Now located just outside Washington's city limits, it serves pregnant teens and new mothers from abused and neglected backgrounds. It also has a nursery full of boarder babies—tiny victims of the city's drug wars.

While the circumstances and needs of these young women are vastly different from those of the home's first residents, they still meet Lincoln's definition. They are "unprotected females," still in need of society's support if they are to make decent lives for themselves and their children. The time has come for society to revive the old maternity homes in a new form.

Who are Teen Mothers?

Policy should not be based on stereotypes and myths about teen mothers. Policy should be based on what is true about teen mothers:

- ▶ *They are poor.* Many come from families strained by poverty and dysfunction. The Alan Guttmacher Institute reports that 83 percent of teenagers who give birth come from economically disadvantaged households, though only 38 percent of all teenage women are from such families. As researcher Joy Dryfoos has noted, teenage pregnancy is just one "marker" of disadvantage.
- ▶ *They are hindered by lack of socialization.* Teen mothers are not the promiscuous and "worldly" young women of the stereotypes. They do not live in any "world" beyond the reality of their own neighborhoods. They are products of the streets where they grew up; they learn how to treat their own children from the parents who raised them; and they model their social behavior after peers who come from the same neighborhoods. These young women have little chance of emulating any other kind of life. They have few models for any other life.
- ▶ *They do badly in school.* For teen mothers, schools are rarely places where they have found any measure of success; most are poor students. Data from the National Longitudinal Survey of Youth demonstrate that 36 percent of students who score in the lowest fifth in basic academic skills become teen parents, compared with less than 5 percent of students in the highest fifth. Contrary to popular belief, most teen mothers do not drop out after becoming pregnant; most leave school before they are pregnant. For many of these young women, a welfare check seems a more realistic goal for obtaining an income than getting a high school degree.

- ▶ *They suffer from poor health; so do their children.* Young, poor, unmarried, uneducated, and uninsured mothers are much less likely than older, more stable mothers to obtain prenatal care. Only three in five teen mothers received early prenatal care in 1992; one in 10 received late or no prenatal care. The result is poor health for the adolescent mothers, whose own nutritional needs compete with the needs of their unborn children. They are more likely to deliver low-birthweight babies. Each low-birthweight baby averages \$20,000 in hospital costs; total lifetime medical costs for such children can average \$400,000. As they grow, low-birthweight babies often suffer developmental problems that severely limit their school achievement.

- ▶ *They have been badly nurtured.* Many come from homes where they are subjected to neglect or physical violence. In a nation in which there were more than one million cases of child abuse or neglect confirmed in 1993, many of those victims are young women who are teen mothers. Some are destined to visit these same tragedies on their own children. Mothers under age 20 were vastly overrepresented among families reported for both abuse and neglect. In one survey, 30 percent of mothers who neglected their children were under the age of 20—three times their proportion of the population.

- ▶ *The majority are victims of sexual abuse.* Sexual abuse and rape play a significant—and largely ignored—role in teenage pregnancy. Studies show that as many as two-thirds of teen mothers were victims of rape or sexual abuse at an early age. These crimes are frequently committed by relatives or other adult males living in the same household with the teen mother. Many teen mothers, in fact, report that they became pregnant to stop sexual abuse.

- ▶ *They suffer from mental and emotional problems.* Their histories of abuse damage the lives of young women in powerful and lasting ways. When abuse goes unreported, these young women can manifest the long-term effects of untreated abuse throughout their lives. Clinical evidence shows that they are prone to psychiatric illnesses including spells of depression, suicidal tendencies, drug addiction, and alcoholism. In addition, researchers Debra Boyer and David Fine note that sexual abuse often delays cognitive, social, emotional, and psychological development. Thus mothers who have been abused not only have difficulty adapting to the difficulties of their own lives; they may be impaired in their ability to nurture their children.

- *They are easy prey for older men.* Young women who have been victims of early sexual abuse often develop emotional patterns that make them especially vulnerable to the attentions of older men. Most men who father children by teen mothers are not adolescents themselves. The National Center for Health Statistics reports that almost 70 percent of children born to teens are fathered by men aged 20 and older. And while the average age gap between teen mothers and the fathers of their babies is four years, the very youngest girls—who are 11 or 12—are often victims of men in their 30s and 40s.

Elements of a Successful Home: A Social Contract

Successful prototypes for group homes respond to the reality of teen mothers' lives, and their design incorporates all three elements necessary to offer them a chance to succeed: socialization, nurturing and support, structure and discipline. And they begin with the basics.

Creating a sense of order. New residents are quickly introduced to rules and regulations. At the Teen Parent Residence program, the teens must sign an agreement to follow house rules: to perform the household chores assigned to them in a timely manner, to be responsible for their own actions, to be contributing members of the TPR community, and to set and meet their individual goals with the help of the staff. If they break the rules, the consequences are clear and swift—they lose their privileges. Repeat offenders are evicted. Most homes have strict curfews and limited visitation policies; many have zero-tolerance drug policies.

The idea that help and support are conditional on behavior is crucial to the success of these programs. At the Casa Maria program in San Diego, CA, young mothers are required to set goals for themselves and expected to live up to them. When a young mother succeeds by following the rules and attains her goals, she becomes a senior resident and assumes responsibilities normally assigned to a house mother. In addition, she is rewarded financially with a reduction in her room and board payment.

Many programs have developed incentive strategies to acknowledge and reward good work. The Father Pat Jackson House in Ann Arbor, MI, charts incremental steps on the self-esteem ladder with concrete incentives. Teen mothers come into the program as probationary "opals." As they adjust to the structure and routine of the home and succeed in their daily tasks, they graduate to the ultimate status of "diamonds" and earn telephone and weekend pass privileges. Privileges are promptly taken away if they transgress.

One important component of self-worth and confidence-building, often overlooked in institutional settings, is the need to celebrate and validate developmental experiences and successes. At the Teen Mothers Program in Washington, DC, teen mothers who graduate from high school are given a special party to mark their success.

Helping teen mothers grow up. Most developmental psychologists agree that growing up takes place in stages and that it involves learning and taking responsibility in ever larger and more complicated doses. Young adolescents, girls up to the age of 14, develop self-esteem by learning and mastering the basic social and cognitive skills required to function at home, in school, and in society at large. They are socialized by learning to play and negotiate with siblings at home and peers at school. They become responsible by doing chores at home and homework for school. And they learn because they can go to school and they have attentive and interested parents who expect them to do well.

These daily experiences and accomplishments, along with the acknowledgement and celebration of successes, help young women shape their self-image and their understanding of who they are and what they can accomplish. Without a sense of self-worth, they lack the inner resources necessary to complete the next stage of development which is to mature, become independent, and prepare for the world of work.

As Toby Herr and Robert Halpern point out in their descriptions of Chicago's Project Match welfare reform program, a child takes steps toward independence, builds self-esteem, and learns responsibility by catching a bus to get to school on time, taking care of pets, getting a library card, setting the table each night, and contributing to a savings account.

Unfortunately, many teen mothers come from unstable homes where there are few such obligations and little discipline. Struggling with the responsibility of parenting without having mastered lesser responsibilities can be an insurmountable task. To help young parents grow up, second-chance homes offer them opportunities they did not have at home for building new coping mechanisms and learning and mastering daily life skills such as cooking, cleaning, budgeting, and eventually job preparation.

Houston's Teen-Age Mothers and Infants (T.A.M.I.) House has developed a point system to give residents an opportunity to build a storehouse of small accomplishments while learning to work cooperatively with other young mothers. Five points are awarded for completing small tasks such as washing dishes or sweeping and mopping the kitchen floor. With 115 points, a resident earns a weekend pass.

In the Teen Mothers Program, young teens learn how to groom themselves, make their beds, and clean their rooms. Older teens take more responsibility for menu planning, shopping, and cooking. When they are ready to leave the home and look for a job, they learn how to use public transportation, and how to dress and conduct themselves for a job interview.

Helping teens learn to be good mothers. Young mothers whose own mothers were inadequate or absent need help learning how to nurture and discipline their children. Most teen parent residences offer classes in child development, scheduling, and nutrition. In a communal environment, young mothers also learn from each other and from the adults who come into the home on a regular basis. A graduate of Teen Mothers Program says it was a "foster grandmother" who visited her young daughter every day for several years, read stories to her, and taught her ABCs and other childhood basics. When the little girl went to school, she was well-prepared and she thrived.

Frances Santiago, the house mother of the Teen Parent Residence program, is always there for a basic question about mothering: Is it time for my baby to switch from a bottle to a cup? When will she learn to roll over? What should I do about biting? And she is there as well to celebrate with the young mothers as their children meet milestones: a first tooth or a first step. Santiago, who calls the babies her grandchildren, is a living example of how to show children affection and love while being firm.

At St. Ann's, lessons about child care are as basic as teaching young mothers never to leave their babies unattended. Each morning, mothers go through the ritual of feeding, bathing, and dressing their babies before their own classes begin. Throughout the day, staff members provide ongoing coaching, prompting, and supervision. In addition, the young mothers are required to participate in workshops and talks on parenting and child development issues. St. Ann's also schedules a family night each week during which mothers and children go on a group outing.

At the Northwest Maternity Center in Washington, DC, the majority of residents were themselves victims of abuse. When they enter the program, they are taught to curb their aggressive behavior and to treat the other residents with respect. They are not allowed to hit or scream. In child development classes, they learn why babies cry and what to do for them. And they are taught to put their babies back in their cribs when they are too angry to hold them carefully. It generally takes six months for the young mothers to learn to treat their babies gently and to demand that others treat them that way too.

Requiring and supporting continued education and job training. Nearly all programs require mothers to be in school or in job training. Some of the larger programs have schools at their own facilities or offer General Equivalency Degrees (GED) on site. Many teen mothers choose GED programs or alternative schools to better accommodate their children's schedules.

Most teen mothers in these programs complete high school, and a significant number go on to vocational school or college. The mothers report that the added responsibility of a child gives them an incentive to succeed. These programs recognize, however, that teen mothers often need help catching up in school. Most insist on scheduled study time and offer tutoring or remedial classes. Many offer links to the world of work as well, helping mothers find vocational programs in fields such as nursing or welding—fields in which they can make enough money to support their children and get health benefits.

At Homes for the Homeless in New York City, the program takes advantage of its large size by offering "in-house" apprenticeships. Residents have part-time jobs in the program's day care center or its housing office or administrative offices. They gain marketable job skills while mastering basics such as learning to dress appropriately, showing up on time, and dealing with co-workers.

Offering health care and mental health services. The majority of young mothers are eligible for Women, Infants, and Children (WIC) and Medicaid. Teen parent residences make sure they get these services. Some of the larger homes are Medicaid providers and

have health care professionals on staff; smaller ones bring in health care professionals as needed.

Perhaps even more than physical health care, many adolescent mothers need mental health care for depression or other psychological problems. At the Florence Crittenton Services, licensed psychologists and psychiatrists provide ongoing clinical supervision and case consultation. Health care is available through various providers in the community. "Rap groups" led by social workers give parenting teens an opportunity to discuss their problems with their peers in a group setting.

Offering opportunities to find mentors. Time after time, studies show that disadvantaged children who are "resilient" and overcome their disadvantages have benefitted by the presence of a strong, caring adult in their lives. Because so many teenage mothers have lacked such a presence in their early years, second-chance homes offer opportunities to introduce them to alternative mentors.

Each teen at Bridgeway is connected to a big sister "Bridger" who acts as a friend, confidante, and role model during the program and in follow-up years. Moreover, Bridgeway offers a curriculum of 104 courses all taught by volunteer "educators." The Father Pat Jackson House Program takes advantage of its proximity to the University of Michigan by recruiting college students to provide transportation and act as role models.

"Foster Grandparents" are a loving and caring presence at St. Ann's. Some of the grandmothers have been coming for years to help with the babies and to nurture the new mothers. "Mentor Mothers" is a volunteer program developed by the Maternity Center in Washington, DC. While some mentor mothers are available only for occasional transportation and tutoring help, others have bonded with their charges and provided surrogate mothering for many years.

Offering protection from abusive and predatory men. For many teen mothers, protection from controlling and abusive boyfriends is essential to success. These homes offer physical protection and refuge from abusers; most have strict rules about male visitation. Strict schedules and rules give young women an "out," a way to avoid contact with men they don't want in their lives. They have an excuse to say no when they are most vulnerable.

For those young women who want to establish stable relationships with their babies' fathers, second-chance homes offer both a neutral place to negotiate; some offer couples' counseling and parenting classes for fathers as well. And in the long-term, perhaps the most important defense that these homes can offer to vulnerable young women is the confidence and self-esteem that comes from positive achievements: raising healthy and stable children and gaining the skills to become self-sufficient.

Providing a sense of family. The proposed name for this network of new institutions—second-chance homes—has two elements. "Chance" implies opportunity. "Second" implies a new home that substitutes for an original home. But for many of these young women, second-chance homes are their first homes. These are the first

opportunity these young women have had to form bonds of trust and caring. Staff and volunteers and other residents are their families.

One of the best examples comes from a group home in Alamogordo, NM, that is shared by elderly low-income women and teen mothers. After an initial period of intergenerational friction, the residents settled into a comfortable arrangement. The elderly women assumed the roles of grandmothers: cuddling babies, reading stories to toddlers, and dispensing their wisdom on child care to the new mothers.

When one of the elderly women, Julia, became ill with cancer and was unable to care for herself, the teen mothers took over her care so that she wouldn't have to leave their home. They arranged class and work schedules to make sure that one of them was always there to watch over her. After a brief stay in the hospital, the doctors released Julia to go home to die with her family. Instead of going home to her blood relatives, she chose to spend her last days with her grandchildren at the Alamogordo home.

Long after they graduate, teen mothers maintain their connections to the people who have cared for them. They send pictures of their children and call to report on successes—good report cards or new jobs or new apartments. They show up at holiday time to be with their families.

The Long-Term Approach: Creating a Climate for Change

What would it take to make these programs work better? Program directors say they need to have some real leverage over the teen mothers. The programs that work best are those that function under true social contracts: Residents know that they must abide by certain standards of behavior and contribute to their own success. House mothers or other program officials must have the ability to discipline these young women and evict them for persistent failure to follow rules and procedures.

Next, enough money to expand the programs to offer a continuum of care. Most observers agree that an ideal program would provide a three-tiered approach. The first tier would require strict 24-hour supervision and an equally demanding hour-by-hour daily structure for teens between the ages of 13 and 15. During this phase, they might live in traditional homes in which they would live and eat communally.

Older teens—including those up to age 18 and perhaps even older—would still be supervised but allowed more independence commensurate with their willingness to be responsible and fulfill their obligations. This phase of the program would be a transitional one. Young mothers would learn to be responsible for managing their children and their jobs and their budgets and households with minimal supervision and support and some help with day care. During this phase, they might live in separate apartments that are clustered in the same building or in a dormitory-style facility that has kitchens.

When they move on to fully independent living, many of these young women still need access to follow-up services—a support group to belong to or a monthly visit from a mentor.

Building such a system will be a long process. But with the support of communities, it is an achievable goal.

How Do We Measure Success?

Even with all of these supports and services, homes for teen mothers have only limited success in turning around the lives of teen mothers. Many of the mothers drop out or are expelled from programs because they are unable to cope with the rigid rules and requirements. Others cannot conquer drug abuse or mental health problems. Some are "reclaimed" by families eager to cash in on their welfare checks. And many of these young women cannot resist the power of old boyfriends who make new promises.

Many successes that may be measurable in the long-term—such as higher lifetime earnings or shorter lifetime spells on welfare—have not been measured. But the prototypes for second-chance homes around the country have produced measurable achievements, unverified but promising.

School completion. It is clear that mothers with higher levels of education and training are more successful at supporting their children. Accordingly, second-chance homes make education a priority:

- ▶ At the Florence Crittenton Homes and Services, they recently reported a high school completion rate of 92 percent for teen mothers in the program.
- ▶ At Amity Street in Lynn, MA, 50 percent of the residents have completed a job training program or have reached an educational goal (GED, college, high school diploma). Of those enrolled in high school, 90 percent graduate.
- ▶ At St. Ann's Infant and Maternity Home, mothers must be in school and can elect to attend the fully accredited high school located on campus, or go to other local schools. Fully 96 percent of its residents graduate from high school or obtain a GED.
- ▶ At the Teen Parent Residence, 117 teen mothers completed educational plans and vocational planning, 74 attended Job Corps, 14 completed requirements for a high school diploma, 19 completed their GEDs, and 20 completed postsecondary training at Job Corps or a private vocational education school.
- ▶ At Bridgeway, half of the program's graduates not only complete high school, but go on to college or other postsecondary education.

Independent living. In the long run, the main goal of a second-chance home is to help teenage mothers make the transition to independence. There are several ways of evaluating this aim:

- ▶ At Seton Home in San Antonio, TX, 100 percent of residents enrolled in classes that taught independent living and survival skills including sewing, cooking, transportation, money management, and cleaning.
- ▶ At Amity Street, 85 percent of the mothers made the successful transition to independent living and were able to set up their own households.
- ▶ At the Northwest Maternity Home, 65 percent of graduates have been placed in permanent jobs.

Reducing second pregnancies. The national average for repeat pregnancies by teenagers is 11 percent-26 percent within one year, and 50 percent in two years:

- ▶ At Bridgeway, only 8 percent of the teens become pregnant again in the two years following completion of the program.
- ▶ At Seton Home, only 10 percent of the teen mothers who go through the program get pregnant a second time within one year.
- ▶ At Amity Street, of the 44 teen parents who have gone through the program during its seven years of operation, only eight second pregnancies have occurred.
- ▶ At the Teen Parent Residence, only six of 117 participants became pregnant with another child while in the program.

Increased placement for adoption. The national average for adoption placement by teen mothers is less than 3 percent:

- ▶ At Bridgeway, almost 20 percent of teen mothers choose adoption.
- ▶ At the Teen Parent Residence, 11 of 117 placed children for adoption.

Healthier babies. Overall, the teenage mothers are less likely to receive prenatal care and their babies are more likely to be born at a low birthweight and suffer from poor nutrition:

- ▶ At Seton Home, early prenatal care has raised the birthweight of its residents' babies to nearly eight pounds.

- ▶ At Bridgeway, a rigorous program that offers prenatal care and teaches the young women better nutrition resulted in an average birthweight of over 7 1/2 pounds.

Saving money. While offering such programs with a full range of services can be expensive, many programs reduce costs by using volunteers. And in the long run, programs that keep families together are significantly less expensive than those that separate mothers and children:

- ▶ At the Teen Parent Residence, for \$67,500 per year in state funding, TPR provides services for 14 teens and their babies. The remainder of the program's funds come from fees paid by program participants and contributions from charity.
- ▶ At Bridgeway, the cost for mother and baby is \$600 per month or \$7,200 per year.
- ▶ At Homes for the Homeless, for \$12,000 per person per year, shelter for mothers and their babies is provided. The normal cost is \$40,000 per child for foster care and \$18,000 per adult for emergency shelter services in New York City.

Kathleen Sylvester is the vice president of domestic policy for the Progressive Policy Institute.

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Copy editor Sarah Jackson-Han polished the final product and Production Manager Julie Kizer Ball skillfully guided it through all stages of production. Finally, PPI President Will Marshall and Communications Director Chuck Alston offered many valuable insights and comments at all stages of the project.

APPENDIX

Examples of residential treatment centers for pregnant teens exist in a number of states. These facilities can be small or large; they are usually funded by varying combinations of private and public monies. Some are located in inner cities, others in more rural areas.

Some have large professional staffs, others are staffed mainly by volunteers. Most accept teen mothers between the ages of 15 and 18 and limit their stay to about two years. The majority accept only teens who already have children, although a handful accept pregnant teens. Some programs must accept mothers assigned to them by the courts or social service agencies; others simply accept all of the applicants or referrals they can accommodate. All programs require participants to be enrolled in school or job training. In general, services include classes in parenting and life skills as well as some counseling and support services. Day care is an important component of these programs, though not always provided on-site. Vocational training and job placement services are sometimes available.

Alamogordo United Futures

1815 N. Florida Avenue

Alamogordo, NM 88310

Mobile Telephone: (505) 430-8897

For more information contact: Richard Brandner, Director

The Group Home serves both low-income elderly women capable of living independently and young women with their children. Family stability and intergenerational experience are encouraged. The 12-unit facility housing the United Futures Project is owned by Northwest Association for Retarded Citizens and mortgaged under HUD Section 202 funding for facilities for special needs populations.

Various services are provided to both the elderly women and the teenage mothers. Services available to seniors include transportation to the Alamo Senior Center, legal services, health promotion, and recreation at the Senior Center. Young mothers are provided child care assistance, assistance in enhancing life and parenting skills, and financial assistance for school. The state spends \$25,000 to pay a portion of the director's salary; teen mothers are eligible for low-income rent subsidies; they pay their rent from their welfare checks.

Amity Street, Transitional Housing for Parenting Teens

Catholic Charities, North Region

55 Lynn Shore Drive

Lynn, MA 01902

(617) 593-2312

For more information contact: Richard D. Muzzy, Director of Outreach and Youth Services

Amity Street consists of a nine-unit building that houses young single mothers ages 18-23 with one or two children under the age of five. The home opened in October 1987, and has served a total of 42 young mothers and 55 children. They are able to maintain their own residences with the support of Catholic Charities' staff for up to two years. The program offers counseling, case management, support groups, and assistance with employment training and education.

