

Kathleen Sylvester

Welfare Reform: For Mothers, Second Homes ...

As the welfare debate begins in the Senate, politicians are still deeply divided about what to do with teenage welfare mothers. Many Republicans, whose goal for welfare reform is to punish illegitimacy, want to teach teenage mothers a lesson. They have a point.

We should teach these young women a lesson. We should teach them to be good mothers, and good workers and good citizens. And we should send a strong message that government no longer offers unconditional support for young women who bear children out of wedlock.

But for welfare reform to accomplish its most appropriate goal—helping young mothers become self-sufficient—it can't be based on stereotypes.

Who are teenage mothers? Most come from homes strained by poverty and dysfunction. Most teenage mothers do badly in school; many drop out before they become pregnant. They have been badly nurtured. Many have been subjected to neglect or physical violence. Some studies show that as many as two-thirds were victims of rape or sexual abuse at an early age—crimes often committed by males living in the same household. As a result, many of these young women suffer from mental and emotional problems.

They are easy prey for older men; young women who have been victims of

early sexual abuse often develop emotional patterns that make them vulnerable to the attentions of older men. A study released last week by the Alan Guttmacher Institute suggests that almost two-thirds of teenage mothers have babies fathered by men who are 20 or older.

Teenage mothers' life prospects are severely limited by their lack of socialization: They learn how to treat their own children from the parents who raised them; they model social behavior after peers from the same neighborhoods. They have few models for any other life. With so many obstacles and so few skills, these very young welfare mothers are the wrong candidates for a thoughtless experiment in welfare reform.

So if Congress is serious about imposing such obligations, it's time to revive an old institution—the maternity home—in a new form. Congress should adopt the proposal, offered by Sens. Daschle, Breaux and Mikulski, or a similar proposal by Sen. Kent Conrad to use federal funds to help communities create a national network of "second-chance homes." These would be homes in which mothers under age 18 would live with adult supervision, while learning to be good parents and good citizens.

The solution to welfare reform is not to cut off the welfare checks of teenage

mothers. Nor, for a large percentage of these young women, is the answer to insist that they continue to live in the homes where they grew up. Politicians who offer such simplistic solutions are ignoring the reality of teenage mothers' lives. Politicians who suggest that they should live at home "or in an adult-supervised setting" are hypocrites unless they guarantee young mothers safe and stable alternatives.

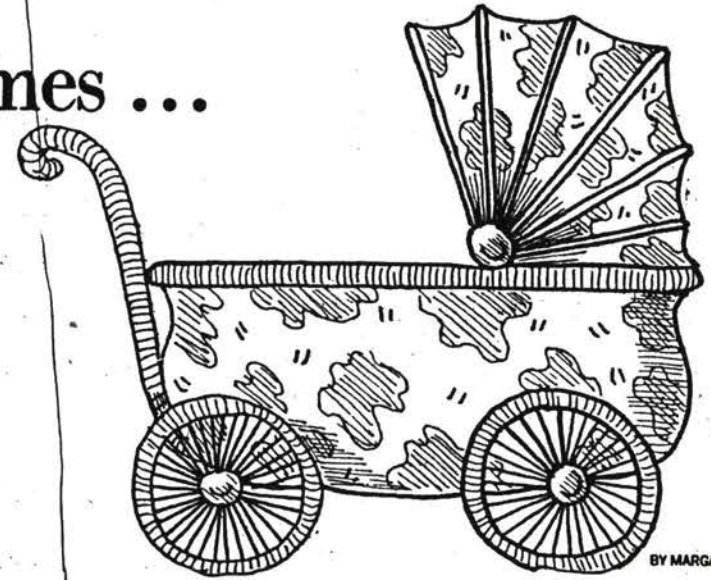
Prototypes for such "second-chance homes" already exist in communities as varied as Washington, New Albany, Ind., Albuquerque and Wheeling, W. Va. These vary widely. But all offer the three elements that teenage welfare mothers need to change their lives: socialization, nurturing and support, structure and discipline.