The program costs approximately \$190,000 per year. Some funding for support services is received through the Department of Social Services. Residents are eligible for rent subsidies through the Massachusetts Rental Voucher Program administered by the Lynn Housing Authority. United Way and local fundraising efforts further maintain the program.

Bridgeway

85 S. Union Boulevard - Suite 204

Lakewood, CO 80228

(303) 969-0515

For more information contact: Rich Haas, Executive Director

Founded in 1986, Bridgeway is a private, nonprofit organization that operates three homes and an education center for 16 pregnant teenagers and their babies. Parenting mothers can stay up to six months or more in a home supervised by live-in houseparents. Bridgeway has an annual budget of approximately \$235,000 and is funded by workplace campaigns and business and individual donations.

Bridgeway provides counseling and classes in Lamaze childbirth, self-esteem, nutrition, parenting, adoption options, prenatal care, resume-writing, job skills, and drug abuse. Volunteers from the community serve as "Bridgers" who act as mentors.

Door of Hope

2799 Health Center Drive

San Diego, CA 92123

(619) 279-1100

For more information contact: Charlie Cox, Director

Door of Hope consists of two homes: one for pregnant teenagers, and one called Havens for young women with emotional and psychological problems. The maternity home serves approximately 50 residents per year, and Havens takes in an average of 25 young women per year. The women are admitted only if they are wards of the court or are legally emancipated from their guardians.

Door of Hope offers 24-hour supervision by residential managers, an on-campus public school, counseling, prenatal care, day care, and classes in independent living skills, parenting, alcohol and drug abuse, Lamaze childbirth, job placement, and discharge planning. There are 40 paid staff members in addition to volunteer support.

The cost of the program per girl for the maternity home is \$2,360 per month, and for Havens it is \$4,423 per month. The babies cost about \$708 per month in both homes. Havens costs more because the young women placed there have fairly severe emotional, psychological, or behavioral problems and need more specialized care.

Father Pat Jackson House Program

1014 South Main Street

Ann Arbor, MI 48104

(313) 761-1440

For more information contact: LaTresa Wiley

Father Pat's is a transitional home that houses five teenage mothers and their babies. Residents can stay for up to two years, but the average stay is four to six months. The house is staffed by a director, social worker, two house mothers, and two overnight staff. Volunteers are generally University of Michigan students who provide transportation and mentoring.

Due to Father Pat's affiliation with St. Mary's Parish, funding comes mostly from grants in the Catholic community and from private grants. The cost of the program is \$260 a month per mother and baby, which is \$15,600 a year for the total program.

Florence Crittenton Homes and Services of West Virginia

2606 National Road

Wheeling, WV 26003-5393

(304) 242-7060

For more information contact: Sharon Perry, Executive Secretary

FCCHS of West Virginia was created in 1895 as a residential home for young mothers. In the 1991-92 program year it served more than 1,100 young mothers throughout West Virginia and Belmont County, Ohio. Pregnant teenagers are referred from the Department of Health and Human Resources, the judicial system, high school counselors, church leaders, and family members.

Located in a residential neighborhood, the facility is equipped with an alternative on-site school, a day care center, a health clinic, and counseling and case management services. The main facility is surrounded by three residential homes that are used for transitional living programs and is staffed full-time.

Crittenton also offers 10 community, home-based service sites. Programs here include maternity care, community outreach, pregnancy and child abuse prevention programs, day care, health clinics, support groups, Lamaze childbirth, child care, parent skills training, adoption and adoption counseling, family and group counseling, life skills training, case management, and family preservation services.

FCCHS is funded by foundations, corporations, private donations, and client fees.

Homes for the Homeless

36 Cooper Square, 6th Floor
New York, NY 10003
(212) 529-5252

For more information, contact: Page Bartels, Director of Development and External Affairs

Founded in 1986, Homes for the Homeless is a comprehensive, residential nonprofit organization that has served 8,400 families including more than 18,300 children in New York City. The cost of the program is \$12,000 per person annually, or \$36,000 per family annually. Homes for the Homeless also operates two summer camps for homeless children.

Homes for the Homeless operates four "American Family Inns," which offer housing and comprehensive services to homeless mothers and their children. A needs assessment is developed for each family upon entry to the centers. Assistance is offered in the areas of health care, educational enhancement for both parents and children, employment training, foster care, independent living skills, substance abuse treatment, and follow-up services. Two innovative aspects of the program are a "safe nursery" for children at risk of abuse and an in-house apprenticeship program, where residents learn job skills by working within the organization.

Northwest Maternity Center

4010 12th Street, N.E.
Washington, DC 20017
(202) 483-7008

For more information contact: Elizabeth Segal

The Northwest Maternity Center is a private/nonprofit residential facility for five mothers with one or two children, which operates in tandem with the Pregnancy Center. The center has been open for two years, and 26 young women have completed the program. The two facilities exist on a shoestring budget of \$160,000 a year, with the Maternity Center getting about \$60,000 of that amount. Funding comes from private individuals and corporate donors and includes donations of food, toys, and furniture.

The center has flexible admission and length of stay requirements. The mothers are between the ages of 15 and 24, and stay less than two years. They are referred from community agencies, schools, and the Pregnancy Center.

The only paid staff members are the director and the social services director, so the home depends heavily on a volunteer staff of 18. The program includes counseling, referrals, and classes in parenting, child development, basic skills, and self-esteem.

Seton Home

1115 Mission Road
San Antonio, TX 78210
(210) 533-3504

For more information contact: Brenda Tatro, Executive Director

Licensed by the state of Texas, Seton Home is a group home for pregnant teenagers and teenage mothers, aged 12-20. The facility consists of two cottages, each of which houses eight mothers and their babies. Approximately 35 mothers go through the program each year.

Each cottage is staffed by one house mother or independent living skills instructor. In addition, Seton Home has a social service director, volunteer coordinator, and an executive director. Volunteers perform such tasks as office work, yard work, and mother's day out activities.

Seton Home has an annual budget of \$330,000. The United Way provides 20 percent of the funding, while the remainder comes from grants, fundraising projects, direct mail campaigns, and support for money for some mothers from the state.

St. Ann's Infant and Mothers' Home

4901 Eastern Avenue
Hyattsville, MD 20782
(301) 559-5500

For more information contact: Peggy Howard Gatewood, Director

St. Ann's, a Catholic charity, has taken in pregnant women since its inception in 1860. In 1983, it established a program for adolescent mothers and their babies. Currently 14 young women, aged 16-19, and their babies live at the home for up to two years. On average, 23 young women go through the program annually. Many are referred from foster care and other public agencies, while some are homeless and come in off the street.

The cost is \$175 daily for a mother and baby. Funding is provided by a combination of state block grants, local government appropriations, allocations from the United Way, and private grants. For those who can afford it, payment is based on sliding scale.

The mothers are supervised 24 hours a day by a staff of 27, including social workers, nurses, child care workers, a parenting specialist, a job placement specialist, and a child psychologist.

St. Elizabeth's Regional Maternity Center, Southern Indiana

621 E. Market Street

New Albany, IN 47150

(812) 949-7305

For more information contact: Joan Smith, Founder and Director

Established in 1989, St. Elizabeth's consists of two homes: a maternity home for pregnant teenage women and an aftercare home for teen mothers and their babies. St. Elizabeth's is funded by donations from private individuals and corporate donors, community development block grants, HUD, the March of Dimes, and HHS. In the past six years, 182 babies have been born at St. Elizabeth's. There are no age restrictions, although most of the mothers are aged 15-20. They are referred from schools, doctors, hospitals, and word of mouth.

The cost per mother and child is \$80 a day in the maternity home, and residents who are able pay the home on a sliding scale. The aftercare home costs \$4,800 per year per mother and child, thanks to a \$1.5 million grant from HUD and a multitude of in-kind contributions from community groups. While it depends heavily on volunteer support, St. Elizabeth's has 14 full-time staffers, including three with MSW degrees, and two part-time employees.

The home offers parenting and child care classes, self-esteem classes, and counseling. One staff member is a sex abuse therapist and provides individual counseling as well as group sessions and family counseling.

T.A.M.I. (Teen-Age Mothers and Infants) House

509 Branard Road

Houston, TX 77006

(713) 527-0718

For more information contact: Barbara Reid, Executive Director

The Teen-Age Mothers and Infants House is a traditional home that houses up to six mothers with their babies. Residents live in T.A.M.I. House for an average of 10-12 months, but others are there anywhere from six-18 months. Mothers can be 16-17 1/2 years old when they enter the program. Funding comes from the Child Protective Services, Community Development Block Grants, the United Way, private donations, and churches. The cost per resident is \$15 a day for a baby and \$35 a day for a mother.

The staff consists of a single female house parent and a nursery worker. In addition, *pro bono* therapists are hired to counsel the residents. Volunteers are used only to augment the professional staff, to help in the nursery, get food at the food bank, or perform general office duties. The program encourages residents to enrich their lives by attending plays, visiting museums, and participating in community events.

Teen Mothers Program/Sasha Bruce Youthwork

701 Maryland Avenue, N.E.

Washington, DC 20002

(202) 675-9380

For more information contact: Brenda Lockley, Director

The Teen Mothers Program is a residential treatment facility for five teenage mothers and their babies run by the Sasha Bruce Youthwork program, a private, nonprofit agency. The Teen Mothers Program is funded directly by grants from the DC Department of Human Services, Family Service Division. It costs approximately \$110 per day per person to run the program. The participants are aged 15-18 and stay from 18 months to two years. The teen mothers are referred by the court system and are wards of the DC government. All court-remanded cases must be accepted into the home.

Residents are offered a number of classes in cooking, child care, female health and sexuality, and living and parenting skills. Counseling, tutoring, art therapy, and referrals are also available.

There are no resident staff members; supervision is provided by two staffers at a time based on rotating shifts. Volunteers and foster grandparents are important elements of the program.

The Teen Parent Residence

1750 Indian School Road, N.E.

Apartment 109

Albuquerque, NM 87104

(505) 246-2497

For more information contact: Barbara Calderon, Center Director, Albuquerque Job Corps

The Teen Parent Residence is a referral-only home for 14 young mothers and their babies, aged 14-22. During the four and a half years the program has been running, 117 participants have gone through the program. Professionals provide counseling and training in health, nutrition, parenting skills, independent living, family planning, safety, child development, self-esteem building, and necessary life skills such as budgeting and shopping.

Each teen and her baby receive AFDC, Food Stamps, WIC, and Medicaid. Out of the AFDC money, the rent and utilities are paid as well as other basic requirements. Child care is provided by the Children, Youth, and Families Department during the day to allow the mothers to attend school. The program is maintained through state funding with community organizations providing furniture for the apartments and supplies for the project.

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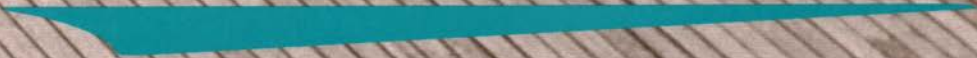
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SUMMARY

THE BEST INTENTIONS



**Unintended
Pregnancy
and the
Well-Being
of Children
and Families**



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Period



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ABOUT
GROWING
UP**



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Fact Sheet

Planned Parenthood® Federation of America, Inc.

810 Seventh Avenue New York, New York 10019 (212) 541-7800

2010 Massachusetts Ave. NW Washington, DC 20036 (202) 785-3351

Pregnancy and Childbearing Among U.S. Teens

Teenage Pregnancy

- ▶ Each year more than one million U.S. teenagers become pregnant -- one in nine women aged 15-19 and one in five who are sexually active.(1)
- ▶ In 1988, the teenage pregnancy rate was 113 per 1,000 women aged 15-19. The rate was 74 per 1,000 among those aged 15-17.(1)
- ▶ Nonwhite teenagers have twice the pregnancy rate of white teenagers -- in 1988, the rates were 197 and 93, respectively.(1)
- ▶ 50 percent of teenage pregnancies conceived in 1987 resulted in a birth, 36 percent in an abortion, and an estimated 14 percent in miscarriage.(2)
- ▶ By age 18, one in four young women (24 percent) will have a pregnancy (21 percent of white teens and 40 percent of nonwhites). By age 20, more than four in 10 (44 percent) will have a pregnancy (41 percent of whites and 63 percent of nonwhites).(3)
- ▶ Nearly one in five teenagers who experience a premarital pregnancy will get pregnant again within a year. Within two years, more than 31 percent will have a repeat pregnancy.(3)
- ▶ Eight in 10 teenage pregnancies are unintended -- nine in 10 pregnancies among unmarried teenagers and about half of those among married young women.(2)
- ▶ U.S. teenagers have one of the highest pregnancy rates in the western world -- twice as high as rates found in England, France, and Canada, three times as high as that in Sweden; and seven times as high as the Dutch rate.(4)
- ▶ A 1985 international teenage pregnancy study concluded that teen pregnancy rates are lower in countries where there is greater availability of contraceptive services and sexuality education.(4)

Teenage Childbearing

- ▶ About half of all teenage pregnancies end in births. In 1989, teenage births totaled 517,989.(5)
- ▶ In 1988, two-thirds of births to women under age 20 were to unmarried women -- 54 percent of the births to whites and 91 percent of the births to blacks were nonmarital.(5)
- ▶ In 1988, there were 10,588 babies born to teenagers aged 14 and younger -- 94 percent of these births were nonmarital.(5)
- ▶ 73 percent of births to teenagers result from pregnancies that are unintended.(2)

- ▶ The teen birth rate in 1988 was 53.6 births per 1,000 women aged 15-19; the rate among those aged 10-14 was 1.4.(5)
- ▶ The birth rate for teens aged 15-17 increased 10 percent between 1986 and 1988; the 1988 rate was higher than in any year since 1977. The increase occurred entirely among nonwhites and Hispanics. The birthrate in 1988 among white teenagers aged 15-19 was 43.7 and 95.3 among nonwhite teenagers.(5)
- ▶ Of women having their first birth in 1988, 23 percent were teenagers -- among whites, two in 10 first births were to teenagers; among blacks, four in 10 were to teenagers.(5)
- ▶ 23 percent of all babies born to teenagers in 1988 were not first births.(5)
- ▶ More than nine in 10 teenagers who give birth keep their babies; few place their babies for adoption.(6)
- ▶ On average, 33 percent of women under age 20 who give birth receive inadequate prenatal care, either because they start care late in their pregnancy or they have too few medical visits.(7)

Consequences of Early Childbearing

- ▶ Teenage mothers are at greater risk of socioeconomic disadvantage throughout their lives than those who delay childbearing until their twenties. They are generally less educated, have larger families, and have higher levels of nonmarital, unintended births.(3)
- ▶ The younger the mother, the greater the likelihood that she and her baby will experience health complications, primarily due to later prenatal care, poor nutrition, and other lifestyle factors.(3)
- ▶ More teenage mothers are now graduating from high school than ever before, yet only half of the women who have their first child at age 17 or younger will have graduated from high school by age 30.(8)
- ▶ Teens who become mothers are disproportionately poor and dependent on public assistance for their economic support.(3)
- ▶ Public funds pay for the delivery costs of at least half of the births to teenagers.(9)
- ▶ Each year, the U.S. government spends an estimated \$25 billion on behalf of families in which the first birth occurred when the mother was a teenager. That estimate for 1990, which includes direct payments from Aid to Families with Dependent Children, Medicaid, and Food Stamps, does not include other public costs such as job training; housing subsidies; the Women, Infants, and Children supplemental food program; subsidized school meals; special education; foster care; or day care.(10)
- ▶ If every birth to a teen mother in 1990 had been delayed until the woman were in her 20s, the federal government would have saved 40 percent of the calculated expenditures, or \$10 billion.(10)
- ▶ A family begun by a first birth to a teen mother in 1990 will cost the taxpayer an average of approximately \$18,133 by the time the child reaches age 20.(10)
- ▶ The children of teenage mothers are at greater risk of lower intellectual and academic achievement, social behavior problems, and problems of self-control than are children of older mothers, primarily due to the effects of single parenthood, lower maternal education, and larger family size.(3)

- ▶ Although it is not inevitable, the daughters of teenage mothers are more likely to become teenage parents themselves.(11)

Adoption

- ▶ In 46 states and the District of Columbia, mothers who are minors may legally place their child for adoption without parental involvement.(12)
- ▶ From 2 to 3 percent of teen pregnancies become live births for which the mother makes an adoption plan.(13)
- ▶ Less than 10 percent of the babies born to unmarried teens are placed in adoptive homes.(13)
- ▶ Unmarried adolescent mothers who place their children for adoption are more likely to be white, have higher socioeconomic status and educational aspirations, and be from suburban residences.(14)

Teenage Abortion

- ▶ Four in 10 teenage pregnancies (excluding miscarriages) end in abortion.(15)
- ▶ While the rate of abortion (number of abortions per 1,000 women) among nonwhite teenagers (73) is considerably higher than the rate among white teenagers (36), the likelihood that nonwhite teenagers will end a pregnancy in abortion (abortion ratio) is about the same as for whites.(1)
- ▶ 26 percent of all abortions in the U.S. each year are to women under age 20 -- in 1988 the total number of abortions in this age group was 406,370.(1)
- ▶ Every year, about 4 percent of women aged 15-19 have an abortion.(16)
- ▶ The top three reasons cited by pregnant teenagers for choosing to have an abortion were concern about how having a baby would change their lives, their feeling that they are not mature enough to have a child, and financial problems.(16)
- ▶ Access to confidential abortion services is essential to teenagers' health. Most teens who become pregnant already involve a parent in their decision; and laws that mandate parental involvement only victimize teens in unstable or abusive family situations -- a disproportionate number of whom are poor or minority. Moreover, such laws, which are required to include judicial bypass provisions, have been shown to have no effect on the percentage of teens who involve their parents.(17)
- ▶ Laws that mandate the involvement of both parents place a special burden on African-American teens -- only 39 percent of whom live with both parents, versus 79 percent of white minors.(18)
- ▶ 23 states currently have mandatory parental consent or notice, or professional counseling laws in effect for a minor to obtain an abortion: AL, AR, GA, ID, IN, KS, LA, MA, MD, ME, MI, MN, MO, NB, ND, OH, RI, SC, TN, UT, WV, WI, WY.(12)

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15. AGI. Teenage Pregnancy in the United States: The Scope of the Problem and State Responses. New York: AGI, 1989.
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17. Blum, R.W., et al, "The Impact of Parental Notification Law on Adolescent Abortion Decision-Making," American Journal of Public Health, 77:619, 1987.
18. U.S. Dept. of Commerce, Bureau of the Census. Studies in Marriage and the Family. Current Population Reports Series P-23, No. 162. Washington, D.C.: U.S. Government Printing Office, 1989.

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Produced by PPFA's Communications Division (FS-D4, 6/93).

The Mingo Group, Inc.

228 EAST 45TH STREET NEW YORK, NY 10017 (212) 697-4575

ANDREA D. FANT
VICE PRESIDENT
ACCOUNT DIRECTOR

January 20, 1995

Ms. Tijuana James-Traore
Director, First Things First
Planned Parenthood Federation of America
810 Seventh Avenue
New York, NY 10019

Dear Tijuana,

Attached for your review are the revised storyboards for the teen pregnancy project.

The boards were revised to reflect the direction from our conference call and my conversation with Mr. Abbey.

Overall, our goal was to more clearly portray the consequence of teen pregnancy, to demonstrate the reality. In some cases, we have incorporated key statistics regarding the parents.

The execution "Crib" was revised to incorporate both a key statistic and the reality of the expenses associated with parenthood.

The execution "Choose" clearly depicts the choices that must be made by teen mothers and more importantly, it demonstrates the missed opportunities.

The execution "Trapped" communicates from the real-life, first person perspective of a real teen mom. It is sincere and the reality is gripping.

Tijuana, please call me once you've had a chance to review and we can discuss these executions and our next steps.

Regards,

Andrea (6)

c: S. Chisholm

\\file\correspond\af

The Mingo Group, Inc.

client | PLANNED PARENTHOOD
 product | TEEN PREGNANCY
 title | "TRAPPED" Rev. 1
 job no. | NEW-M-1174
 date | 1-20-1995

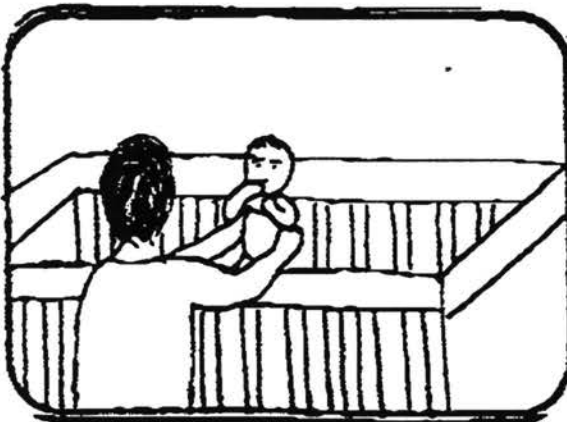
Pg. 1 of 3

VIDEO

OPEN ON GIRL TALKING
ON SCREEN.



DISSOLVE TO GIRL HOLD-
ING SCREAMING BABY.



WIPE TO SNAPSHOT OF
BABY SHOWER.



FADE TO CU OF GIRL
TALKING ON THE PHONE
WITH FRIEND.



AUDIO

TEEN F. ANNCR (VO):
When I was 14, I thought
being a mother would be
fun.

SFX: BABY CRYING

TEEN F. ANNCR (VO):
All my friends were there
for me in the beginning, but
things changed fast.

TEEN F. ANNCR (OC):
I can't go out. I don't have
anybody to watch the baby.

The Mingo Group, Inc.

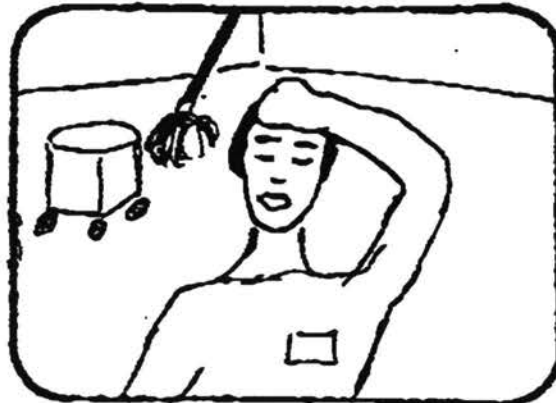
client
product
title
job no.
date

PLANNED PARENTHOOD
TEEN PREGNANCY
"TRAPPED" Rev. 1
NEW-M-1174
1-20-1995

Pg. 2 of 3

VIDEO

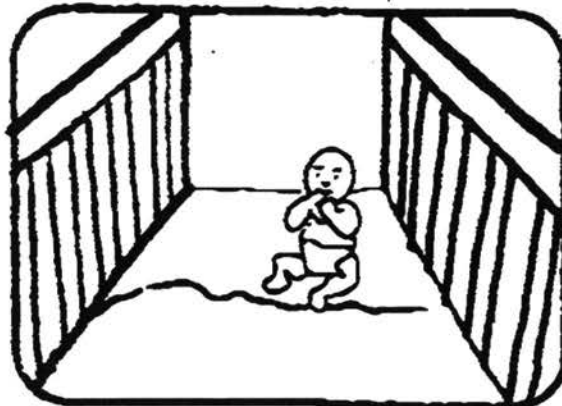
CUT TO ECU OF GIRL
WIPING HER FOREHEAD
AT WORK.



AUDIO

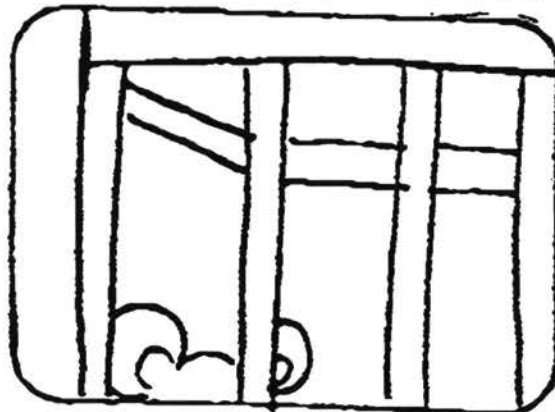
TEEN F. ANNCR (OC):
I can't keep this up!

CUT TO BABY PLAYING IN
CRIB.



TEEN F. ANNCR (VO):
I thought I'd be able to
handle it.

WIPE TO CAMERA
MOVING ACROSS BARS
OF CRIB.



TEEN F. ANNCR (VO):
But nothing's working out
the way I thought it would.
Now - I don't know - I just
feel so...

CUT TO ECU OF TEEN
BEHIND BARS OF CRIB.



TEEN F. ANNCR (OC):
Trapped.

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<i>client</i>	PLANNED PARENTHOOD
<i>product</i>	TEEN PREGNANCY
<i>title</i>	"TRAPPED" Rev. 1
<i>job no.</i>	NEW-M-1174
<i>date</i>	1-20-1995

Pg. 3 of 3

VIDEO

SUPER:

Life. Get One Before You
Make One.

PLANNED PARENTHOOD

For More Information Call

1-800-000-0000.

GET ONE BEFORE YOU MAKE ONE
PLANNED PARENTHOOD

AUDIO

The Mingo Group, Inc.

client | PLANNED PARENTHOOD
 product | TEEN PREGNANCY
 title | "CHOOSE" Rev. 1
 job no. | NEW-M-1174
 date | 1-20-1995

Pg. 1 of 3

VIDEO

AUDIO

OPEN ON CU OF GIRL ON
 SCREEN. CAMERA
 SLOWLY ZOOMS OUT AS
 SHE SPEAKS.



TEEN F. ANNCR (OC):

If you choose to become a
 teenage mother, get ready to
 make a lot of other choices.

CUT TO GIRL GOING OUT
 WITH FRIENDS.



TEEN F. ANNCR (VO):

Like choosing between what
 you want to do,

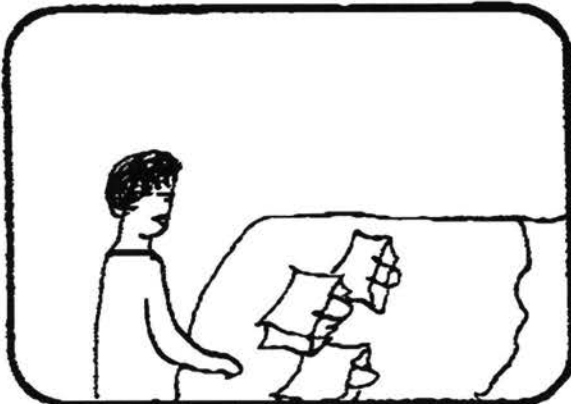
WIPE TO GIRL HOLDING
 SCREAMING BABY SAYING
 GOODBYE TO FRIENDS.

*who are going out
 without her*



and what you have to do for
 the baby.

CUT TO GIRL THROWING
 SHOPPING BAGS ON BED.



And choosing between buy-
 ing what *you* want,

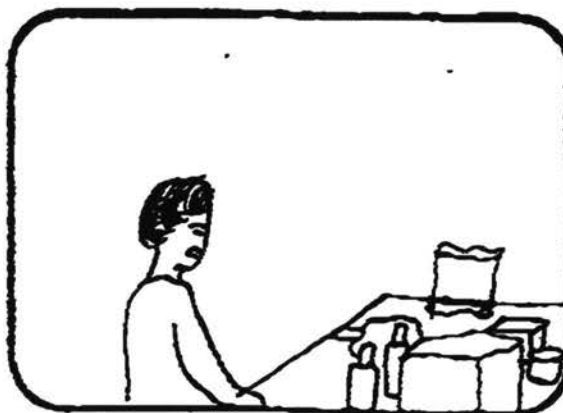
The Mingo Group, Inc.

client | PLANNED PARENTHOOD
 product | TEEN PREGNANCY
 title | "CHOOSE" Rev. 1
 job no. | NEW-M-1174
 date | 1-20-1995

Pg. 2 of 3

VIDEO

WIPE TO GIRL THROWING
 BABY SUPPLIES ON BED.



CUT TO GIRL SURROUND-
 ED BY BOOKS. SHE LIFTS
 HER HEAD UP.

*she's studying for
 her future.*



WIPE TO GIRL LIFTING
 HER HEAD FROM
 MOPING THE FLOOR AT
 HER JOB.



CUT TO GIRL TALKING ON
 SCREEN.



AUDIO

and buying what your baby
 needs.

And even choosing between
 working toward your future,

or just working.

TEEN F. ANNCR (OC):
 The choice is yours.

The Mingo Group, Inc.

<i>client</i>	PLANNED PARENTHOOD
<i>product</i>	TEEN PREGNANCY
<i>title</i>	"CHOOSE" Rev. 1
<i>job no.</i>	NEW-M-1174
<i>date</i>	1-20-1995

Pg. 3 of 3

VIDEO

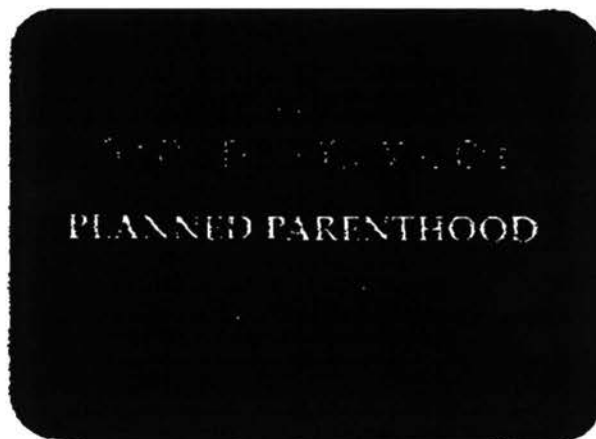
SUPER:

Life. Get One Before You
Make One.

PLANNED PARENTHOOD

For More Information Call

1-800-000-0000.



AUDIO

TEEN E. ANNCR (VO):

Life. Get one before you
make one.

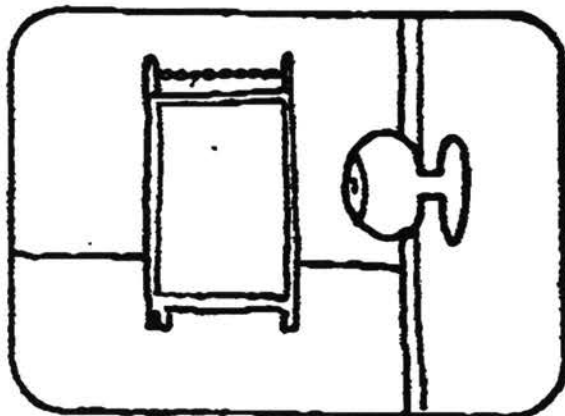
The Mingo Group, Inc.

client | PLANNED PARENTHOOD
product | TEEN PREGNANCY
title | "CRIB" Rev. 1
job no. | NEW-M-1174
date | 1-20-95

Pg. 1 of 2

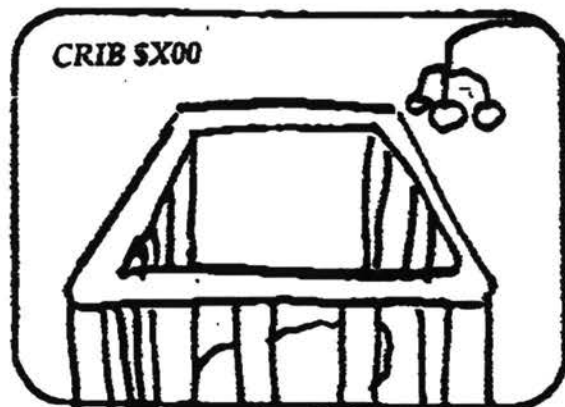
VIDEO

OPEN ON NURSERY DOOR
OPENING SLOWLY. CRIB
IN THE FAR CORNER OF
THE ROOM.



CUT TO OVERHEAD VIEW
OF CRIB.

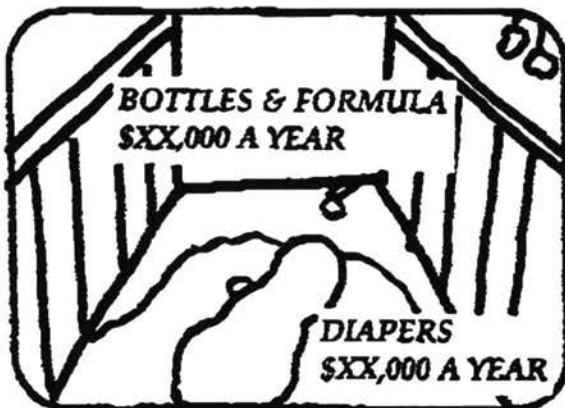
SUPER (FADES IN & OUT):
CRIB \$X00



CUT TO CU OF TOYS IN
CRIB AS CAMERA MOVES
SLOWLY INTO CRIB TO SEE
FIGURE UNDER BLANKET.

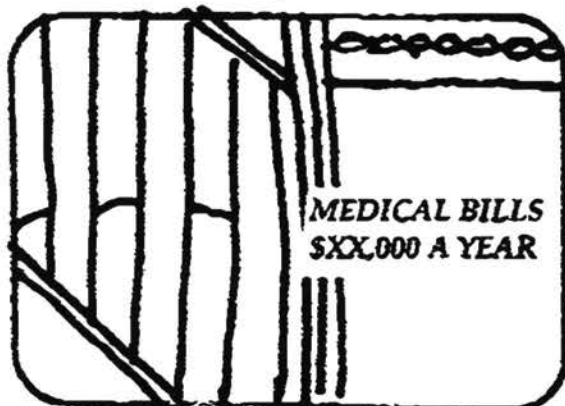
SUPER (FADES IN & OUT):
BOTTLES/FORMULA
\$XX,000 A YEAR

DIAPERS \$XX,000 A YEAR



DISSOLVE TO CAMERA
MOVING ACROSS BARS OF
CRIB.

SUPER (FADES IN & OUT):
MEDICAL BILLS \$XX,000 A
YEAR



AUDIO

MUSIC UP:
"ROCK-A-BYE BABY"
CHIMES

ANNCR (VO):
Having a baby

too early in your life

can make you feel...

The Mingo Group, Inc.

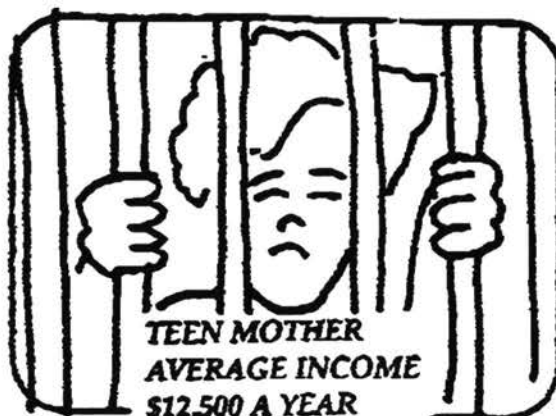
client | PLANNED PARENTHOOD
 product | TEEN PREGNANCY
 title | "CRIB" Rev. 1
 job no. | NEW-M-1174
 date | 1-20-95

Pg. 2 of 2

VIDEO

CAMERA CUTS TO CU OF
 PERSON GRIPPING BARS.
 THE PERSON IN CRIB IS A
 TEENAGE GIRL, PEERING
 THROUGH BARS AS IF IN
 A CELL.

SUPER (FADES IN & OUT):
 TEEN MOTHER AVERAGE
 INCOME \$12,500 A YEAR



AUDIO

Trapped.

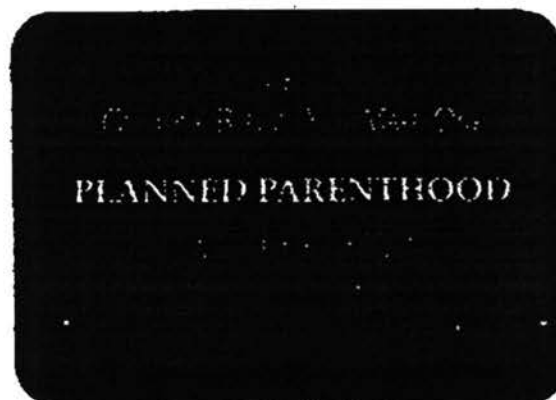
SUPER:

TEENS WHO HAVE BABIES
 ARE MORE LIKELY TO GET
 TRAPPED IN A LIFE OF
 POVERTY.



SUPER:

Life. Get One Before You
 Make One.
 PLANNED PARENTHOOD
 For More Information Call
 1-800-000-0000.





First Things First

A Planned Parenthood® Adolescent Pregnancy Prevention Initiative

First Things First is a nationwide adolescent pregnancy prevention program of Planned Parenthood Federation of America. Launched in 1989, First Things First represents a rededication to Planned Parenthood's 75-year commitment to reducing teenage pregnancy. Taking a new, coordinated approach involving Planned Parenthood's nearly 170 affiliates and other community-based organizations, First Things First has outlined an ambitious goal: reducing by half, by the year 2000, the number of adolescents who become pregnant and give birth annually.

The First Things First **"FIRST TEAM"** consists of well-known, respected people who help us reach young people with effective messages about responsible decision making.

"FIRST TEAM" Committee

Edward Asner
Mayim Bialik
Judy Blume, Author of Literature for
Young People
Whoopi Goldberg
Larry Holmes, Former Heavyweight Champion
Dawnn Lewis, Singer, Songwriter, Actress
Earl "The Pearl" Monroe, Basketball
Hall-of-Famer

Martina Navratilova
Susan Ruttan, Actress
Jimmy Smits
Tori Spelling, "Beverly Hills, 90210"
Robert Townsend, Actor, Filmmaker
Malcolm-Jamal Warner
Dr. Ruth Westheimer
and many more...

First Things First acknowledges the right of every child to accomplish **First Things First** — to secure an education, attain physical and emotional maturity, and become goal directed — before assuming the responsibilities of parenthood. Each year, the reality of too-early parenthood cruelly denies one-half million U.S. teens the right to first things first and changes their lives forever.

The personal costs of too-early childbearing are often devastating — perpetuating poverty, hopelessness, and the abandonment of school and productive work. And the cost to society is far-reaching. More than \$21 billion is spent annually on federally funded social services for young families. As a result, vast resources are spent, not in preventing too-early childbearing, but in attempting to repair its tragic consequences.

First Things First recognizes that the decision to participate in sexual intercourse represents the conclusion of a process, and that the potential for change occurs when a young person takes the first steps toward a sense of self, gender identity, and awareness of one's role in society. Planned Parenthood's goal is to have these steps precede sexual activity rather than result from it. Joining PPFA in this effort are well-known, respected individuals in a variety of fields, private health organizations, state health departments, and other youth-serving organizations that provide a broad base of program support.

First Things First offers guidance and materials to Planned Parenthood affiliates and other participating organizations. Our strategies include:

● **EDUCATIONAL ASSISTANCE**

Recognizing the family's role as primary sexuality educators by providing assistance to parents and caretakers in communicating with children about sexuality

■ **MALE INVOLVEMENT**

Highlighting effective programs that involve, educate, and provide services to adolescent men — whose role in sexual decision making has often been neglected

▲ **OUTREACH TO COMMUNITIES OF COLOR**

Providing outreach to youth in communities of color who otherwise have limited access to services, education, and information

● **TEEN RECRUITMENT**

Gaining insight into adolescent motivation and behavior through a national panel of paid youth advisors to review program materials and methods

■ **MEDIA CAMPAIGN**

Developing a media campaign for print, radio, and TV, employing hard-hitting messages targeted to teens

▲ **TECHNICAL ASSISTANCE**

Assisting in community-based program development and implementation by providing an information clearinghouse and technical assistance

The problem of teen pregnancy, sometimes dismissed as a phenomenon of urban poverty, exists at every income level and in every kind of community. PPFA's nationwide network of more than 900 family planning clinics in 49 states uniquely enables it to reach teens and families in this diverse range of communities. As the nation's oldest, best-known, and most comprehensive provider of voluntary reproductive health care, PPFA has unmatched experience and credibility in the field of family planning. We have been helping Americans take charge of their lives for 75 years. With the support and involvement of families and communities everywhere, we can shape a future for our children that continues to emphasize **First Things First**.

For further information, contact:

Tijuana A. James, M.S.W.

Director, FIRST THINGS FIRST

Planned Parenthood Federation of America, Inc.

810 Seventh Avenue

New York, N.Y. 10019

212/261-4306 212/247-6269 (fax)



First Things First[®]

First Things First

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and many more...



Planned Parenthood[®]
Federation of America, Inc.

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212/261-4306 212/247-6269 (fax)



FIRST THINGS FIRST® PROJECTS

FIRST THINGS FIRST National Youth Advisory Groups, based in Atlanta, Chicago, New York, and San Francisco, consist of teens from varied cultural and ethnic backgrounds, representing 20 cities. The teen perspective on topics such as sex, pregnancy, education, and birth control helps us develop more effective materials, clinical services, and educational programs. Youth advisors review publications, respond to questionnaires, and participate in meetings. A candid 35-minute video of portions of these meetings is designed to help parents and other adults understand the complexity of life for today's adolescent and help teens see that they are not alone in their concerns and fears.

The Brotherhood Program

The Brotherhood Program was developed by Planned Parenthood of Essex County in Newark, NJ, and targets young African-American men. Through three program components - athletic, role model interaction, and education and health - participants are given the tools to help them develop healthy concepts about family, relationships, and male sexuality and responsibility. **FIRST THINGS FIRST** awarded two \$2,000 and two \$5,000 grants in 1990 to the following affiliates to implement similar programs: Planned Parenthood of the Triad (Winston-Salem, NC), Planned Parenthood of Cameron & Willacy Counties (Brownsville, TX), Mountain Maternal Health League (Berea, KY), and Planned Parenthood of Central Texas (Waco, TX).

Youth Involvement Grants

In 1991 **FIRST THINGS FIRST** awarded eight \$3,000 grants to Planned Parenthood affiliates throughout the country (two in each of four regions) for Youth Involvement Programs. The winning programs are: Reproductive Health Care Center--Planned Parenthood (Kalamazoo, MI)--The Teen Puppet Company; Planned Parenthood of Southern Arizona (Tucson, AZ)--Teen Survey; Planned Parenthood of the Capital and Coast (Raleigh, NC)--Male Youth Advisory Council; Planned Parenthood of East Central Illinois (Champaign, IL)--Teen Radio Program; Planned Parenthood of Tompkins County (Ithaca, NY)--Ambassador Program to Reach Youth of Color; Planned Parenthood of Chester County (West Chester, PA)--Peer Educators; Planned Parenthood of Missoula (MT)--Teen Advisory Panel; and Planned Parenthood of the Palm Beach Area (West Palm Beach, FL)--Youth Advisory Board.