And they all offer a genuine social contract. The mothers who live in these homes must stay in school or job training. They must stay drug-free and abide by curfews. They learn to cook and clean, to manage money, to get along with each other and resolve conflicts. In return, they get protection from violent family members and abusive boyfriends. They get help with day care and health care and schoolwork. Most important, they learn to nurture their children well.

Not every young woman who gets a "second chance" in one of these homes

succeeds. But these homes have produced notable and promising results: fewer second pregnancies, slightly higher adoption rates, less child abuse, better maternal and child health, dramatically increased school completion rates for mothers, higher employment rates and reduced welfare dependency.

Thus the homes offer a critical element now missing in most efforts to help welfare mothers: connection to community and community standards. Most of the homes are shoestring operations, reliant on community support. The churches and civic organizations and local businesses become engaged in the lives of the young mothers and children.



This idea may not be bold enough for those politicians who want to make teenage mothers a "moral" issue. But it is the moral choice to make because it will help their children—those whom the welfare system was designed to protect.

The goal is far from impossible. In 1993 the U.S. Department of Health and Human Services reported that about 67,000 welfare mothers were under age 18. Surely a nation as large as ours can find a way to take in 67,000 mothers and their babies.

The writer is vice president for domestic policy at the Progressive Policy Institute.

No Loophole for Insurance Companies

Robert Novak has now written three columns on the taxation of mutual life insurance companies and has demonstrated that even a giant among syndicated columnists occasionally strikes out.

In his most recent column ["Long Lived Loophole," op-ed, July 20], Mr. Novak asserts, first, that a loophole in the tax law allows mutual companies to obtain a \$1 billion to \$1.5 billion annual advantage and, second, that the effective rate of tax on mutual companies is 11 percent. Each of these assertions is demonstrably incorrect.

Far from being a loophole, the provision of the tax code to which Mr.

Novak refers, Section 809, imposes an additional tax on mutual companies not imposed on their shareholder-owned competitors. Since its enactment in 1984, Section 809 has been studied by the Treasury Department, the General Accounting Office and a number of independent public finance economists, including Henry Aaron of the Brookings Institution and Michael Boskin of Stanford University, former chairman of the Council of Economic Advisers. These studies have uniformly concluded that Section 809 imposes an unjustified extra tax on mutual companies in the nature of a penalty and that the provision should be repealed.

To put it bluntly, each and every knowledgeable authority has reached a conclusion exactly opposite to that of Mr. Novak, a point nowhere mentioned in his column.

Mr. Novak's claim that mutuals pay an effective tax rate of 11 percent is hugely in error, even judged under the most lenient journalistic standards. In fact, the effective tax rate actually imposed on mutual companies is 33 percent, triple the rate postulated by Mr. Novak.

HARRY P. KAMEN

Chairman of the Board and Chief Executive Officer
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Banks Don't Discriminate Against Women

The story "Women Do Well in Business, but Not as Well at the Bank" [Business, July 27] offers no persuasive evidence that banks discriminate against women in terms of loans and provides a prime example of distortionary statistics.

The article cites a survey of 1,071 female business owners in which two-thirds of respondents said they had problems working with their financial institutions and one third perceived gender discrimination. I'm sure that all businesses—both male- and female-owned—have trouble working with their banks on occasion (Woodward & Lothrop, for example), and perception of discrimination does not constitute proof.

Significantly, the one case of discrimination cited in the article was denial of a loan to a woman from the (female-operated) First Women's National Bank without her husband's signature. The applicant then received a loan from the presumably

male-dominated Maryland National Bank.

Few studies of commercial lending by sex have been produced because of the difficulty of tracing the sex of the borrower. However, extensive data is collected on mortgage applications by sex, and the latest analysis of the Home Mortgage Disclosure Act data in the February 1995 Federal Reserve Bulletin shows conclusively that the rate of denial of mortgage applications is far higher for single males than for single females for both government-backed and conventional loans. Similar results were found almost 25 years ago in a book analyzing housing markets in New York and California titled "Discrimination in Mortgage Lending" by Robert Schaefer and Helen Ladd.