Preteen Grants

In 1992 **FIRST THINGS FIRST** awarded five \$10,000 grants to Planned Parenthood affiliates throughout the country. Each program represents a collaborative approach to targeting small groups of preteens for a two-year period. Each addresses various needs for the family and child which may include recreational, educational, sexuality and mental health. The winning programs are: Planned Parenthood Association of the Atlanta Area (Atlanta, GA)-- a collaborative effort with the YMCA for young people and their families from the Brickwood housing project; Planned Parenthood of the Blue Ridge (Roanoke, VA)-- an expansion of a program operated with the support of over 30 community-based organizations; Planned Parenthood of the Capital and Coast (Raleigh, NC)-- a collaborative effort with the 4-H club and the Raleigh Public Housing Authority integrating existing services and adding a entrepreneurial experience; Planned Parenthood of



810 Seventh Avenue
New York, New York 10019
212/541-7800

Central Indiana (Indianapolis, IN)-- a program which implements four of the seven components of the Carrera model with the help of 25 local agencies; InterMountain Planned Parenthood (Billings, MT)-- a program working with Native-American girls which also provides cultural sensitivity training for staff.

First Team

This diverse group of well-known and respected people helps us reach young people with effective messages about responsible decision making. First Team members participate in activities such as public service announcements (PSAs), photo shoots for posters and publications, and press conferences. To date we have enlisted the support of Edward Asner, Mayim Bialik, Judy Blume, Daphne, Whoopi Goldberg, Larry Holmes, KCB, Dawnn Lewis, Earl "The Pearl" Monroe, Martina Navratilova, Susan Ruttan, Donnie Simpson, Jimmy Smits, Tori Spelling, Robert Townsend, Malcolm-Jamal Warner, and Dr. Ruth Westheimer.

Media Strategy

Given what we know about the impact of the media on the lives of young people, we have undertaken an innovative approach. The **FIRST THINGS FIRST** theme song, available in CD and audio cassette formats, is designed to raise the awareness of young people about teen pregnancy. Planned Parenthood affiliates will also be helped through regional workshops and ongoing technical assistance to develop marketing strategies to promote their teen programs using **FIRST THINGS FIRST** materials. The campaign consists of local and national events, radio PSAs featuring **First Team** members, and other activities.

Future Projects for FIRST THINGS FIRST

Consistent with our goals, we have sought funding for projects that will expand our scope and reach communities where the need is greatest. The following projects are under consideration:

Male Initiative: To date there has been no clear blueprint for how to successfully involve young men in reproductive responsibility. Many existing programs lack resources and expertise to properly evaluate their efforts and often merely mirror programs designed for females. Our intention is to implement a three-year pilot project with selected Planned Parenthood affiliate sites. Affiliates will be provided with ongoing technical assistance on the program's design and evaluation, training, and staff development. Comprehensive services will be provided through a collaborative arrangement with community organizations such as the Urban League, YMCA and YWCA. Through extensive evaluation and training, we hope to substantially advance our knowledge about serving young men.

Publications: According to our teen advisors, many of their peers learn about sex from older brothers and sisters. Recognizing the role older teens play in molding behavior of younger siblings, we hope to develop a siblings brochure to provide information and resources to assist them in this role.



"Do you think adults really listen to teens? They should." We agree with this teen advisor and that's why we have provided you with examples of some of the insightful and spontaneous things they have to say. We have met with teens from all across the country to discuss their views on sex, pregnancy, education, birth control and a variety of other issues. Read what they had to say. You might learn something. We sure did!

MALES - *"It's not all our fault"*

- "Males get pressure from females to have sex or they'll call them a sissy."
- "If a man wants to use a condom then the female thinks that either he has something or that he thinks **she** has something".
- "It was like a macho thing for him to have a kid."

FAMILY - *Parents should "let children learn about their sexuality...They'll find out anyway."*

- "What do you do if your mom is young, single and dating and you watch her do anything to keep a man? What kind of message does this give her children, especially her daughters?"
- Families continue to play a key role in teens decision making but mixed messages from parents, the lack of clarity of expectations, and double standards based on gender leave them confused.
- Religion and culture also seemed to be significant factors in the "degree of guilt" they felt about issues related to sexuality but did not necessarily effect behavior.

SEX EDUCATION - *"People think if you talk about sex they'll do it, and don't realize if you don't talk about it, they'll discover it for themselves."*

- "If you educate kids they can make the best decisions for themselves."
- "Programs should be for younger kids." "They should start in elementary school."
- "Teachers are often embarrassed to talk about sex with students."
- "I felt good talking about [sex] and I think that it is important that people feel secure and unashamed about talking about sex because that provides a situation for optimum information."
- "I enjoyed talking to teens with different backgrounds and of the opposite sex. I learned a lot about how others think and feel." "It's important for teens to have a forum to speak up in."
- We need information on "how to say no."



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- Programs should use "parenting teens to talk with them about the realities of parenting."
- Blacks and Hispanics "are stereotyped as having a better chance of being teen parents but everyone has that chance." "Adults have more stereotyped beliefs and set up expectations, but teens can turn this around" with more education.

TEEN POLITICAL INVOLVEMENT - *"We might be able to prove a point if we got together."*

- "Teens don't like to get politically involved but they might become passively involved -signing something as opposed to going on a march."
- "Adults have a misconception of teens -- that they don't know anything, that they're just stupid. Maybe getting politically involved proves we care about what's going on and do have opinions."

THE MEDIA - *"The media should be held more accountable for the images they portray."*

- "We don't have to hear it from celebrities but from kids just like us."
- "Kids just let it happen and don't plan for it." A myth fostered by the media is that it has to be spontaneous, that you should be "swept away." "Kids end up wanting sex to 'just happen' like it does on TV, but when it 'just happens' they're not ready."

RELATIONSHIPS - *"When a girl has sex with a guy she is giving her soul to him but when guys have sex they are just trying to score"*

- Males are not encouraged to be sensitive and responsible.
- "Now I see that [boys] feel pressure about sex the same as girls do."
- "Males and females talk about sex differently. The males talk about it in a bad way. Girls talk more about love, emotions."
- "Younger girls are having sex with older guys in order to look cool to the older kids."

BIRTH CONTROL - *"From a man's point of view, if you bring up the topic of birth control then the female thinks 'that's all he wants from me'."*

- "Some girls are misinformed about how and when they can get pregnant."
- "Birth Control is a hard thing to bring up."
- "Boys will give detailed descriptions of sex but won't ask about birth control; they can't show that they're worried. "Guys talk more about the act and less and about relationships and emotions. They get cheered on for sexual stories."

CHOICE - *"Men don't necessarily care... Maybe if a man could go through [a pregnancy] they would think differently."*

- One young man felt that "rallying against abortion was wrong, it is not giving females a choice to have a better life. The woman knows she has no money now, how is she going to have it when the baby comes? They are not giving her good options for a future."

**PHOTOCOPY
PRESERVATION**



810 Seventh Avenue
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*file teen
preg '9*

THE BEST INTENTIONS:
THE CAUSES, CONSEQUENCES, AND PREVENTION OF
UNINTENDED PREGNANCY

Committee on Unintended Pregnancy
Institute of Medicine
National Academy of Sciences

Edited by:

Sarah S. Brown, M.P.H., Study Director
Leon Eisenberg, M.D., Committee Chair

Washington, D.C.
May 1995

Contents

ACKNOWLEDGEMENTS

SUMMARY

- 1 INTRODUCTION
- 2 THE DEMOGRAPHY OF UNINTENDED PREGNANCY
- 3 THE CONSEQUENCES OF UNINTENDED PREGNANCY
- 4 CONTRACEPTIVE USE
- 5 CONTRACEPTIVE KNOWLEDGE AND ACCESS TO SERVICES
- 6 PERSONAL AND INTERPERSONAL FACTORS
- 7 SOCIOECONOMIC AND CULTURAL INFLUENCES
- 8 STRATEGIES TO REDUCE UNINTENDED PREGNANCY
- 9 CONCLUSIONS AND RECOMMENDATIONS

APPENDICES:

- A List of Commissioned and Contributed Papers
- B The Political Storms Over Family Planning: Supplement to Chapter 1
- C The National Survey of Family Growth: Principal Source of Statistics on Unintended Pregnancy: Supplement to Chapter 2
- D Tables of Odds Ratios: Supplement to Chapter 3
- E Technical Notes on the Recalculation Exercise: Supplement to Chapter 3
- F Summaries of Evaluated Programs: Supplement to Chapter 8
- G Assessing Program Effectiveness and Cost-Effectiveness: Supplement to Chapter 8

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SUMMARY

Unintended pregnancy is both frequent and widespread in the United States. The most recent estimate is that almost 60 percent of all pregnancies are unintended, either mistimed or unwanted altogether¹—a percentage that is higher than in many other industrialized countries. Unintended pregnancy is not just a problem of teenagers or unmarried women, or poor women or minorities; it affects all segments of society.

The consequences of unintended pregnancy are serious, imposing appreciable burdens on children, women, men, and families. A woman with an unintended pregnancy is less likely to seek early prenatal care and is more likely to expose the fetus to noxious substances (for example, by smoking). The child of an *unwanted* conception especially (as distinct from a mistimed one) is at greater risk of being born at low birthweight, of dying in its first year of life, of being abused, and of not obtaining sufficient resources for healthy development. The mother may be at greater risk of depression and of physical abuse herself, and her relationship with her partner is at greater risk of dissolution. Both mother and father may suffer economic hardship and fail to achieve their educational and career goals.

¹These terms have precise demographic meanings and are defined carefully in the body of the report.

1 In addition, an unintended pregnancy increases the probability of a child being born
2 to a mother who is adolescent, unmarried, or over 40—demographic attributes which
3 themselves have important socioeconomic and medical consequences for both children and
4 parents. Pregnancy begun without planning and intent also means that individual women
5 and couples are often not able to take full advantage of the growing field of preconception
6 risk identification and management, nor the rapidly expanding knowledge regarding human
7 genetics. Moreover, unintended pregnancy currently leads to approximately 1.5 million
8 abortions in the United States annually, a ratio of about one abortion to every three live
9 births. This ratio is two to four times higher than that of other industrialized countries.
10 Reflecting the widespread occurrence of unintended pregnancy, abortions are obtained by
11 women of all reproductive ages, by both married and unmarried women, and by women in
12 all income categories.

13 During the 1970s and early 1980s, a decreasing proportion of births were unintended
14 at time of conception. Between 1982 and 1988, however, this trend reversed and the
15 proportion of births that were unintended at conception began *increasing*. This unfortunate
16 trend appears to be continuing into the 1990s.

17 Many factors help to explain the nation's high level of unintended pregnancy. Most
18 obvious is the failure to use contraceptive methods carefully and consistently—or
19 sometimes even at all—as well as actual technical failures of the methods themselves.
20 Individuals using reversible means of contraception (a large group) and those using no

1 contraception at all despite having no clear intent to become pregnant (a small group)
2 contribute roughly equally to the pool of unintended pregnancies. Many women and couples
3 who are not seeking pregnancy move between these two groups, sometimes using
4 contraception, sometimes not.

5 Contraceptive use and unintended pregnancy are influenced by numerous factors:
6 knowledge about contraceptive methods and reproductive health generally, individual skill
7 in using contraception properly, a wide range of personal feelings and attitudes, access to
8 methods of birth control, cultural values regarding sexuality, religious and political
9 preferences, racism and violence, the content of media, and others as well. The sheer
10 number and complexity of these forces mean that no single or simple remedy is likely to
11 “solve” the unintended pregnancy problem, particularly because the interrelationships
12 among all of these factors are not well understood. Nonetheless, the information reviewed
13 in this report, past experience in the public health sector with addressing complex health
14 and social problems, and common sense itself are all helpful in developing a plan of action
15 to address this important national problem.

COMMITTEE RECOMMENDATIONS

The extent of unintended pregnancy and its serious consequences are poorly appreciated throughout America. Although there is considerable attention now focused on teenage pregnancy and “illegitimate” childbearing, along with continuing controversy and even violence over abortion, the common link among all these issues—pregnancy that is unintended at time of conception—is essentially invisible. The committee has concluded that reducing unintended pregnancy will require a new national understanding about this problem, and a new consensus that pregnancy should be undertaken only with clear intent. Accordingly, the committee urges, first and foremost, a new social norm:

● All pregnancies ought to be intended, consciously and clearly desired at time of conception.

This goal has three important attributes. First, it is directed to all Americans and does not single out only one group. Second, it emphasizes personal choice and intent. And third, it speaks as much to planning *for* pregnancy as to *avoiding* unintended pregnancy. Bearing children and forming families are among the most significant and often satisfying tasks of adult life, and it is in that context that encouraging intended pregnancy is so central.

1 The U.S. Department of Health and Human Services, through its National Health
2 Promotion and Disease Prevention Objectives, has urged that the proportion of all
3 pregnancies that are unintended be reduced to 30 percent by the year 2000. The committee
4 endorses this goal, and stresses that it is a *realistic* one, already reached by some other
5 Western democracies. Achieving this goal would mean, in absolute numbers, that there
6 would be more than 200,000 fewer births each year that were unwanted at time of
7 conception, and about 800,000 fewer abortions annually as well.

8 **● To begin the long process of building national consensus around this norm, a**
9 **public-private consortium should be formed to lead a multifaceted, long-term**
10 **campaign to (a) educate the public about the major social and public health benefits of**
11 **intended pregnancy, and (b) stimulate a comprehensive set of activities at national,**
12 **state, and local levels to reduce unintended pregnancy.**

13 Funding and leadership of this consortium should be provided by private
14 foundations, given their unique capacity to draw many disparate groups together around a
15 shared concern. Members of this campaign consortium should be recruited from numerous
16 sectors, both public and private, and especially from the groups that speak on behalf of
17 children and their needs, such as the maternal and child health community.

18 The campaign should emphasize that reducing unintended pregnancy will ease many
19 contemporary problems that are of such concern. Both teenage pregnancy and nonmarital

1 childbearing would decline, and abortion in particular would be reduced dramatically. The
2 campaign should also draw on the successful experience of other major efforts to address
3 complicated public health problems, such as the national campaigns to reduce smoking,
4 limit drunk driving, and increase the use of seat belts.

5 **CAMPAIGN FOCUS**

6 The campaign to reduce unintended pregnancy should stress five core goals:

- 7 1. improve knowledge about contraception and reproductive health;
- 8 2. increase access to contraception;
- 9 3. explicitly address the major role that feelings, attitudes and motivation
10 play in using contraception and avoiding unintended pregnancy;
- 11 4. develop and scrupulously evaluate a variety of local programs to reduce
12 unintended pregnancy; and
- 13 5. stimulate research to (a) develop new contraceptive methods, (b) increase
14 the capacity of the health care system generally to reduce unintended
15 pregnancy, and (c) understand more fully the antecedents of
16 unintended pregnancy.

17 Each of these five goals is elaborated below.

Campaign Goal #1: Improve knowledge about contraception and reproductive health.

An important reason for inadequate contraceptive vigilance, and therefore unintended pregnancy, is that many Americans lack adequate knowledge about contraception and reproductive health generally. The fact that many Americans continue to think that childbearing is less risky medically than using oral contraceptives is a sobering example of this problem. The resulting fears and misconceptions that stem from such erroneous beliefs can impede the careful, consistent use of contraception, which in turn contributes to the risk of unintended pregnancy.

Accordingly, the campaign should develop a series of information and education activities directed to women of all ages, not just adolescent girls, describing available contraceptive methods and highlighting, in particular, the common occurrence of unintended pregnancy among women age 20 and above, especially those over age 40 for whom an unintended pregnancy may carry particular medical risks. Activities must also target boys and men, emphasizing their stake in avoiding unintended pregnancy, the contraceptive methods available to them, and how to support their partners' use of contraception. And both males and females need balanced, accurate information about the benefits and risks attached to specific contraceptive methods.

Parents, families, and both religious and community institutions, should be major sources of information and education about reproductive health and family planning,

1 especially for young people, and they should be supported in serving this important
2 function. In addition, U.S. school systems should continue developing comprehensive, age-
3 appropriate programs of family life and sex education that build on new research about
4 effective content, timing, and teacher training for such courses.

5 Information and education about contraception should include abstinence as one of
6 many methods available to prevent pregnancy. And particularly in programs directed to
7 young adolescents, it is important to encourage and help young people resist precocious
8 sexual involvement. Sexual intercourse should occur in the context of a major interpersonal
9 commitment based on mutual consent and caring, and on the exercise of personal
10 responsibility, including taking steps to avoid both unintended pregnancy and sexually
11 transmitted diseases (STDs).

12 The electronic and print media should reinforce the material presented in schools and
13 elsewhere, thereby helping to educate adults as well as school-aged children about
14 contraception and reproductive health. The media should present accurate material on the
15 benefits and risks of contraception, and should broaden current messages about preventing
16 STDs to include preventing unintended pregnancy as well. Media producers, advertisers,
17 story writers and others should also balance current entertainment programming so that, at a
18 minimum, sexual activity is preceded by a mutual understanding of both partners regarding
19 its possible consequences, and, when appropriate, accompanied by contraception. Similarly,

advertising of contraceptive products and public service announcements regarding unintended pregnancy and contraception should be more plentiful.

Campaign Goal #2: Increase access to contraception.

Through a combination of financial and structural factors, the health care system in America makes access to contraception a complicated, sometimes expensive proposition. Private health insurance often does not cover contraceptive costs; the various restrictions on Medicaid eligibility make it an unreliable source of steady financing for contraception except for the poorest women; and the net decline in public investment in family planning services, in the face of higher costs and sicker patients, may have decreased access to care for those who depend on publicly-financed services. Condoms, the most accessible form of contraception, provide valuable protection against STDs but must be accompanied by prescription methods to afford maximum protection against unintended pregnancy. Unfortunately, other accessible nonprescription methods (e.g., foam and sponge) neither prevent the transmission of STDs nor offer the best protection against unintended pregnancy.

The campaign to reduce unintended pregnancy should promote increased access to contraception generally, but especially to the more effective methods that require contact with a health care professional. Financial barriers in particular should be reduced by (a)

1 increasing the proportion of all health insurance policies that cover contraceptive services
2 and supplies, including both male and female sterilization, with no copayments or other
3 cost-sharing requirements, as for other selected preventive health services; (b) extending
4 Medicaid coverage for all postpartum women for two years following childbirth for
5 contraceptive services, including sterilization; and (c) continuing to provide public funding--
6 federal, state and local--for comprehensive contraceptive services, especially for those low-
7 income women and adolescents who face major financial barriers in securing such care.

8 This last point speaks to the major role that public financing programs, such as Title
9 X and Medicaid, have played in helping millions of people secure contraception. Although
10 evaluation research has not yet defined the precise effect of these programs on unintended
11 pregnancy, there is no question that they help to finance contraceptive services for many
12 women (and some men), the principal means by which unintended pregnancy is prevented.
13 Accordingly, it is essential that such public investment be maintained. In addition,
14 foundations and government should fund high-quality evaluations of both Title X and
15 Medicaid especially. Without better data on their impact, they remain particularly
16 vulnerable to attack, and it is difficult to know how best to strengthen them.

17 As another way to increase access to contraceptive services, the campaign should
18 also broaden the range of health professionals and institutions that promote and provide
19 methods of birth control. Campaign leaders, for example, should work with medical
20 educators to revise the training curricula of a wide variety of health professionals

(physicians, nurses, and others) to increase their competence in reproductive health and contraceptive counseling for both males and females and, where appropriate, in actually providing contraceptive devices. The campaign should also find ways to encourage those who provide social work, child care, employment training, and other social services to counsel their clients about the benefits of pregnancy planning and how to do so.

Campaign Goal #3: Explicitly address the major role that feelings, attitudes and motivation play in using contraception and avoiding unintended pregnancy.

Personal attitudes, motivation and feelings—within individuals and between couples—clearly affect contraceptive use and therefore unintended pregnancy. Partner preferences, and particularly the quality of a couple’s relationship, are also important influences, as is overall comfort with sexuality. Feelings about specific contraceptives can affect an individual’s choice of method and the success with which it is used.

In truth, avoiding unintended pregnancy can be hard to do, requiring specific skills and steady dedication over time, often from both partners. The strong, consistent motivation that many forms of reversible contraception require is often fueled by a view of life in which pregnancy and childbearing are seen, at a given point in time, as less attractive than other alternatives. Being pregnant and bearing a child often bring significant psychological and social rewards, and there must be good reason to forego them.

1 In order to address feelings, attitudes and motivation more directly, contraceptive
2 services should be sufficiently well funded (through adequate reimbursement rates and/or
3 public sector support) to include extensive counseling—of both partners, whenever
4 possible—about the skills and commitment needed to use contraception successfully.
5 Similarly, school curricula and programs that train health and social services professionals
6 should both include ample material about the influence of personal factors (especially
7 motivation) on successful contraceptive use, along with more conventional information
8 about reproductive physiology and contraceptive technology.