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THE WHITE HOUSE

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January 29, 1996

REMARKS BY THE PRESIDENT
IN STATEMENT ON TEEN PREGNANCY

The Roosevelt Room

11:53 P.M. EST

THE PRESIDENT: Thank you. Thank you. Thank you, Secretary Shalala, Dr. Foster, to the distinguished American citizens who are here behind me, and all of you who are out here with them. I thank the members of Congress who are here: Senator Pell, Senator Murray, Senator Chafee, Congresswoman Clayton and Congressman Stokes. Thank you all for being here and for your interest in this important issue.

In the State of the Union address I said that I felt our country was facing seven great challenges that we had to meet together as a community, challenges that we could not solve if our people were simply left to fend for themselves. I do believe that we are moving into a period of enormous possibility for our people. I honestly believe that for Americans who are positioned to take advantage of the world that we're living in and the one toward which we are going, there will be more opportunities to fulfill their dreams than ever before in our history.

But I also know that many, many Americans -- indeed, millions of Americans will be blocked from that age of possibility unless we succeed in meeting all these challenges. And the very first one that I started with in the State of the Union is the one I want to talk about today -- our obligation to cherish our children and strengthen our families.

Secretary Shalala talked about the efforts we're making in welfare reform and how it relates to this. And we've talked elsewhere about what we're trying to do to discourage young people from smoking because that presents, by far, the greatest health damage that they face today.

This morning we want to talk about teen pregnancy, because it is a moral problem and a personal problem and a challenge that individual young people should face, and because it has reached such proportions that it is a very significant economic and social problem for the United States. The rates here, of course, are mirrored in many other countries in the world, but they're also causing the same kind of problems elsewhere, and that doesn't make it right.

Teen parents often don't have the education they need, don't have the self-awareness they need, don't have the self-confidence they need to make the most of their own lives in the work force or to succeed themselves as parents.

We know, too, that almost all the poor children in this country are living with one parent; that there are very, very few poor children, without regard to race, region or income, living in two-parent married households. We know that there are an awful lot of good, single parents out there doing their best, but we also know it would be better if no teenager ever had a child out of wedlock;

MORE

that it is not the right thing to do, and it is not a good thing for the children's future and for the future of our country.

We also know, finally, that we all have to work together to solve this problem, and that the people who deserve the lion's share of credit are people like those who are behind me today -- people who are giving their lives to try to give our young people things to say yes to, to try to give our young people a sense of self-confidence, a sense of identity and a sense of the future so that they can make good personal decisions about their own lives.

Members of our administration have been meeting with citizens like these folks from all sectors of our society, and from all over the country, to determine whether we could help to support the establishment of a new national organization that would expand upon and reinforce and elevate these community-based efforts.

This is not a problem which can be solved in Washington. This is not a problem that can be dealt with by a politician's speech, no matter how statesmanlike. This is a challenge that has to be dealt with one-on-one-on-one throughout this country. But there are things, as these people have told me today, for political leaders to do, there are things for business leaders to do, there are things for people in the media to do, things for the health care system to do.

And I am very pleased that from the grass roots, we have gotten input about how you ought to design the right kind of national campaign against teen pregnancy. And today I am pleased to announce that a group of very prominent Americans will agree to become the first leaders for the National Campaign to Reduce Teen Pregnancy. A dozen are ready to begin the effort, including leaders in the field of helping our young people, like former Surgeon General Dr. Koop and David Hamburg of the Carnegie Corporations. Others who have agreed to play a role include the President of Drew University and the former Governor of New Jersey, Tom Keane; former New Hampshire Senator Warren Rudman; Ogilvy and Mather Chair Charlotte Beers; Whoopie Goldberg; former Mayor of Atlanta, Congressman and U.N. Ambassador Andrew Young, who is now the cochair of the Olympics in Atlanta; and the President of MTV, Judy McGrath.

I'd like also especially to thank Dr. Isabel Sawhill who is here with me now, and now with the Urban Institute and used to be a part of this administration, for her serious efforts and leadership in spearheading this and getting all these folks together and trying to make sure that this effort will be rooted in America's communities.

This will be a serious bipartisan effort to address this issue. We all know it ought to be an effort that goes on year-in and year-out; it ought to be completely beyond partisan politics. Many of the people who have agreed to meet, to serve, will be meeting tomorrow in New York. And within the next month this group will be up and running. When it holds its first board meeting the National Campaign to Reduce Teen Pregnancy, I hope, will be coming to the White House to discuss how we can work together and how we can all do our part to advance this important work.

Because government does have to do its part, again as I said in the State of the Union, we don't have a big government anymore, it's smaller than it was when I took office. But we don't want a weak government and we don't want to go back to the time when the American people were left to fend for themselves. We need to go forward in a sense of the spirit of partnership. And I have asked Dr. Henry Foster to serve as my senior advisor on this issue and to be my liaison to this national campaign, to make absolutely sure that we have done everything we can do to support this effort.

In his career as a doctor and through his I Have A Future program in Nashville, Dr. Foster has dedicated his energies to dealing with this complex, profoundly human problem of teen pregnancy, and he's had a remarkable amount of success. In this new role he will work in partnership with community-based organizations all across America to help give our young people the strength and the tools they need to lead responsible and successful lives.

Ultimately, I believe what is needed on this issue is a revolution of the heart. We have to work to instill within every young man and woman a sense of personal responsibility, a sense of self respect and a sense of possibility. Having a child is the greatest responsibility anybody can assume, and it's still every American parent's most important job -- I don't care what else they're doing. And it is not the right choice for a teenager to make before she or he is ready. This message has to be constantly enforced and reinforced by community organizations and by other groups who are in a position to help our children make good choices.

The last point I want to make is that everybody can play a role, and those of us who are older and no longer subject to the drama that these children live with every day find it easier to make these speeches, perhaps, than young people do, but young people are more likely to be more effective in doing it.

So I want to say a special word of thanks to one of the people who met with me today, the young gentleman here to my left, Collin Sears. He is demonstrating the kind of contribution one person can make. He has worked at Baltimore's Young People's Health Connection since he was in middle school, teaching other young people to make the right decisions and to take responsibilities for their lives.

You know, he said -- and when we were in the meeting, he was asked what was his most effective argument. And he said, "Well, I really have three strategies that I use," and he laid out his strategies. Afterward, I couldn't help thinking, if he'd been here helping me to lobby Congress on the budget, it might all be solved. (Laughter.) I was absolutely carried away that he had, sort of, thought through how he ought to get inside the mind and heart of each young person with whom he was dealing. We need to lift people like him up. We need to lift programs up, like the Best Friends program here in Washington, D.C., and I know we have some participants here.

We need to lift these comprehensive efforts up where these people are actually out there now, literally giving their lives to help young people secure a better future for themselves, and we need to do it together. Let me say that there are a lot of things I would like to see done in this country over the next four or five years. But you just imagine what a difference America could make, and what a different America we would have, if we could cut the teen pregnancy rate in half. Just imagine how it would change the whole face of the country, and the whole future of America, and how our young people think about that future.

That is really what this is about. It is an effort worth making. It ought to be completely bipartisan. We ought to commit ourselves to do it for as long as it takes, year in and year out, and we ought to root it in our communities and recognize that every one of us has a role to play, and a responsibility to play it.

Thank you very much.

END

12:06 P.M. EST

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THE CLINTON ADMINISTRATION RECORD ON REDUCING TEEN PREGNANCY

A Summary Report

President Clinton has called teen pregnancy one of the nation's most serious social problems, and reducing its incidence has been a key goal of this administration's policy for young people. All over the country Americans are beginning to address this and other issues by reasserting responsibility for themselves, their families and their communities, and they are starting to make a difference -- the teen pregnancy rate has come down two years in a row.