9 On a broader level, policy leaders need to confront the notion that, especially for
10 those most impoverished, reducing unintended pregnancy may well require that other more
11 compelling alternatives than pregnancy and childbearing be available—better schools,
12 realistic expectations that a high school diploma will lead to an adequate income, jobs that
13 are available and satisfying. Increasing knowledge about contraception and
14 improving access to it as well, may not be enough to achieve major reductions in
15 unintended pregnancy when the surrounding environment offers few incentives to postpone
16 childbearing. This comment is not meant to suggest that unless poverty is eliminated,
17 unintended pregnancy cannot be reduced. The point is rather that, in the poorest
18 communities especially, only modest reductions in unintended pregnancy will likely be
19 achieved by the usual prescription of “more education, information and services.”

Campaign Focus #4: Develop and scrupulously evaluate a variety of local programs to reduce unintended pregnancy.

Little is known about effective programming at the local level to reduce unintended pregnancy. Accordingly, the campaign to reduce unintended pregnancy should encourage public and private funders to support a series of new research and demonstration programs. The focus and design of these new programs should be based, at a minimum, on a careful assessment of 23 programs identified by the committee that have been well enough evaluated to understand their impact on specific fertility measures. Evaluation data from these programs support several broad conclusions: even those few programs showing positive effects report only small gains, which demonstrates how difficult it can be to achieve major decreases in unintended pregnancy; because most evaluated programs target adolescents, especially adolescent girls, knowledge about how to reduce unintended pregnancy among adult women and their partners is exceedingly limited; there is insufficient evidence to determine if “abstinence only” programs are effective, but encouraging results are being reported by programs with more complex messages stressing both abstinence and contraceptive use once sexual activity has begun; few evaluated programs actually provide contraceptive devices, which may help to explain the small effects of many programs; and only mixed success has been reported from programs trying to prevent rapid repeat pregnancies among adolescents and young women.

1 New research and demonstration programs should be designed to answer a series of
2 clearly articulated questions, evaluated very carefully, and replicated when promising results
3 emerge. One theme that these programs should explore is how to build community support
4 for contraception. Although contraceptive use is ultimately a personal matter, community
5 values and the surrounding culture clearly shape the actions of individuals and couples.
6 Nonetheless, virtually none of the 23 evaluated programs reviewed by the committee
7 attempted to influence the surrounding social environment. Accordingly, at least some
8 demonstration programs should target *both* community and individual, and some might also
9 work exclusively at the community level.

10 **Campaign Focus #5: Stimulate research to (a) develop new contraceptive**
11 **methods, (b) increase the capacity of the health care system generally to reduce**
12 **unintended pregnancy, and (c) understand more fully the antecedents of unintended**
13 **pregnancy.**

14 Investigating the antecedents of unintended pregnancy (item (c) above) merits
15 emphasis. There is a clear need for more research to understand relationships among the
16 complex cultural, economic, social, biological and psychological factors that lie behind
17 widely varying patterns of contraceptive use and therefore unintended pregnancy. Material
18 on personal feelings and beliefs, and especially several recent ethnographic investigations of
19 motivation, offer particularly intriguing explanations for the observed phenomena. Careful

1 work is needed to integrate these ideas with the more traditional explanations of unintended
2 pregnancy, such as inaccessible contraceptive services or insufficient knowledge about how
3 to prevent pregnancy. And in all investigations, more attention should be paid to the
4 socioeconomic and cultural environment shaping both sexual activity and contraceptive use,
5 and therefore unintended pregnancy.

NARAL Promoting Reproductive Choices

Melanne Verveer
Deputy Chief of Staff to the First Lady
Office of the First Lady
The Old Executive Office Building
Room 100
Washington, DC 20500

February 2, 1995

Dear Melanne:

I am writing to follow-up on our phone conversation about the critical need for a national focus on teenage pregnancy prevention.

We have done some research and analysis of the underlying causes of teenage pregnancy as well as effective programs and policies to reduce the teen pregnancy rate. I am enclosing a chapter on adolescent reproductive health from our policy paper, "Promoting Reproductive Choices: A New Approach to Reproductive Health," which you may find helpful.

Informing our work in this area is our fundamental belief that the nation must elevate the value of reproduction and child-bearing to a higher level; it must then adopt policies that help make every pregnancy a wanted pregnancy and encourage responsible, deliberate decision-making about child-bearing. I sincerely hope that President Clinton's emphasis in his State of the Union address on preventing teenage pregnancy will begin a sorely needed national dialogue on this important issue.

Given the First Lady's interest in this matter, I would like to suggest a meeting with Mrs. Clinton to discuss the elements of an effective national campaign to address teenage pregnancy prevention. I look forward to hearing from you.

Sincerely,



Kate Michelman
President

Enclosure

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PROTECTING ADOLESCENT REPRODUCTIVE HEALTH

SECTIONS

Comprehensive Sexuality Education

Accessible Reproductive Health Services

Confidential Reproductive Health Services

Successful Life Options Programs

Effective Support Services for Pregnant and Parenting Teens

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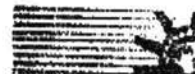
PREGNANCY RATES AMONG AMERICA'S YOUTH ARE AT AN EPIDEMIC HIGH — each year there are approximately one million teen pregnancies.¹ Sexually transmitted diseases (STDs) are rampant — each year three million new cases are diagnosed among adolescents, and one out of five are infected before they reach age 21.² Adolescents often receive inadequate prenatal care and give birth to almost 50,000 low birthweight babies annually.³ Many teens in the United States do not know how to protect their health, and many are living in circumstances that rob them of the motivation and ability they need to take responsibility for their futures. Too many adolescents do not know how to prevent pregnancy, and too many girls choose teen motherhood because they have no hope of finding fulfillment elsewhere.

This escalating crisis is threatening the health of our children and fueling mounting health care costs: every year Americans spend more than 21,000 dollars in neonatal care for each low birthweight infant and almost 40,000 dollars for each person with AIDS.⁴ Unless we ensure that teens have the information, skills and services they need to protect their reproductive health, many of these needless and preventable physical, financial and societal costs will increase. An aggressive national campaign to curb teenage pregnancy and promote adolescent health is essential to protecting our children and to promoting a healthier society.

Comprehensive Sexuality Education >>>

> PROBLEM: American teens are dangerously uninformed about pregnancy prevention and STDs. Many lack the information and skills they need to postpone premature sexual activity and protect their reproductive health. The physical, financial and societal costs that result can be attributed, in part, to a lack of commitment to comprehensive sexuality education in our nation's schools.

Although teens in this country are no more sexually active than those in other developed nations, they are less likely to use contraception, more likely to get pregnant and more likely to contract a sexually transmitted disease.⁵ Many adolescents are not getting information from their parents,



>>>

The Poor Status of Teen Reproductive Health in America:

- *Nearly half of all sexually active teenage girls in the U.S. do not use birth control.¹⁰*
- *Every year there are approximately one million teenage pregnancies, 81 percent of which are unintended.¹¹*
- *Three million teens annually are infected with a sexually transmitted disease. By age 21, one out of five young people requires treatment for a sexually transmitted disease.¹²*
- *Almost 10,000 cases of AIDS have been reported in Americans aged 20 to 24, most of whom were probably infected during their teen years.¹³*

doctors or schools and are left to rely on cultural and media messages about sex and sexuality: 31 percent of teens have never discussed sexuality or contraceptives with their parents⁶ and pediatricians spend on average only seven seconds per office visit discussing contraception with teenagers.⁷ Almost 30 percent of teens cannot determine whether this statement is true or false: "A girl cannot become pregnant if she douches with Coca-Cola after intercourse."⁸ Moreover, fewer than one in ten children in America receives comprehensive human development and sexuality education from kindergarten through grade 12.⁹

➤ ***RECOMMENDATION: Comprehensive and age-appropriate human development and sexuality education in grades kindergarten through 12 will lay the foundation for long-term efforts to bring down teenage pregnancy rates and improve adolescent reproductive health. Enabling teens to postpone premature sexual involvement and acquire the information they need to prevent pregnancy and protect their health is crucial to these efforts.***

Parents have the primary responsibility for educating their children about sexuality and reproductive health. Schools, however, also play an important role in the process: 89 percent of adults support the provision of sexuality education in schools,¹⁴ and when given the opportunity to remove their children from such programs, fewer than five percent of parents actually do so.¹⁵ Comprehensive sexuality education is essential to improving adolescent reproductive health and ensuring that adolescents have the information and skills they need to postpone premature sexual activity and protect themselves when they become sexually active. Although many teens are not sexually active, as adults they will need the ability to make responsible decisions about sexuality and their reproductive health. Educational programs should include information about abstinence, but must also prepare teens for healthy and responsible sexual involvement.

The federal government has done little to ensure that there is comprehensive sexuality education in the schools and states have addressed the problem in a largely haphazard and ineffective way. Most teens graduate from high school never having participated in a sequential and developmentally

CHAPTER ONE

appropriate sexuality education program. Although 38 states, the District of Columbia and Puerto Rico have developed curricula or guidelines to provide program direction to local school districts,¹⁶ most do not assist schools in developing sexuality education programs that are comprehensive. Fewer than one third of state guidelines cover topics on sexual behavior other than abstinence, and most omit or prohibit controversial topics such as abortion and sexual orientation.¹⁷ South Carolina prohibits discussion of sexual practices outside marriage, and Utah prohibits discussion of homosexuality and the use of contraceptives by unmarried minors.¹⁸

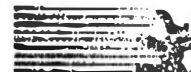
Abstinence should be a major focus of sexuality education. It cannot, however, be the only component. More than 60 percent of males and the majority of females between the ages of 15 and 19 are sexually active.¹⁹ Many programs that focus exclusively on abstinence are ineffective and, in fact, harmful. One widely used program is Sex Respect, a curriculum that links sex with guilt, fear and shame and uses catchy phrases such as "Control your urgin,' be a virgin" and "Don't be a louse, wait for your spouse," to instruct teens to avoid all premarital sexual activity.²⁰ Such programs offer virtually no information about how to prevent disease and unintended pregnancy and often alienate teens who are already sexually active. Another prevalent program, Teen-Aid, teaches that "[s]everal factors have been advanced to explain why subsequent children [of a woman who has had an abortion] are battered. Some of the mechanisms are ... after one has aborted a child, an individual loses instinctual control over rage."²¹

In Louisiana, a court found that the Sex Respect curriculum violated a state statute requiring that sexuality education materials be free of medical inaccuracies.

To help ensure that adolescents get the accurate information they need to protect their reproductive health, federal and state policies should promote effective sexuality education in schools. State legislative mandates for comprehensive and accurate programs can help ensure that schools implement more effective and age-appropriate programs, and that teachers receive appropriate and adequate training. In addition, they can provide grounds for challenging curricula that provide teens with inaccurate, misleading or incomplete information. In Louisiana, a court found that the Sex Respect curriculum violated a state statute requiring that sexuality education materials be free of medical inaccuracies, citing a number of passages, including the following:

A male can experience complete sexual release with a woman he doesn't like, whereas a woman usually can't do so unless she loves her partner It's often the girls who are starved for male affection because they didn't have a good relationship with their father who get involved in sex outside of marriage.²²

In addition to requiring that sexuality education programs are comprehensive and accurate, states should also ensure that instructors who teach sexual health topics are adequately trained and provided with up-to-date materials. When sexuality education is taught at all, it is often offered as a short section in another course and the materials used are outdated, uninteresting, inaccurate or difficult to read.²³ Frequently programs are offered by teachers of biology, health education,



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A comprehensive sexuality education curriculum should:

- encourage young people to postpone premature sexual involvement;*
- start early and provide culturally sensitive, developmentally appropriate information for all age groups from kindergarten through 12th grade;*
- define sexuality as a normal and healthy part of life;*
- provide an opportunity for young people to explore their values and beliefs, and prepare them to deal with controversial issues by supplying factual information and support;*
- help develop self-esteem, personal responsibility, relationship skills and respect for self and others;*
- provide age-appropriate information on contraceptive methods, use and effectiveness;*
- provide age-appropriate information about preventive reproductive health care, including protection against STDs and HIV infection; and*
- furnish information on life options for teens, including education and career planning.*

home economics and physical education who are not trained to teach sexual health education.²⁴ States should establish minimum training standards for teachers responsible for sexuality education and help ensure that appropriate materials are available. Today, only nine states require specialized instruction for sexuality education teachers.²⁵

Effective sexuality education programs taught by trained instructors can promote healthier and more responsible behavior among teens. In the Reducing the Risk program, instructors assist tenth-grade students in developing strategies and skills to resist sexual pressure and avoid unprotected intercourse, either by not having sex or by using contraceptives. Students who participated were more knowledgeable about pregnancy prevention and were less likely to become sexually active in the two years following the program.²⁶ In addition to pregnancy prevention, sexuality education programs must teach adolescents how to recognize early signs of pregnancy and the importance of early prenatal care.

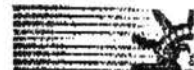
CHAPTER ONE

Parents, schools, community organizations, health care professionals and religious institutions all have important roles to play in the sexuality education of the nation's youth. To reach teens in the community, school programs must have the support of parents and teachers. The most effective programs coordinate school-based education with services offered by community and religious institutions and provide accurate information in the context of the values and ethical standards of the community.

The religious right is organizing a nationally coordinated grassroots effort to promote harmful curricula like Sex Respect, and to prohibit sexuality education programs that offer teens alternatives other than abstinence to prevent unintended pregnancy or to protect themselves against sexually transmitted diseases. Advocates for comprehensive sexuality education must aggressively organize and educate at the local level so that we as a nation may help our children take responsibility for their reproductive health.

> ACTIONS:

- *Encourage parents to provide sexuality education to their children by providing accessible resource materials, courses, workshops and programs designed for parents and children together.*
- *Organize at the local level to build support among parents, teachers, school boards and political, religious and community leaders for comprehensive and accurate sexuality education in schools.*
- *Enact state legislation requiring comprehensive and accurate human development and sexuality education in grades K through 12 and ensure model curricula and guidelines are available at the local level.*
- *Provide funding for model comprehensive teen pregnancy prevention programs that include accurate information on sexuality, postponing premature sexual involvement, protection against STDs and HIV infection, and contraceptive use.*
- *Require training and certification for sexuality education teachers and ensure that accurate and updated materials are available.*





Accessible Reproductive Health Services >>>

> PROBLEM: *School-based and school-linked health clinics are an important source of health care for adolescents, but there are not enough clinics nationwide and too few provide reproductive health services, including contraceptive care.*

A national reproductive health policy that emphasizes the importance of school-based and school-linked clinics can play a significant role in reducing the alarmingly high rates of teen pregnancy and sexually transmitted diseases. Many adolescents do not have access to comprehensive reproductive care including gynecological exams, nutrition education, contraceptive services, prenatal care, STD prevention and treatment, and abortion services. Approximately 4.5 million adolescents have no health insurance and many have no regular source of health care.²⁷ Medicaid, the single largest public funding source for adolescent health care, assists only one third of all poor adolescents.²⁸ In addition, one third of all Title X clients are teens, and since 1980 the federal government has cut funds for the program by almost two-thirds.²⁹ School clinics provide an accessible, affordable option for teens in need of reproductive health care. In fact, half of the adolescents who rely on school health clinics do not have other sources of health care.³⁰

Although there are more than 84,000 public schools across the country, only 415 of these schools offer school-based health clinics, and only 95 have school-linked clinics.³¹ School clinics can provide an excellent forum to educate and enable teens to protect themselves against sexually transmitted diseases and unintended pregnancy, but most do not provide adequate reproductive health services. Although a majority made referrals for family planning services during the 1989-90 school year, only 28 percent of school-based clinics wrote prescriptions for birth control pills and fewer than 20 percent dispensed contraceptives on site.³² Although school-linked clinics are more likely to provide family planning services, in part because they are not located on school grounds, less than 50 percent write prescriptions for contraceptives or dispense birth control pills, and only 53 percent make condoms available at the clinic.³³ Seventy-three percent of Americans favor making birth control information and contraceptives available through school-based and school-linked clinics.³⁴ In addition, few school clinics, if any, make referrals to abortion providers.³⁵

> RECOMMENDATION: *The most effective pregnancy prevention programs integrate education with the provision of reproductive health services. School-based and school-linked clinics and other programs that provide health services, including contraceptive care as well as pregnancy counseling and referrals for prenatal care, adoption and abortion, will better enable teens to protect their reproductive health.*

School-based and school-linked clinics can make a significant difference in the lives of adolescents; for many teens the clinics provide access to reproductive health services, including contraceptives and STD testing, that would be otherwise unavailable. The clinics are located on or near school grounds, provide free or low cost services, and have convenient appointment times, thereby eliminating many of the common barriers faced by adolescents seeking care.³⁶

School-based and school-linked health clinics that provide contraceptive services appear to have helped reduce teen pregnancy rates. A Baltimore, Maryland program called the Self Center offered students classroom-based sexuality education and reproductive health care including gynecological exams, STD testing and contraceptive services in a clinic across the street from the school. By the end of the program's third year, teen pregnancies declined by 30 percent, while pregnancies rose 58 percent in similar schools without clinics.³⁷

A very successful program in South Carolina that combined sexuality education by teachers, parents and community leaders with a school-based clinic helped reduce the teen pregnancy rate from 61 to 25 percent in three years.³⁸ The positive results of the program were dramatically diminished, however, after the South Carolina legislature banned the distribution of contraceptives in school clinics.³⁹ Only one year after the ban went into effect, pregnancy rates rose to the previous level, largely because contraceptive services were no longer available to many teens in the program.⁴⁰

Projects to increase condom availability provide another avenue through which schools, community groups and religious organizations can address the problems associated with teen pregnancy and sexually transmitted diseases. Next to abstinence, condoms are the most effective method available for reducing the transmission of STDs and HIV infection. Also, unlike the majority of pregnancy prevention efforts, condom availability projects reach adolescent males as well as females.⁴¹ A 1992 Gallup poll found that 68 percent of adults believe condoms should be available in high schools.⁴² Condoms are already available to teens from supermarkets, drugstores, convenience stores and vending machines. Making them available through school programs helps ensure that when teens obtain condoms, they also receive accurate and understandable information on how to use them properly.

More than 70 school-based health clinics make condoms available to sexually active students.⁴³ In the first year that condoms were distributed in the District of Columbia public schools, 1,600 students requested them and preliminary data indicates 300 fewer teenage pregnancies during the school year and a 30 percent decrease in the number of sexually transmitted diseases compared to pre-existing levels.⁴⁴

More than half of the funding for school-linked and school-based clinics is provided by state and federal sources, predominantly from state health departments and federal Maternal and Child Health block grants.⁴⁵ Government support for contraceptive services is necessary to ensure that school health clinics provide reproductive health care, including contraceptive services. In addition, school board members, parents, teachers and religious and community leaders committed to ensuring the availability of sexuality education and contraceptive care are essential to the success of any school-based health program.

By the end of the third year of the Self Center program in Baltimore, teen pregnancies declined by 30 percent, while pregnancies rose 58 percent in similar schools without clinics.



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> ACTIONS:

- *Ensure national health care reform recognizes the importance of reproductive health care for teens and encourages the provision of confidential services within the school system.*
- *Make government and private funds available for school-based and school-linked health clinics that fully address the reproductive health needs of adolescents.*
- *Organize at the community level to ensure that the full range of reproductive health services are provided in school clinics, including treatment for sexually transmitted diseases, contraceptive services, and information about and referral for prenatal care, abortion and adoption.*
- *Build local support to implement programs in schools that provide education about and access to condoms.*

Confidential Reproductive Health Services >>>

- **PROBLEM:** *Teen health is endangered when confidentiality is not assured because many adolescents will delay or avoid seeking early and appropriate reproductive health services. Laws that require parental consent for reproductive health care can lead to inadequate prenatal care, later and more risky abortions and even dangerous illegal alternatives.*

The need for privacy and confidentiality is repeatedly cited by teenagers as a critical factor in deciding whether to seek reproductive health care.⁴⁶ Healthy outcomes for pregnancy, sexually transmitted diseases and other reproductive health conditions often depend on an individual obtaining timely medical care. Decisions about pregnancy are best made early, so that if a young woman plans to carry to term she can get adequate prenatal care, and if she decides to terminate the pregnancy she can obtain a safe abortion. Early diagnosis and treatment of sexually transmitted diseases enable teens to avoid the much more serious and expensive health problems that result from untreated infections.⁴⁷ Because some teens will delay or avoid seeking reproductive health services if they think their parents will be told, virtually every state has enacted legislation that protects the confidentiality of minors seeking health care for STDs, yet many states have imposed mandatory parental consent or notice laws on minors in need of abortion services, at times with tragic results.⁴⁸

Laws that restrict minors' access to abortion by mandating parental involvement harm teens and families. In a recent study, the American Medical Association found that "[b]ecause the need for privacy may be compelling, minors may be driven to desperate measures to maintain the confidentiality of their pregnancies. They may run away from home, obtain a 'back alley' abortion, or resort to self-induced abortion. The desire to maintain secrecy has been one of the leading reasons for

illegal abortion deaths since ... 1973.⁴⁹ Rebecca Bell, a young woman in Indiana, died tragically from an illegal abortion because she did not want her parents to know about her pregnancy and state law required parental notice before she could have a legal abortion.⁵⁰ Thirty-eight states have enacted parental consent or notice requirements for minors seeking abortion, although only 22 are enforced.⁵¹

- **RECOMMENDATION:** *Confidential reproductive health services must be available to teens. Concerns about privacy and confidentiality are paramount to adolescents deciding whether and where to seek reproductive health care. Though adolescents should be encouraged to involve a parent, laws that require parental consent or notice for reproductive health care endanger teens.*

Parents should be involved when a child is facing any health problem, and most teens do involve a parent when they are facing a crisis pregnancy. Regardless of mandatory parental consent or notice requirements for abortion, more than 75 percent of minors under age 16 involve one or both parents.⁵² The government, however, cannot mandate healthy family communication where it does not already exist. Patient-doctor confidentiality is critical to providing reproductive health services for young people.⁵³ Major health organizations, including the American College of Obstetricians and Gynecologists, the American Academy of Family Physicians, the American Academy of Pediatrics, the National Medical Association and the Organization of Obstetric, Gynecologic, and Neonatal Nurses agree that though health professionals must make every "reasonable effort to encourage adolescents to involve parents ... [u]ltimately the health risks to the adolescents are so compelling that legal barriers and deference to parental involvement should not stand in the way of needed health care."⁵⁴ Unless adolescents have access to confidential health care, too many will be left untreated or will turn to unhealthy and dangerous alternatives.

..... **R**egardless of mandatory parental consent or notice requirements for abortion, more than 75 percent of minors under age 16 involve one or both parents.

➤ **ACTIONS:**

- **Ensure national health care reform protects confidentiality for adolescents seeking reproductive health care.**
- **Eliminate mandatory parental consent and notice laws, as these restrictions discourage and prevent minors from seeking early and appropriate treatment.**



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Successful Life Options Programs >>>

> PROBLEM: *Teens need more than sexuality education and contraceptive care to avoid too-early childbearing. Adolescents are not motivated to postpone pregnancy if they have low self-esteem, limited employment and educational opportunities, and little hope for the future.*

Even if sexuality education and reproductive health services are made available, young people will not avoid pregnancy unless they can envision positive alternatives to teen parenthood and are motivated to plan for the future.⁵⁵ The young women and men most likely to become teen parents are those who live in poverty and who have low self-esteem and low expectations for completing

their education or finding employment.⁵⁶

Teenage girls with poor academic skills are five times as likely to become mothers before age 16 as are teenagers with average or above average skills in school.⁵⁷ When young girls are shown alternatives to teen pregnancy and empowered with the belief that they can achieve alternative goals, they are more likely to postpone childbearing until after their teen years.

Participants in the Girls Inc.

life options programs were more likely to postpone sexual involvement, more likely than other teens to use contraceptives and less likely to become pregnant.

Successful teen pregnancy prevention programs build on the premise that in order to avoid pregnancy, adolescents need opportunities and motivation as well as sexuality education and contraceptive services.⁵⁸ The challenge is to make options available to adolescent girls that are just as emotionally satisfying as the idea of motherhood.⁵⁹ Life options programs emphasize decision-making and problem-solving skills, provide work and educational experiences, and help teens develop self-esteem and social responsibility.⁶⁰

> RECOMMENDATION: *In order to postpone childbearing, adolescents need motivation, self-esteem and opportunities for the future as well as sexuality education and contraceptive services.*

Life options programs are critical to the reproductive health of some adolescents at risk of unintended pregnancy, particularly those who have few expectations for the future. In combination with education and health services, life options programs can be effective in providing teens with the motivation to postpone childbearing. One life options program, the Summer Training and Education Program (STEP), is designed to help 14- and 15-year-olds avoid unintended pregnancy and stay in school. STEP is a 15-month program that uses summer income as an incentive for teens to enroll for two consecutive summers of reading and math instruction, work experience and developing skills for responsible social and sexual attitudes and behavior. STEP also provides support services

CHAPTER ONE

during the academic year, such as counseling, group activities, workshops and meetings with parents. Preliminary findings indicate that STEP is effective in reducing school dropout rates and educating participants about contraceptive use.⁶¹

Girls Inc.'s three-year Preventing Adolescent Pregnancy Program offers a comprehensive approach to preventing unintended pregnancy, including education, health services and life options. Through the "Growing Together" component of the program, girls and their mothers practice communicating about sexuality. Girls learn to resist pressures to have sexual intercourse in "Will Power/Won't Power." It is imperative that job training and educational programs address the needs and goals of female adolescents and the "Taking Care of Business" segment offers older girls career planning and goal-setting together with information on sexuality, reproduction and contraception. The "Health Bridge" program coordinates health education, including contraception, with comprehensive health services in a neighborhood clinic. Participants in the Girls Inc. life options programs were more likely to postpone sexual involvement, more likely than other teens to use contraceptives and less likely to become pregnant.⁶²

► **ACTIONS:**

- *Make government funds available for life options programs, and organize partnerships among state and local agencies, civic groups, businesses, religious organizations and community groups to establish community-based programs that enhance the life options of teens.*
- *Engage local businesses in mentoring programs, internships and adopt-a-classroom programs that enhance life options and future employment opportunities for teens.*
- *Ensure that educational and job training programs include female adolescents and address their particular needs and goals.*

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Effective Support Services for Pregnant and Parenting Teens >>>

- **PROBLEM:** *A serious lack of support services for pregnant adolescents and teen parents is endangering their health and the well-being of their children.*

A comprehensive policy to address the reproductive health needs of teens must include services for pregnant teens as well as programs designed to reduce unintended pregnancy. Many young women lack the information and resources necessary to meet their health needs during pregnancy. More than half a million children each year are born to teenage girls.⁶³ Between 1986 and 1991, birth rates for teenagers under 18 increased by 27 percent, and 19 percent for women aged 18 and 19.⁶⁴



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Adolescents are more likely than other women to deny they are pregnant, less likely to understand the importance of early and regular prenatal care, and less likely to know how or where to receive care.⁶⁵ As a consequence, infants of adolescents are more likely to have low birth weight, be born prematurely, and die in the first year of life.⁶⁶ Thirty-three percent of pregnant teens obtain inadequate care, and the rate is even higher for younger teens.⁶⁷ Due to their young age, adolescents have greater nutritional needs and are less likely to gain adequate weight during pregnancy.⁶⁸ In addition, they are at high risk for unhealthy births because they are less likely to know which behaviors can harm a pregnancy.⁶⁹ Adolescents need access to counseling that can assist them in making the right decision for themselves about whether or not to carry their pregnancies to term and how and where to obtain affordable, quality prenatal care, adoption or abortion services.

Without adequate support services, the negative social, economic and health consequences of too-early childbearing can be profound and often last a lifetime. Many teen mothers have few skills and little education, and face low paying jobs, unemployment, poverty and dependence on government assistance.⁷⁰ Families headed by young women are seven times as likely as other families to live below the poverty level.⁷¹ Women who become mothers in their teen years are less likely to complete their education and are at greater risk of low wages and poverty throughout their lives.⁷² Although high school completion rates have increased in recent years for pregnant and parenting adolescents, it is estimated that only 56 percent of teen mothers will graduate from high school.⁷³ Moreover, young women with children are less likely to go to college and on average will make half the lifetime earnings of those who delay childbearing until after their teen years.⁷⁴

> RECOMMENDATION: Comprehensive programs that coordinate education, confidential health care, child care, employment and social services for pregnant and parenting adolescents will have positive long-term effects on the health and well-being of families. The provision of adequate and timely support services will better enable teen mothers to raise healthy children and attain economic self-sufficiency.

Pregnant teens need access to prenatal care offered in a comfortable setting that includes guidance about how to stay healthy and avoid risky behavior. Young pregnant women who are dependent on drugs or alcohol need to know such behaviors can seriously endanger a pregnancy, and must have access to treatment programs tailored to the needs of pregnant adolescents. To reach pregnant girls at risk of unhealthy births, Johns Hopkins University Hospital opened a bright storefront clinic offering "prenatal-plus" services at a shopping mall. In addition to providing health services, the staff offers counseling to pregnant girls about their school/work and job prospects, relationships with family and friends, and fears about parenthood and how they will care for their children.⁷⁵

Pregnant and parenting adolescents often need special assistance to complete their education and to properly care for their children, including information about prenatal care, nutrition, immunization and family planning, as well as hands-on training in bathing an infant and child-proofing a house. In San Francisco, the Teenage Pregnancy and Parenting Program (TAPP) links teens with

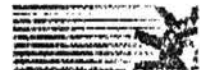
CHAPTER ONE

health and social services offered by over 30 agencies, and provides an alternative school with on-site child care and health care. TAPP has been effective in encouraging school attendance and preventing subsequent pregnancies, which compound the consequences of first births.⁷⁶

Just as those adolescents who choose to continue their pregnancies need special support such as counseling and prenatal care, those adolescents who decide to have an abortion should also receive support in exercising that choice. Many teens have difficulty obtaining early abortion services because they do not have access to medical care, money and transportation. To ensure that adolescents receive health services, including abortion, as early as possible during a pregnancy, they should have ready access to confidential counseling and health care, referrals to qualified local health professionals who provide abortion services, and funds to pay for abortion services and other associated costs.

> ACTIONS:

- *Make funds available for teen parenting support programs that include an aggressive outreach component. Programs should help pregnant teenagers obtain early and adequate prenatal care and include stay-in-school components such as General Equivalency Diploma (GED) preparation, child care and vocational education programs.*
- *Ensure the availability of parenting programs that provide teens with practical instruction on how to care properly for their infants.*
- *Expand existing services such as Medicaid and the Special Supplemental Food Program for Women, Infants and Children (WIC) to reach more pregnant adolescents.*
- *Ensure access to counseling and services that will enable teens to make and implement responsible decisions about pregnancy, including parenthood, adoption and abortion.*



file teen preg '97

CHILDREN HAVING CHILDREN

Teenage Pregnancy Is Imposing a Terrible Social Cost on America

BY KATHLEEN SYLVESTER

An unfortunate, inexorable cycle characterizes welfare in America. There are 9 million children living on welfare today. And like many of their parents, many of these children will become teen parents, rely on the welfare system for support, and produce a new generation of needy children—unless this nation intervenes.

As we reform this nation's failed welfare system to help poor families make the transition from dependency to self-sufficiency, we must also consider the next generation. We must pay attention to poor families' adolescent children before they, too, become parents too soon.

There is no time to waste. Each year, more than 1 million American teenage girls become pregnant—that's one in nine. About half of those young women give birth. According to Advocates for Youth (formerly the Center for Population Options), 24 percent of U.S. teenage girls have become pregnant once by age 18. By age 20, 43 percent have become pregnant.

The only way to consider the issue of teenage pregnancy is to consider what is best for the next generation of children. The debate about teenage pregnancy must begin—and end—with a focus on children.

In the past decade, the debate has lost that critical focus. Conservatives have opted to morally condemn teenage parents without offering to help them avoid early parenting. Liberals have offered palliatives for teen parents, but refused to condemn their behavior or acknowledge its calamitous results. If we keep our focus on the children, we must acknowledge that the best way to improve their lives is to ensure that they are born into families able to support and nurture them. In practical terms, that means parents who have finished school, have jobs, and are married.

The trends, however, are moving in the

wrong direction. And as teen pregnancy rates are rising, an increasing percentage of teen mothers are remaining unmarried. While only 14 percent of teen mothers were unmarried in 1950, 66 percent were unmarried in 1988. Evidence now confirms that the convergence of these two high-risk factors—youth and non-marriage—threatens the lives of many of our children and many more yet to be born.

This is what we know about the children of young, single parents: They are likely to grow up in poverty; they are at greater risk of drug and alcohol abuse, mental illness, suicide, poor educational performance, dropping out of school, and criminality than children of older two-parent families. As adults, they are more likely to be poor and to become heads of single-parent families themselves. Such consequences are not hard to comprehend: It is difficult to socialize the next generation when a new one is born every 13 years.

Teenage childbearing is not only the seed of a new generation of disadvantage, it is the nexus of many other social ills that burden our health, education, and criminal justice systems.

If there is one word that captures the essence of the teen pregnancy calamity, it is inevitability. In many communities, teenage childbearing is never questioned. It is a matter of when—not if—a young woman will have a baby. Many factors contribute to this sense of inevitability: a popular culture that promotes sex and destigmatizes unmarried parenting; a social welfare system that offers incentives for young women who have babies, yet offers little hope of a better future for teens who behave responsibly.

Teenagers are bombarded with music videos and soap operas in which rich, beautiful people indulge in endless sexual encounters



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with no adverse consequences. Unfortunately, most teens are not mature enough to distinguish their own lives from television fantasies. They are unable to understand that for them, such irresponsible behavior is self-destructive.

Ask teachers and social workers to identify their greatest obstacle in helping young people face the realities of their lives, and they name Madonna or a popular rap music group. A once-a-week counseling session is no counterweight to the pervasive influence of television in a country where teenagers spend an average of

21 hours a week watching TV.

The proportion of births outside of marriage is rising dramatically for all age groups, all races, and all social groups in the United States. The rate of increase in unmarried births has been much greater for women in their 30s than for teens, and for whites than for African-Americans. Not only poorly educated women, but high school and college graduates too are giving birth outside of marriage. Of all of these groups, however, the half-million children born to teen mothers each year face the most severe disadvantages.

SAYING NO

A New York Center Gives Teens Concrete Reasons To Stay Childless

BY ELLEN FLAX

NEW YORK
Katherine Mims knew at an early age that she didn't want to become a teenage mother. A 21-year-old majoring in business at Hunter College, Mims says when she was 12 she watched as her cousin, only three years older, worked hard to raise a toddler.

"I saw how she had to struggle, and I said, 'I don't want to be like that,'" she says.

Mims had help staying off the premature mommy track. In 1985, she and 21 other teenagers and 12 parents became charter participants in the Children's Aid Society's Teen Pregnancy Prevention Program.

According to Dr. Michael Carrera, the program's founder and director, one of the program's main goals is providing disadvantaged male and female youths with an enduring social-support network—something that middle-class teenagers take for granted—that will help them forgo parenthood. Children as young as 10 can enter the program and can take advantage of its services until they become independent.

The program's offerings, which are also open to parents and guardians, include health and contraceptive services; sex education; summer employment; sports and performing arts lessons; tutoring; counseling; and perhaps most alluring, guaranteed admission to

Hunter College, part of the City University of New York system, for those participants who graduate from high school and are recommended by the program.

The program "challenges the way things had been done in the past" in that it views pregnancy as a symptom, not simply a cause, of a troubled life, says Carrera, the Thomas Hunter professor emeritus of health sciences at Hunter College. "While one of the goals was to reduce teen pregnancy, we knew we had to do this by focusing on 'above the waist' issues."

The program puts a heavy emphasis on introducing teenagers to the potential for success in the real world. They are required to get a Social Security card and are encouraged to open a bank account. They learn how to write a résumé, dress for an interview, and fill out working papers. In return, they get paid jobs and biweekly checks for attending job-related classes.

Carrera says that these tangible rewards send teenagers a powerful message: Your future is bright, especially if you put off having a child. "We find that this produces behavior in young people that is not self-destructive or exploitative," he says.

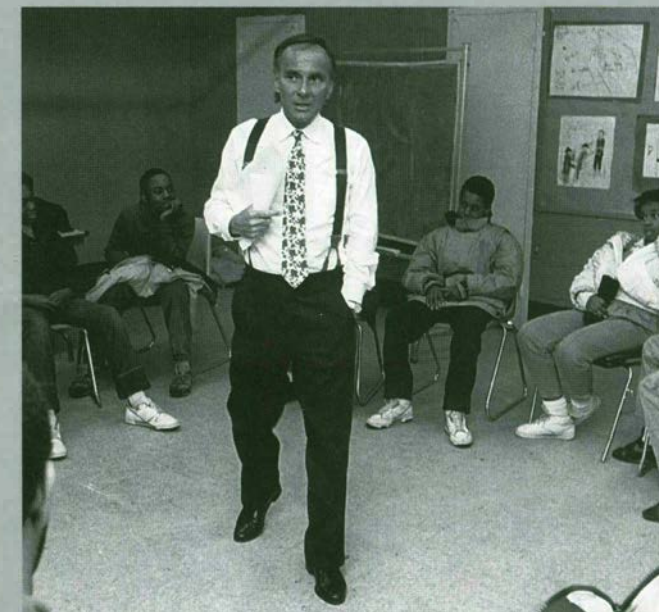
The program isn't cheap—it costs from \$1,200 to \$1,700 a year per participant, not including overhead. New York state and private foundations foot most of the bill. The program now consists of three sites in

But as the social welfare system steps in to counter this disadvantage, it creates what many young women perceive as a reward for early childbearing. The system nurtures young women who have children. It offers them money, status, and some measure of independence for becoming mothers. They receive more attention than those who delay childbearing. Schools for teen mothers are warm and cheerful refuges. Teen mothers who have only one child, in fact, are just as likely to complete high school as their childless classmates. Why? Probably because the system pays so much attention to them.

Fathers, who can be "replaced" with a welfare check, are marginalized. Jobless young men are often shunned by their children's mothers and dismissed by the social welfare establishment as useless. If a family can exist without a stable father figure, why should a young woman seek a permanent father for her children? Why should a young man feel compelled to take responsibility for his children?

It will take bold strategies to reverse this tide of inevitability.

One dramatic solution now being proffered would



The Teen Pregnancy Prevention Program "challenges the way things had been done in the past" in that it views pregnancy as a symptom, not simply a cause, of a troubled life, says Dr. Michael Carrera, the program's director.

Harlem and 20 others across the country, each serving about 40 youths on a first-come, first-served basis.

Carrera's approach seems to work. Between 1985 and 1991, he says, only 12 of the 275 teens participating either became pregnant or fathered a child. A total of 65 participants and parents will be enrolled in Hunter College this fall, and six others will attend college elsewhere.

Geri Peak, director of evaluation and research for

Advocates for Youth, formerly the Center for Population Options, a Washington-based group that follows teenage pregnancy issues, says the program's main strength is its one-stop-shopping approach, which fosters flexibility in addressing participants' needs.

"The emphasis there is on the individual and on what they hope to achieve and gain, and how sexuality can influence those achievements," Peak says. "The emphasis is taken off of pregnancy prevention and sexual intercourse and put on other needs."

The program is also distinctive in that, unlike many other pregnancy-prevention efforts, about half of the 800 teens who take part nationwide are boys. Each center has several male staff members, Carrera says, and makes special efforts to define manhood and maleness in ways that do not involve intercourse.

Zranwea Kpan, a participant at one of the Harlem centers, says he felt particularly comfortable with this approach. The 19-year-old Hunter College student admits he was a "wild child" when he entered the program at age 11. But over the years, he says, the program has taught him self-control and self-awareness.

"It gave me insight that if I do this, this or that might happen," he says.

Earnings from summer jobs obtained through the center helped pay for his new computer, he says. In addition, lessons at the center about the importance of establishing a good credit record prepared him to use his year-old credit card responsibly.

As for family and children, Kpan says, that will have to wait until he is about 30 and done with medical school. "I know that if I were a father now, I'd be short-changing my own future," he says. ♦

Ellen Flax is a New York-based free-lance writer specializing in health, education, and social issues.

cut off welfare payments to mothers and place their children in orphanages, or deny parental rights to men who do not marry their children's mothers. While these strategies would send a powerful message that the current system is failing badly, they would harm the children we seek to protect and undermine the family values we claim to revere.

To reverse this culture of inevitability, we must adopt solutions that strengthen families. Rather than limiting the "rewards" in the welfare system to young women who have out-of-wedlock children, we must consider incentives for delayed childbearing, school completion, community service, work, and marriage. And we must take into account the roles of others who are responsible for teenage childbearing.

The Facts About Teenage Pregnancy

- Every year, more than 1 million American teenage girls become pregnant—roughly one in nine.
- 2,800 adolescents become pregnant each day—1,300 will give birth, 1,100 will have an abortion, and 400 will miscarry.
- 43 percent of all young women become pregnant at least once by the time they reach 20.
- In 1991, American taxpayers spent almost \$30 billion to support families started by a teenage mother.

SOURCE: Advocates for Youth (formerly the Center for Population Options).

It is critical that the men involved in the teen pregnancy explosion be held responsible. Two-thirds of men who father children out of wedlock assume little responsibility—either financially or physically—for their children. Even though paternity establishment among this group of men has increased by 50 percent over the last decade, the rate of those assuming responsibility remains low at 31 percent.

Who are these fathers? While many are teenagers, not all fathers of the children of teen mothers are adolescents—a fact that most teen pregnancy programs fail to address. It is time to acknowledge that many older men

prey on very young teenagers and father their children.

Another set of predators preys on young women too: There is growing evidence of the significant role of rape and sexual abuse as a factor in teenage pregnancy. While the men who commit these crimes may not actually father children, their abuse is a contributing factor in early pregnancy. Any approach to teen pregnancy that ignores—or fails to differentiate—the role of these men is inadequate.

If it is time to demand responsibility, it is also time to be practical.

We must stop condemning *all* sexual activity by *all* teenagers. We should redefine "moral behavior" as responsible sexual activity and agree on a goal of preventing the consequences of irresponsible sexual behavior: sexually transmitted diseases, unnecessary abortions, and out-of-wedlock pregnancy.

For young teens, there is no such thing as consensual or "safe" sex. Younger teens are incapable of making mature and rational decisions about sex and incapable of using birth control effectively. For such teens, abstinence is responsible behavior. For older teens, responsible sexual behavior should be defined as behavior that prevents disease, abortion, and early pregnancy.

It is not enough to give teenagers the resources to behave responsibly. We must also give them incentives. Middle-class teens who avoid early parenting do so in part because they have "futures" to risk: They see themselves completing school and going on to jobs and marriages. There is growing evidence that "hope in the concrete form" is a powerful incentive for disadvantaged teens as well.

Like the teenagers we chastise for seeking immediate gratification, policy makers also are guilty of seeking immediate gratification. There is no instant solution to the calamity of teenage pregnancy. No strategy will reduce the 80 percent teenage pregnancy rates in some urban neighborhoods overnight. A social change that took decades to reach a crisis point cannot be eradicated in a year or two. But the trend can be reversed.

Each strategy that we employ may have only a small effect—a percentage point or two—on teenage childbearing. Yet each percentage point represents an enormous achievement: It represents 5,000 children not born into likely poverty and to parents unable to care for them well. ♦

Kathleen Sylvester is the Progressive Policy Institute's vice president for domestic policy. In the next issue of The New Democrat, Sylvester will outline solutions for easing the teen pregnancy crisis.

NARAL Promoting Reproductive Choices

*file
Jan
Jan '95*

Melanne Verveer
Deputy Chief of Staff to the First Lady
Office of the First Lady
The Old Executive Office Building
Room 100
Washington, DC 20500

February 2, 1995

Dear Melanne:

I am writing to follow-up on our phone conversation about the critical need for a national focus on teenage pregnancy prevention.

We have done some research and analysis of the underlying causes of teenage pregnancy as well as effective programs and policies to reduce the teen pregnancy rate. I am enclosing a chapter on adolescent reproductive health from our policy paper, "Promoting Reproductive Choices: A New Approach to Reproductive Health," which you may find helpful.

Informing our work in this area is our fundamental belief that the nation must elevate the value of reproduction and child-bearing to a higher level; it must then adopt policies that help make every pregnancy a wanted pregnancy and encourage responsible, deliberate decision-making about child-bearing. I sincerely hope that President Clinton's emphasis in his State of the Union address on preventing teenage pregnancy will begin a sorely needed national dialogue on this important issue.

Given the First Lady's interest in this matter, I would like to suggest a meeting with Mrs. Clinton to discuss the elements of an effective national campaign to address teenage pregnancy prevention. I look forward to hearing from you.

Sincerely,

Kate

Kate Michelman
President

Enclosure

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PROTECTING ADOLESCENT REPRODUCTIVE HEALTH

SECTIONS

Comprehensive Sexuality Education

Accessible Reproductive Health Services

Confidential Reproductive Health Services

Successful Life Options Programs

Effective Support Services for Pregnant and Parenting Teens

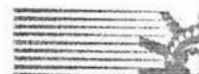
PREGNANCY RATES AMONG AMERICA'S YOUTH ARE AT AN EPIDEMIC HIGH – each year there are approximately one million teen pregnancies.¹ Sexually transmitted diseases (STDs) are rampant – each year three million new cases are diagnosed among adolescents, and one out of five are infected before they reach age 21.² Adolescents often receive inadequate prenatal care and give birth to almost 50,000 low birthweight babies annually.³ Many teens in the United States do not know how to protect their health, and many are living in circumstances that rob them of the motivation and ability they need to take responsibility for their futures. Too many adolescents do not know how to prevent pregnancy, and too many girls choose teen motherhood because they have no hope of finding fulfillment elsewhere.

This escalating crisis is threatening the health of our children and fueling mounting health care costs: every year Americans spend more than 21,000 dollars in neonatal care for each low birthweight infant and almost 40,000 dollars for each person with AIDS.⁴ Unless we ensure that teens have the information, skills and services they need to protect their reproductive health, many of these needless and preventable physical, financial and societal costs will increase. An aggressive national campaign to curb teenage pregnancy and promote adolescent health is essential to protecting our children and to promoting a healthier society.

Comprehensive Sexuality Education >>>

> PROBLEM: *American teens are dangerously uninformed about pregnancy prevention and STDs. Many lack the information and skills they need to postpone premature sexual activity and protect their reproductive health. The physical, financial and societal costs that result can be attributed, in part, to a lack of commitment to comprehensive sexuality education in our nation's schools.*

Although teens in this country are no more sexually active than those in other developed nations, they are less likely to use contraception, more likely to get pregnant and more likely to contract a sexually transmitted disease.⁵ Many adolescents are not getting information from their parents,



The Poor Status of Teen Reproductive Health in America:

- *Nearly half of all sexually active teenage girls in the U.S. do not use birth control.¹⁰*
- *Every year there are approximately one million teenage pregnancies, 81 percent of which are unintended.¹¹*
- *Three million teens annually are infected with a sexually transmitted disease. By age 21, one out of five young people requires treatment for a sexually transmitted disease.¹²*
- *Almost 10,000 cases of AIDS have been reported in Americans aged 20 to 24, most of whom were probably infected during their teen years.¹³*

doctors or schools and are left to rely on cultural and media messages about sex and sexuality: 31 percent of teens have never discussed sexuality or contraceptives with their parents⁶ and pediatricians spend on average only seven seconds per office visit discussing contraception with teenagers.⁷ Almost 30 percent of teens cannot determine whether this statement is true or false: "A girl cannot become pregnant if she douches with Coca-Cola after intercourse."⁸ Moreover, fewer than one in ten children in America receives comprehensive human development and sexuality education from kindergarten through grade 12.⁹

► ***RECOMMENDATION: Comprehensive and age-appropriate human development and sexuality education in grades kindergarten through 12 will lay the foundation for long-term efforts to bring down teenage pregnancy rates and improve adolescent reproductive health. Enabling teens to postpone premature sexual involvement and acquire the information they need to prevent pregnancy and protect their health is crucial to these efforts.***

Parents have the primary responsibility for educating their children about sexuality and reproductive health. Schools, however, also play an important role in the process: 89 percent of adults support the provision of sexuality education in schools,¹⁴ and when given the opportunity to remove their children from such programs, fewer than five percent of parents actually do so.¹⁵ Comprehensive sexuality education is essential to improving adolescent reproductive health and ensuring that adolescents have the information and skills they need to postpone premature sexual activity and protect themselves when they become sexually active. Although many teens are not sexually active, as adults they will need the ability to make responsible decisions about sexuality and their reproductive health. Educational programs should include information about abstinence, but must also prepare teens for healthy and responsible sexual involvement.

The federal government has done little to ensure that there is comprehensive sexuality education in the schools and states have addressed the problem in a largely haphazard and ineffective way. Most teens graduate from high school never having participated in a sequential and developmentally

appropriate sexuality education program. Although 38 states, the District of Columbia and Puerto Rico have developed curricula or guidelines to provide program direction to local school districts,¹⁶ most do not assist schools in developing sexuality education programs that are comprehensive. Fewer than one third of state guidelines cover topics on sexual behavior other than abstinence, and most omit or prohibit controversial topics such as abortion and sexual orientation.¹⁷ South Carolina prohibits discussion of sexual practices outside marriage, and Utah prohibits discussion of homosexuality and the use of contraceptives by unmarried minors.¹⁸

Abstinence should be a major focus of sexuality education. It cannot, however, be the only component. More than 60 percent of males and the majority of females between the ages of 15 and 19 are sexually active.¹⁹ Many programs that focus exclusively on abstinence are ineffective and, in fact, harmful. One widely used program is Sex Respect, a curriculum that links sex with guilt, fear and shame and uses catchy phrases such as "Control your urgin, be a virgin" and "Don't be a louse, wait for your spouse," to instruct teens to avoid all premarital sexual activity.²⁰ Such programs offer virtually no information about how to prevent disease and unintended pregnancy and often alienate teens who are already sexually active. Another prevalent program, Teen-Aid, teaches that "[s]everal factors have been advanced to explain why subsequent children [of a woman who has had an abortion] are battered. Some of the mechanisms are ... after one has aborted a child, an individual loses instinctual control over rage."²¹

In Louisiana, a court found that the Sex Respect curriculum violated a state statute requiring that sexuality education materials be free of medical inaccuracies.

To help ensure that adolescents get the accurate information they need to protect their reproductive health, federal and state policies should promote effective sexuality education in schools. State legislative mandates for comprehensive and accurate programs can help ensure that schools implement more effective and age-appropriate programs, and that teachers receive appropriate and adequate training. In addition, they can provide grounds for challenging curricula that provide teens with inaccurate, misleading or incomplete information. In Louisiana, a court found that the Sex Respect curriculum violated a state statute requiring that sexuality education materials be free of medical inaccuracies, citing a number of passages, including the following:

A male can experience complete sexual release with a woman he doesn't like, whereas a woman usually can't do so unless she loves her partner It's often the girls who are starved for male affection because they didn't have a good relationship with their father who get involved in sex outside of marriage.²²

In addition to requiring that sexuality education programs are comprehensive and accurate, states should also ensure that instructors who teach sexual health topics are adequately trained and provided with up-to-date materials. When sexuality education is taught at all, it is often offered as a short section in another course and the materials used are outdated, uninteresting, inaccurate or difficult to read.²³ Frequently programs are offered by teachers of biology, health education,



A comprehensive sexuality education curriculum should:

- *encourage young people to postpone premature sexual involvement;*
- *start early and provide culturally sensitive, developmentally appropriate information for all age groups from kindergarten through 12th grade;*
- *define sexuality as a normal and healthy part of life;*
- *provide an opportunity for young people to explore their values and beliefs, and prepare them to deal with controversial issues by supplying factual information and support;*
- *help develop self-esteem, personal responsibility, relationship skills and respect for self and others;*
- *provide age-appropriate information on contraceptive methods, use and effectiveness;*
- *provide age-appropriate information about preventive reproductive health care, including protection against STDs and HIV infection; and*
- *furnish information on life options for teens, including education and career planning.*

home economics and physical education who are not trained to teach sexual health education.²⁴ States should establish minimum training standards for teachers responsible for sexuality education and help ensure that appropriate materials are available. Today, only nine states require specialized instruction for sexuality education teachers.²⁵

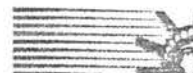
Effective sexuality education programs taught by trained instructors can promote healthier and more responsible behavior among teens. In the Reducing the Risk program, instructors assist tenth-grade students in developing strategies and skills to resist sexual pressure and avoid unprotected intercourse, either by not having sex or by using contraceptives. Students who participated were more knowledgeable about pregnancy prevention and were less likely to become sexually active in the two years following the program.²⁶ In addition to pregnancy prevention, sexuality education programs must teach adolescents how to recognize early signs of pregnancy and the importance of early prenatal care.

Parents, schools, community organizations, health care professionals and religious institutions all have important roles to play in the sexuality education of the nation's youth. To reach teens in the community, school programs must have the support of parents and teachers. The most effective programs coordinate school-based education with services offered by community and religious institutions and provide accurate information in the context of the values and ethical standards of the community.

The religious right is organizing a nationally coordinated grassroots effort to promote harmful curricula like Sex Respect, and to prohibit sexuality education programs that offer teens alternatives other than abstinence to prevent unintended pregnancy or to protect themselves against sexually transmitted diseases. Advocates for comprehensive sexuality education must aggressively organize and educate at the local level so that we as a nation may help our children take responsibility for their reproductive health.

➤ **ACTIONS:**

- *Encourage parents to provide sexuality education to their children by providing accessible resource materials, courses, workshops and programs designed for parents and children together.*
- *Organize at the local level to build support among parents, teachers, school boards and political, religious and community leaders for comprehensive and accurate sexuality education in schools.*
- *Enact state legislation requiring comprehensive and accurate human development and sexuality education in grades K through 12 and ensure model curricula and guidelines are available at the local level.*
- *Provide funding for model comprehensive teen pregnancy prevention programs that include accurate information on sexuality, postponing premature sexual involvement, protection against STDs and HIV infection, and contraceptive use.*
- *Require training and certification for sexuality education teachers and ensure that accurate and updated materials are available.*



Accessible Reproductive Health Services >>>

- **PROBLEM:** *School-based and school-linked health clinics are an important source of health care for adolescents, but there are not enough clinics nationwide and too few provide reproductive health services, including contraceptive care.*

A national reproductive health policy that emphasizes the importance of school-based and school-linked clinics can play a significant role in reducing the alarmingly high rates of teen pregnancy and sexually transmitted diseases. Many adolescents do not have access to comprehensive reproductive care including gynecological exams, nutrition education, contraceptive services, prenatal care, STD prevention and treatment, and abortion services. Approximately 4.5 million adolescents have no health insurance and many have no regular source of health care.²⁷ Medicaid, the single largest public funding source for adolescent health care, assists only one third of all poor adolescents.²⁸ In addition, one third of all Title X clients are teens, and since 1980 the federal government has cut funds for the program by almost two-thirds.²⁹ School clinics provide an accessible, affordable option for teens in need of reproductive health care. In fact, half of the adolescents who rely on school health clinics do not have other sources of health care.³⁰

Although there are more than 84,000 public schools across the country, only 415 of these schools offer school-based health clinics, and only 95 have school-linked clinics.³¹ School clinics can provide an excellent forum to educate and enable teens to protect themselves against sexually transmitted diseases and unintended pregnancy, but most do not provide adequate reproductive health services. Although a majority made referrals for family planning services during the 1989-90 school year, only 28 percent of school-based clinics wrote prescriptions for birth control pills and fewer than 20 percent dispensed contraceptives on site.³² Although school-linked clinics are more likely to provide family planning services, in part because they are not located on school grounds, less than 50 percent write prescriptions for contraceptives or dispense birth control pills, and only 53 percent make condoms available at the clinic.³³ Seventy-three percent of Americans favor making birth control information and contraceptives available through school-based and school-linked clinics.³⁴ In addition, few school clinics, if any, make referrals to abortion providers.³⁵

- **RECOMMENDATION:** *The most effective pregnancy prevention programs integrate education with the provision of reproductive health services. School-based and school-linked clinics and other programs that provide health services, including contraceptive care as well as pregnancy counseling and referrals for prenatal care, adoption and abortion, will better enable teens to protect their reproductive health.*

School-based and school-linked clinics can make a significant difference in the lives of adolescents; for many teens the clinics provide access to reproductive health services, including contraceptives and STD testing, that would be otherwise unavailable. The clinics are located on or near school grounds, provide free or low cost services, and have convenient appointment times, thereby eliminating many of the common barriers faced by adolescents seeking care.³⁶

School-based and school-linked health clinics that provide contraceptive services appear to have helped reduce teen pregnancy rates. A Baltimore, Maryland program called the Self Center offered students classroom-based sexuality education and reproductive health care including gynecological exams, STD testing and contraceptive services in a clinic across the street from the school. By the end of the program's third year, teen pregnancies declined by 30 percent, while pregnancies rose 58 percent in similar schools without clinics.³⁷

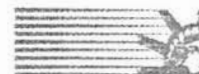
A very successful program in South Carolina that combined sexuality education by teachers, parents and community leaders with a school-based clinic helped reduce the teen pregnancy rate from 61 to 25 percent in three years.³⁸ The positive results of the program were dramatically diminished, however, after the South Carolina legislature banned the distribution of contraceptives in school clinics.³⁹ Only one year after the ban went into effect, pregnancy rates rose to the previous level, largely because contraceptive services were no longer available to many teens in the program.⁴⁰

Projects to increase condom availability provide another avenue through which schools, community groups and religious organizations can address the problems associated with teen pregnancy and sexually transmitted diseases. Next to abstinence, condoms are the most effective method available for reducing the transmission of STDs and HIV infection. Also, unlike the majority of pregnancy prevention efforts, condom availability projects reach adolescent males as well as females.⁴¹ A 1992 Gallup poll found that 68 percent of adults believe condoms should be available in high schools.⁴² Condoms are already available to teens from supermarkets, drugstores, convenience stores and vending machines. Making them available through school programs helps ensure that when teens obtain condoms, they also receive accurate and understandable information on how to use them properly.

More than 70 school-based health clinics make condoms available to sexually active students.⁴³ In the first year that condoms were distributed in the District of Columbia public schools, 1,600 students requested them and preliminary data indicates 300 fewer teenage pregnancies during the school year and a 30 percent decrease in the number of sexually transmitted diseases compared to pre-existing levels.⁴⁴

More than half of the funding for school-linked and school-based clinics is provided by state and federal sources, predominantly from state health departments and federal Maternal and Child Health block grants.⁴⁵ Government support for contraceptive services is necessary to ensure that school health clinics provide reproductive health care, including contraceptive services. In addition, school board members, parents, teachers and religious and community leaders committed to ensuring the availability of sexuality education and contraceptive care are essential to the success of any school-based health program.

By the end of the third year of the Self Center program in Baltimore, teen pregnancies declined by 30 percent, while pregnancies rose 58 percent in similar schools without clinics.





► **ACTIONS:**

- *Ensure national health care reform recognizes the importance of reproductive health care for teens and encourages the provision of confidential services within the school system.*
- *Make government and private funds available for school-based and school-linked health clinics that fully address the reproductive health needs of adolescents.*
- *Organize at the community level to ensure that the full range of reproductive health services are provided in school clinics, including treatment for sexually transmitted diseases, contraceptive services, and information about and referral for prenatal care, abortion and adoption.*
- *Build local support to implement programs in schools that provide education about and access to condoms.*

.....
Confidential Reproductive Health Services ►►►

- **PROBLEM:** *Teen health is endangered when confidentiality is not assured because many adolescents will delay or avoid seeking early and appropriate reproductive health services. Laws that require parental consent for reproductive health care can lead to inadequate prenatal care, later and more risky abortions and even dangerous illegal alternatives.*

The need for privacy and confidentiality is repeatedly cited by teenagers as a critical factor in deciding whether to seek reproductive health care.⁴⁶ Healthy outcomes for pregnancy, sexually transmitted diseases and other reproductive health conditions often depend on an individual obtaining timely medical care. Decisions about pregnancy are best made early, so that if a young woman plans to carry to term she can get adequate prenatal care, and if she decides to terminate the pregnancy she can obtain a safe abortion. Early diagnosis and treatment of sexually transmitted diseases enable teens to avoid the much more serious and expensive health problems that result from untreated infections.⁴⁷ Because some teens will delay or avoid seeking reproductive health services if they think their parents will be told, virtually every state has enacted legislation that protects the confidentiality of minors seeking health care for STDs, yet many states have imposed mandatory parental consent or notice laws on minors in need of abortion services, at times with tragic results.⁴⁸

Laws that restrict minors' access to abortion by mandating parental involvement harm teens and families. In a recent study, the American Medical Association found that "[b]ecause the need for privacy may be compelling, minors may be driven to desperate measures to maintain the confidentiality of their pregnancies. They may run away from home, obtain a 'back alley' abortion, or resort to self-induced abortion. The desire to maintain secrecy has been one of the leading reasons for

illegal abortion deaths since . . . 1973.”⁴⁹ Rebecca Bell, a young woman in Indiana, died tragically from an illegal abortion because she did not want her parents to know about her pregnancy and state law required parental notice before she could have a legal abortion.⁵⁰ Thirty-eight states have enacted parental consent or notice requirements for minors seeking abortion, although only 22 are enforced.⁵¹

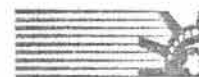
► **RECOMMENDATION:** *Confidential reproductive health services must be available to teens. Concerns about privacy and confidentiality are paramount to adolescents deciding whether and where to seek reproductive health care. Though adolescents should be encouraged to involve a parent, laws that require parental consent or notice for reproductive health care endanger teens.*

Parents should be involved when a child is facing any health problem, and most teens do involve a parent when they are facing a crisis pregnancy. Regardless of mandatory parental consent or notice requirements for abortion, more than 75 percent of minors under age 16 involve one or both parents.⁵² The government, however, cannot mandate healthy family communication where it does not already exist. Patient-doctor confidentiality is critical to providing reproductive health services for young people.⁵³ Major health organizations, including the American College of Obstetricians and Gynecologists, the American Academy of Family Physicians, the American Academy of Pediatrics, the National Medical Association and the Organization of Obstetric, Gynecologic, and Neonatal Nurses agree that though health professionals must make every “reasonable effort to encourage adolescents to involve parents . . . [u]ltimately the health risks to the adolescents are so compelling that legal barriers and deference to parental involvement should not stand in the way of needed health care.”⁵⁴ Unless adolescents have access to confidential health care, too many will be left untreated or will turn to unhealthy and dangerous alternatives.

..... **R**egardless of mandatory parental consent or notice requirements for abortion, more than 75 percent of minors under age 16 involve one or both parents.

► **ACTIONS:**

- **Ensure national health care reform protects confidentiality for adolescents seeking reproductive health care.**
- **Eliminate mandatory parental consent and notice laws, as these restrictions discourage and prevent minors from seeking early and appropriate treatment.**



Successful Life Options Programs >>>

- **PROBLEM:** *Teens need more than sexuality education and contraceptive care to avoid too-early childbearing. Adolescents are not motivated to postpone pregnancy if they have low self-esteem, limited employment and educational opportunities, and little hope for the future.*

Even if sexuality education and reproductive health services are made available, young people will not avoid pregnancy unless they can envision positive alternatives to teen parenthood and are motivated to plan for the future.⁵⁵ The young women and men most likely to become teen parents are those who live in poverty and who have low self-esteem and low expectations for completing

their education or finding employment.⁵⁶

Teenage girls with poor academic skills are five times as likely to become mothers before age 16 as are teenagers with average or above average skills in school.⁵⁷ When young girls are shown alternatives to teen pregnancy and empowered with the belief that they can achieve alternative goals, they are more likely to postpone childbearing until after their teen years.

..... **P**articipants in the Girls Inc. life options programs were more likely to postpone sexual involvement, more likely than other teens to use contraceptives and less likely to become pregnant.

Successful teen pregnancy prevention programs build on the premise that in order to avoid pregnancy, adolescents need opportunities and motivation as well as sexuality education and contraceptive services.⁵⁸ The challenge is to make options available to adolescent girls that are just as emotionally satisfying as the idea of motherhood.⁵⁹ Life options programs emphasize decision-making and problem-solving skills, provide work and educational experiences, and help teens develop self-esteem and social responsibility.⁶⁰

- **RECOMMENDATION:** *In order to postpone childbearing, adolescents need motivation, self-esteem and opportunities for the future as well as sexuality education and contraceptive services.*

Life options programs are critical to the reproductive health of some adolescents at risk of unintended pregnancy, particularly those who have few expectations for the future. In combination with education and health services, life options programs can be effective in providing teens with the motivation to postpone childbearing. One life options program, the Summer Training and Education Program (STEP), is designed to help 14- and 15-year-olds avoid unintended pregnancy and stay in school. STEP is a 15-month program that uses summer income as an incentive for teens to enroll for two consecutive summers of reading and math instruction, work experience and developing skills for responsible social and sexual attitudes and behavior. STEP also provides support services

during the academic year, such as counseling, group activities, workshops and meetings with parents. Preliminary findings indicate that STEP is effective in reducing school dropout rates and educating participants about contraceptive use.⁶¹

Girls Inc.'s three-year Preventing Adolescent Pregnancy Program offers a comprehensive approach to preventing unintended pregnancy, including education, health services and life options. Through the "Growing Together" component of the program, girls and their mothers practice communicating about sexuality. Girls learn to resist pressures to have sexual intercourse in "Will Power/Won't Power." It is imperative that job training and educational programs address the needs and goals of female adolescents and the "Taking Care of Business" segment offers older girls career planning and goal-setting together with information on sexuality, reproduction and contraception. The "Health Bridge" program coordinates health education, including contraception, with comprehensive health services in a neighborhood clinic. Participants in the Girls Inc. life options programs were more likely to postpone sexual involvement, more likely than other teens to use contraceptives and less likely to become pregnant.⁶²

► **ACTIONS:**

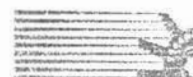
- *Make government funds available for life options programs, and organize partnerships among state and local agencies, civic groups, businesses, religious organizations and community groups to establish community-based programs that enhance the life options of teens.*
- *Engage local businesses in mentoring programs, internships and adopt-a-classroom programs that enhance life options and future employment opportunities for teens.*
- *Ensure that educational and job training programs include female adolescents and address their particular needs and goals.*

.....

Effective Support Services for Pregnant and Parenting Teens >>>

- **PROBLEM:** *A serious lack of support services for pregnant adolescents and teen parents is endangering their health and the well-being of their children.*

A comprehensive policy to address the reproductive health needs of teens must include services for pregnant teens as well as programs designed to reduce unintended pregnancy. Many young women lack the information and resources necessary to meet their health needs during pregnancy. More than half a million children each year are born to teenage girls.⁶³ Between 1986 and 1991, birth rates for teenagers under 18 increased by 27 percent, and 19 percent for women aged 18 and 19.⁶⁴



Adolescents are more likely than other women to deny they are pregnant, less likely to understand the importance of early and regular prenatal care, and less likely to know how or where to receive care.⁶⁵ As a consequence, infants of adolescents are more likely to have low birth weight, be born prematurely, and die in the first year of life.⁶⁶ Thirty-three percent of pregnant teens obtain inadequate care, and the rate is even higher for younger teens.⁶⁷ Due to their young age, adolescents have greater nutritional needs and are less likely to gain adequate weight during pregnancy.⁶⁸ In addition, they are at high risk for unhealthy births because they are less likely to know which behaviors can harm a pregnancy.⁶⁹ Adolescents need access to counseling that can assist them in making the right decision for themselves about whether or not to carry their pregnancies to term and how and where to obtain affordable, quality prenatal care, adoption or abortion services.

Without adequate support services, the negative social, economic and health consequences of too-early childbearing can be profound and often last a lifetime: Many teen mothers have few skills and little education, and face low-paying jobs, unemployment, poverty and dependence on government assistance.⁷⁰ Families headed by young women are seven times as likely as other families to live below the poverty level.⁷¹ Women who become mothers in their teen years are less likely to complete their education and are at greater risk of low wages and poverty throughout their lives.⁷² Although high school completion rates have increased in recent years for pregnant and parenting adolescents, it is estimated that only 56 percent of teen mothers will graduate from high school.⁷³ Moreover, young women with children are less likely to go to college and on average will make half the lifetime earnings of those who delay childbearing until after their teen years.⁷⁴

► **RECOMMENDATION:** *Comprehensive programs that coordinate education, confidential health care, child care, employment and social services for pregnant and parenting adolescents will have positive long-term effects on the health and well-being of families. The provision of adequate and timely support services will better enable teen mothers to raise healthy children and attain economic self-sufficiency.*

Pregnant teens need access to prenatal care offered in a comfortable setting that includes guidance about how to stay healthy and avoid risky behavior. Young pregnant women who are dependent on drugs or alcohol need to know such behaviors can seriously endanger a pregnancy, and must have access to treatment programs tailored to the needs of pregnant adolescents. To reach pregnant girls at risk of unhealthy births, Johns Hopkins University Hospital opened a bright storefront clinic offering "prenatal-plus" services at a shopping mall. In addition to providing health services, the staff offers counseling to pregnant girls about their schoolwork and job prospects, relationships with family and friends, and fears about parenthood and how they will care for their children.⁷⁵

Pregnant and parenting adolescents often need special assistance to complete their education and to properly care for their children, including information about prenatal care, nutrition, immunization and family planning, as well as hands-on training in bathing an infant and child-proofing a house. In San Francisco, the Teenage Pregnancy and Parenting Program (TAPP) links teens with

health and social services offered by over 30 agencies, and provides an alternative school with on-site child care and health care. TAPP has been effective in encouraging school attendance and preventing subsequent pregnancies, which compound the consequences of first births.⁷⁶

Just as those adolescents who choose to continue their pregnancies need special support such as counseling and prenatal care, those adolescents who decide to have an abortion should also receive support in exercising that choice. Many teens have difficulty obtaining early abortion services because they do not have access to medical care, money and transportation. To ensure that adolescents receive health services, including abortion, as early as possible during a pregnancy, they should have ready access to confidential counseling and health care, referrals to qualified local health professionals who provide abortion services, and funds to pay for abortion services and other associated costs.

➤ **ACTIONS:**

- ***Make funds available for teen parenting support programs that include an aggressive outreach component. Programs should help pregnant teenagers obtain early and adequate prenatal care and include stay-in-school components such as General Equivalency Diploma (GED) preparation, child care and vocational education programs.***
- ***Ensure the availability of parenting programs that provide teens with practical instruction on how to care properly for their infants.***
- ***Expand existing services such as Medicaid and the Special Supplemental Food Program for Women, Infants and Children (WIC) to reach more pregnant adolescents.***
- ***Ensure access to counseling and services that will enable teens to make and implement responsible decisions about pregnancy, including parenthood, adoption and abortion.***



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THE WHITE HOUSE

WASHINGTON

May 4, 1995

MEMORANDUM FOR: THE FIRST LADY
MAGGIE WILLIAMS
MELANNE VERVEER

FROM: BILL GALSTON *WAG*
JANET ABRAMS

SUBJECT: ADMINISTRATION INITIATIVES IN TEEN
PREGNANCY PREVENTION

Since the State of the Union, efforts have been underway to create a national voluntary organization to serve as a focal-point for efforts to reduce teen pregnancy. As you have noted, it is important that this initiative be presented and perceived as a private-sector partner for administration initiatives. To that end, we have assembled summaries of the range of administration policies that contribute to reducing teen pregnancy. They include:

- o a number of service and research programs within the Department of Health and Human Services
- o programs across several agencies to promote youth development and address various risk factors associated with teen pregnancy
- o current and proposed welfare reform measures to provide young men and women with incentives to delay parenthood until they are married and able to support their children
- o a comprehensive attack on background economic and social factors contributing to rising teen pregnancy rates, including poverty, unequal educational opportunity, and disinvestment in distressed urban and rural communities

We attach first drafts of background documents on each of these categories. Suitably refined, these documents could be made public, or used as the basis of administration statements, when the new voluntary organization is announced. This approach would add substance and credibility to our overall message of public/private partnership to combat teen pregnancy.

Department of Health and Human Services Efforts in Adolescent Pregnancy Prevention

Numerous offices and agencies across the Department have programs that address the issue of adolescent pregnancy prevention, including repeat pregnancies. Only a few focus specifically on teen pregnancy. Given that the multiple problems adolescents face are often interrelated, the specific problems that other programs emphasize (i.e., substance abuse, education, etc.) are also related to adolescent pregnancy prevention. Below is a brief summary of some of these efforts. This list is not meant to be a comprehensive list, but one that demonstrates the types of activities occurring in the Department.

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- Through the MCH Services Block Grant and Special Projects of Regional and National Significance (SPRANS) funding, adolescent health has become a major component of each state's Maternal and Child Health program. Forty-three states and the District of Columbia have adolescent health coordinators/directors. The Maternal and Child Health Bureau has sponsored annual meetings since 1988 for training, networking, and resource sharing for these adolescent health coordinators/directors. The Bureau recently completed the State Adolescent Health Coordinator 1995 Profile of Adolescent Pregnancy Prevention which summarizes the assessment, policy development, and assurance activities found in 35 states.

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and alcohol abuse, tobacco use, unintentional and intentional injuries, diet and physical inactivity. These high risk behaviors are associated with increased risk of adolescent pregnancy.

- The Centers for Disease Control and Prevention Division of Reproductive Health and Division of Adolescent and School Health received approximately \$4.5 million in FY 1995 to develop a teen pregnancy prevention initiative. These funds are being used to improve teen pregnancy surveillance, to support the development of a national strategy for teen pregnancy prevention and to assist local communities in designing, implementing and evaluating Community Demonstration Programs for Teen Pregnancy Prevention. Surveillance activities include the enhancement of state-based vital records systems to provide the information for the calculation of teen pregnancy rates and the development of an ongoing system for routinely generating national and state pregnancy reports for teens. The national strategy is designed to enlist the assistance of various public and private partners in national communication and programmatic efforts necessary to positively influence teen decisions regarding abstinence, use of contraceptives and pregnancy. Approximately 12 Community Demonstration Programs will be funded to develop plans for implementing innovative, comprehensive, community-based interventions to reduce teen pregnancy. Eligible communities must have an existing community partnership, experience in dealing with prevention of teen pregnancy, a base population of at least 200,000 and a teen birth rate at least 1.5 times as high as the national average. Program evaluation assistance will also be provided to communities so that lessons learned by these programs can be used in support of other community-based efforts throughout the country to prevent teen pregnancy and related problems. This initiative is being developed and implemented in strong partnership with the Office of Population Affairs (OPA).
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- States would have the flexibility to try innovative ways to encourage responsible behavior, such as rewarding teen recipients who make progress in school and sanctioning those who drop out.

The Clinton plan also included provisions to support communities in their teen pregnancy prevention efforts:

- Grants would be provided to school-based teen pregnancy prevention programs in high-risk areas of the country.
- A national teen pregnancy clearinghouse would be established to disseminate information on model prevention programs.

LIFELONG LEARNING

"We can do all these things -- put our economic house in order, expand world trade, target the jobs of the future, guarantee equal opportunity -- but if we're honest, we'll admit that this strategy still cannot work unless we also give our people the education, training, and skills they need to seize the opportunities of tomorrow."

President Clinton
State of the Union Address
January 25, 1994

Pre-School and Parenting, so that every child starts school ready to learn.

- Reformed Head Start to create tough new quality standards, reduce child-to-teacher ratios, expand services, and create the new Early Head Start for infants and toddlers.
- Expanded Head Start to enable over 130,000 more children to participate in 1995 than in 1993 -- with a proposed increase of 31,500 for 1996.
- Introduced the new Early Head Start for infants and toddlers.

Goals 2000 and School Improvement, to enable our K-12 students to pursue challenging academic standards -- and meet them.

- Signed the Goals 2000: Educate America Act, including the Safe Schools Act, and the Improving America's Schools Act, to provide top-down support for bottom-up reform.
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School to Work Opportunities, to prepare all young people for further education and first jobs that lead to high-wage, high-skill careers.

- Signed the School-to-Work Opportunities Act to support efforts in all 50 states to create and reform school-to-work systems. The Act sunsets in 2001 -- a limited national catalyst for local initiatives.
- Every school-to-work initiative will enable all participants to develop high-level academic and technical skills, obtain a high school diploma and an occupational skills

certificate, and move toward further training and first jobs that lead to high-skill, high-wage careers.

National Service, so young people have a chance to help their communities -- and help pay for college, too.

- Signed the National and Community Service Trust Act, creating AmeriCorps, the new national service initiative.
- AmeriCorps gives young people the chance to spend a year or more in tough, direct service making our people safer, smarter, and healthier -- while earning an award of nearly \$5000 per year to pay for college or job training.
- AmeriCorps already engages 20,000 Americans as AmeriCorps Members in more than 350 community efforts around the country.
- AmeriCorps relies on the initiative of communities and the support of states to change communities from the inside out -- not with bureaucracy, but with citizens helping each other and building voluntary organizations -- getting things done.
- College Loans, so that every American is able to borrow the money to pay for college and pay it back on an affordable schedule.
- Signed into law the biggest change in student loans ever -- a new direct lending program which takes the middlemen out of the process.
- Will enable any student to get loans for college or job training and repay them in one of four ways, including "pay-as-you-can" repayments as a small percentage of income over time. Students can change repayment plans throughout the life of their loans, and "pay-as-you-can" gives them more freedom to choose careers without repayments as a dominant concern.
- Dramatically cut back red tape, making it faster and easier for students to get the money to pay for college.
- Will save taxpayers more than \$6 billion by the year 2000.

Training and Reemployment, so Americans can continuously learn to obtain better jobs and better wages.

- President Clinton has proposed comprehensive reforms for Congress to enact.

REWARDING WORK FOR WORKING FAMILIES

Earned Income Tax Credit

- The 1993 expansion gives 15 million working families a tax cut.
- The credit returns a total of \$21 billion to working families making up to \$28,500 per year.
- When fully phased in, the EITC will offer a maximum credit of about \$3,560 for families with two or more children, more than double the maximum basic credit of \$1,511 in 1993.

Making Work Pay -- The Minimum Wage

- The President has proposed increasing the minimum wage from \$4.25 to \$5.15 over two years through two 45-cent increases.
- The proposal would offer 11 million workers a raise and provide a full-time, year-round worker a raise of \$1800 a year -- as much as the average family spends on groceries in over 7 months.
- Over a dozen empirical studies show a proposal like the President's can increase wages without costing jobs.

Family and Medical Leave Act

- In February 1993, President Clinton signed the Family and Medical Leave Act, mandating 12 weeks of unpaid, job-guaranteed leave for childbirth, adoption, or illness of an employee or family member.
- The Department of the Treasury estimates that 42.5 million American workers are covered under the new legislation.
- The General Accounting Office estimates that up to 2.54 million workers were likely to need unpaid leave in 1993.

COMMUNITY EMPOWERMENT

"For a long time the government really thought that if we just had a solution designed here in Washington that was properly funded, we could solve the problems of every community in the country. Well, we learned that that wasn't true. But we've also learned ... that neglect is not a very good policy either. (There) needs to be a new partnership between Washington and the communities and the individuals of this country, and there needs to be a way of doing business in which we try to create the conditions in which people can seize opportunities for themselves."

President Clinton

January 17, 1994

Empowerment Zones and Enterprise Communities

- In 1993, President Clinton's Empowerment Zones and Enterprise Communities ("EZ/EC") legislation passed Congress, offering \$2.5 billion in tax incentives and \$1 billion in flexible block grants to more than 100 communities. The initiative is designed to create jobs and help communities to rebuild themselves from the inside out.
- 526 communities around the country engaged in long planning processes and submitted EZ/EC applications to the Administration.
- After a lengthy and thorough review process, on December 21, 1994, President Clinton and Vice President Gore announced nine EZs and two supplemental urban zones, along with the 95 ECs four of which received enhanced grants.

The Community Development Banking and Financial Institutions Act

- In 1994, the President's Community Development Banking and Financial Institutions Act became law, the first step to fulfilling his pledge to create a national network of community development financial institutions (CDFIs). In 1995, Congress appropriated \$125 million for the initiative, and the Administration has requested an additional \$375 million over the next four years.
- The Act creates a fund to provide equity investments, deposits, grants, loans, technical and training assistance to CDFIs that are starting up or expanding.
- When fully leveraged, the Act could create about \$2 billion in new investments by homeowners, businesspeople, and others who are building up low-and moderate-income communities.
- The Act will provide as many as 40,000 loans to entrepreneurs, expanding businesses, homeowners, and others who might not otherwise be able to obtain credit.

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THE WHITE HOUSE

WASHINGTON

May 4, 1995

MEMORANDUM FOR: THE FIRST LADY
MAGGIE WILLIAMS
MELANNE VERVEER ✓

FROM: BILL GALSTON WA9
JANET ABRAMS

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- AmeriCorps relies on the initiative of communities and the support of states to change communities from the inside out -- not with bureaucracy, but with citizens helping each other and building voluntary organizations -- getting things done.
- College Loans, so that every American is able to borrow the money to pay for college and pay it back on an affordable schedule.
- Signed into law the biggest change in student loans ever -- a new direct lending program which takes the middlemen out of the process.
- Will enable any student to get loans for college or job training and repay them in one of four ways, including "pay-as-you-can" repayments as a small percentage of income over time. Students can change repayment plans throughout the life of their loans, and "pay-as-you-can" gives them more freedom to choose careers without repayments as a dominant concern.
- Dramatically cut back red tape, making it faster and easier for students to get the money to pay for college.
- Will save taxpayers more than \$6 billion by the year 2000.

Training and Reemployment, so Americans can continuously learn to obtain better jobs and better wages.

- President Clinton has proposed comprehensive reforms for Congress to enact.

REWARDING WORK FOR WORKING FAMILIES

Earned Income Tax Credit

- The 1993 expansion gives 15 million working families a tax cut.
- The credit returns a total of \$21 billion to working families making up to \$28,500 per year.
- When fully phased in, the EITC will offer a maximum credit of about \$3,560 for families with two or more children, more than double the maximum basic credit of \$1,511 in 1993.

Making Work Pay -- The Minimum Wage

- The President has proposed increasing the minimum wage from \$4.25 to \$5.15 over two years through two 45-cent increases.
- The proposal would offer 11 million workers a raise and provide a full-time, year-round worker a raise of \$1800 a year -- as much as the average family spends on groceries in over 7 months.
- Over a dozen empirical studies show a proposal like the President's can increase wages without costing jobs.

Family and Medical Leave Act

- In February 1993, President Clinton signed the Family and Medical Leave Act, mandating 12 weeks of unpaid, job-guaranteed leave for childbirth, adoption, or illness of an employee or family member.
- The Department of the Treasury estimates that 42.5 million American workers are covered under the new legislation.
- The General Accounting Office estimates that up to 2.54 million workers were likely to need unpaid leave in 1993.

COMMUNITY EMPOWERMENT

"For a long time the government really thought that if we just had a solution designed here in Washington that was properly funded, we could solve the problems of every community in the country. Well, we learned that that wasn't true. But we've also learned ... that neglect is not a very good policy either. (There) needs to be a new partnership between Washington and the communities and the individuals of this country, and there needs to be a way of doing business in which we try to create the conditions in which people can seize opportunities for themselves."

President Clinton
January 17, 1994

Empowerment Zones and Enterprise Communities

- In 1993, President Clinton's Empowerment Zones and Enterprise Communities ("EZ/EC") legislation passed Congress, offering \$2.5 billion in tax incentives and \$1 billion in flexible block grants to more than 100 communities. The initiative is designed to create jobs and help communities to rebuild themselves from the inside out.
- 526 communities around the country engaged in long planning processes and submitted EZ/EC applications to the Administration.
- After a lengthy and thorough review process, on December 21, 1994, President Clinton and Vice President Gore announced nine EZs and two supplemental urban zones, along with the 95 ECs four of which received enhanced grants.

The Community Development Banking and Financial Institutions Act

- In 1994, the President's Community Development Banking and Financial Institutions Act became law, the first step to fulfilling his pledge to create a national network of community development financial institutions (CDFIs). In 1995, Congress appropriated \$125 million for the initiative, and the Administration has requested an additional \$375 million over the next four years.
- The Act creates a fund to provide equity investments, deposits, grants, loans, technical and training assistance to CDFIs that are starting up or expanding.
- When fully leveraged, the Act could create about \$2 billion in new investments by homeowners, businesspeople, and others who are building up low-and moderate-income communities.
- The Act will provide as many as 40,000 loans to entrepreneurs, expanding businesses, homeowners, and others who might not otherwise be able to obtain credit.