Although there has been progress, teenage pregnancy remains a profound problem, and we need to do more. Real solutions lie at the grassroots level, with families, communities and young people themselves. The federal government can help focus resources in support of work at the local level, and most important, it can help ensure that our policies support our national values. The Clinton Administration's policy on teen pregnancy, and on youth generally, have been built on two fundamental values:

Responsible Behavior: Personal responsibility has been a central part of the President's message to young people, as he has urged them not to become parents before they are adults, have finished school, and are ready to support their children. He has supported policies that embody this principle, including abstinence-based curricula, welfare reforms that discourage early parenting and require young mothers to live at home and stay in school, and tough new child support enforcement provisions that drive home the responsibility of parenthood to young men.

Opportunities for Youth: Teen pregnancy cannot be addressed in isolation from the wide range of other problems confronting youth, their families, their communities and their schools. Much of the Administration's social and economic agenda, ranging from education to crime prevention to empowerment zones, is designed to provide increased opportunities for young people and to give them something to say 'yes' to. If our youth do not have access to education, health services, jobs, or safe places to go after school and on weekends, they will not have a chance to make the right choices.

This summary report provides some facts about teen pregnancy in the United States and highlights some of the key components of Administration's teen pregnancy and youth agenda, including: (1) Research and Evaluation to learn more about the causes of teen pregnancy, (2) Community demonstrations to help communities try different approaches to learn what works, (3) Policies that promote responsible behavior among young people, and (4) Policies that provide young people with greater opportunities.

Recognizing that government cannot solve this problem alone, the President has called for a national private sector campaign to prevent teen pregnancy, and the administration has been working to catalyze such an effort. This report is not intended to address the status of private sector initiatives, nor does it provide a comprehensive description of all federal efforts directed at teens.

January 27, 1996

The Facts About Teen Pregnancy

A NATIONAL EPIDEMIC

- Every year, about 1 million American teenagers become pregnant -- that's approximately 11% of women ages 15-19.
- From the 1950s through the early 1980s, the rate of births to teens decreased steadily. However, in 1986, that trend reversed, and over the period 1986-91, the rate grew by 24%. Recent news has been somewhat positive: From 1991 to 1993, the national rate declined by 4%.
- As the teenage population grows, teen births are expected to increase. Even if the teen birth rate remains constant, the number of births is expected to jump 30% by the year 2010.

TREND TOWARDS OUT-OF-WEDLOCK CHILDBEARING

- In 1960, only 15% of teenage mothers were unmarried. As of 1993, 71% were unmarried.

INTERNATIONAL COMPARISONS

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

ROLE OF ADULT MALES

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

COSTS TO THE CHILDREN

- Children born to teens are more likely to die in their first year of life, to have lower cognitive achievement, to repeat a grade in school, to be victims of abuse and neglect, and to become teen parents themselves.
- 80% of children born to unwed teenage mothers who have not completed high school live in poverty. In contrast, of those children born to 20 year-old married parents who are high school graduates, only 8% live in poverty.

COSTS TO SOCIETY

- In 1990, slightly more than half of all mothers receiving Aid to Families and Dependent Children (AFDC) first had children as teenagers. And 43% of the long-term welfare recipients are women who gave birth at or before age 17.
- More than three-fourths of all unmarried teen mothers receive welfare (AFDC) at some point during the 5 years following the birth of their child.

Research and Evaluation: Learning What Works to Prevent Teen Pregnancy

The Clinton Administration supports comprehensive approaches to research and evaluation with an emphasis on prevention of both first and repeat pregnancies. Working to understand teen populations and the many forces that influence behavior both in and outside of the home, monitoring and targeting new data, and evaluating old and new programs to learn more about what approaches may be most effective in lowering teen pregnancy rates in the United States are priority elements of our approach to research and evaluation. Following are some examples:

- Comprehensive Study: In June of 1995, the Department of Health and Human Services issued, "**Beginning Too Soon: Adolescent Sexual Behavior, Pregnancy, and Parenthood**," a two volume report containing a comprehensive and exhaustive review of the most recent research literature on teenage sexual behavior, pregnancy and parenthood and on effectiveness of teenage pregnancy prevention programs. This report was produced by Child Trends, Inc. with funding from the Department of Health and Human Services, and is now available on the Internet at <http://aspe.os.dhhs.gov/hsp/cyphome.htm>.
- State Data: In September 1995, HHS reported **state-level teenage pregnancy data** for 1991 and 1992. This marks the first time that HHS is able to report state-level teen pregnancy data. Updating trends on a state-by-state basis regularly provides more information for making effective policy decisions and enables us to see where we need to target our resources.
- Family Planning and Adolescent Family Life : HHS funds, as part of Family Planning and Adolescent Family Life programs, research projects and studies that focus on **adolescent sexual behavior**. Goals of these studies range from developing strategies to improve services to sexually active adolescents who are at-risk for contraceptive non-compliance and young women who visit family planning clinics, to learning more about: precursors and results of pregnancy and birth among adolescent males, the factors that influence teen attitudes toward sexual behavior, and the consequences for teen mothers who decide to parent as compared to those who place their children for adoption.
- New Mothers' Study: HHS funds The New Mothers' Study and has expanded its original scope to provide support for a 5-year follow-up to look at longer term outcomes, including employment and welfare dependency. *The Study focuses on research and analysis of a study in Memphis, Tennessee, where a sample of first-time, low-income, pregnant women received weekly visits from a nurse. Approximately 65% of the research sample were 18 or younger at enrollment. Early findings indicate that there were significantly fewer repeat pregnancies within two years following the birth of the child for those women who received home visits. It was originally started in 1988, and is also supported by other government agencies and private foundations.*

- Teenage Parent Demonstration: In order to gain further insight into the occurrence of repeat pregnancies, in 1993, HHS funded a 5-year follow-up evaluation of the Teenage Parent Demonstration, initially conducted from 1986 to 1991. This program targeted the high-risk population of teenage mothers on welfare, providing case management and support services such as education, training and child care. The follow-up evaluation continues to monitor these mothers and focuses on the occurrence of repeat pregnancies.

Reaching Into Our Communities And Promoting Partnerships to Prevent Teen Pregnancy

"I'm trying to do things that I believe will help our country meet the challenges we face today so that young people will have a better future. And it's obvious to me that.... unless young people have good, healthy, constructive lives at the grass-roots level, the things that I do will not succeed in getting you the future you deserve." **President Clinton; August 9, 1995**

The Clinton Administration encourages local governments and communities to pilot new and innovative demonstration efforts to prevent teenage pregnancy, and works with them to help make these programs a reality. The Administration has sponsored a range of approaches from abstinence-based education to service-oriented community collaborations. If a program proves effective, one goal of collaboration is to foster sustainability so that it can eventually operate without government assistance. Following are some examples of programs funded under the Clinton Administration:

- Adolescent Family Life Program: In September of 1995, HHS's Adolescent Family Life Program awarded 15 grants totaling \$4.2 million dollars for comprehensive demonstration programs aimed at preventing early teenage sexual activity and reducing teenage pregnancies. These programs feature innovative ways to **emphasize abstinence as the best way to prevent adolescent pregnancy** and to encourage the involvement of parents in these discussions with their children.
- Community Coalition Partnership Programs for Prevention of Teen Pregnancy: In September of 1995, Centers for Disease Control and Prevention launched the new Community Coalition Partnership Programs for Prevention of Teen Pregnancy by awarding 13 grants totalling \$6.5 million over two years. These grants enable communities to develop plans for implementing and evaluating **community-wide interventions** that are innovative, comprehensive and sustainable. In addition, these demonstrations include an evaluation component.

- Healthy Schools/Healthy Communities: In 1994, the Administration started the new Healthy Schools/Healthy Communities program -- funding 27 **new school-based health centers** in 20 states and the District of Columbia. These centers provide for the health services and education needs of children and teenagers at high risk for poor health, teenage pregnancy, and other problems. A comprehensive evaluation of this program is currently being conducted.
- The Corporation for National Service: Created under the Clinton Administration in 1993, the Corporation for National Service supports over 50 teen pregnancy programs in 20 states across the country -- working both to **prevent teen pregnancy and to assist teen parents**. National service participants provide case management, mentor pregnant teens, sponsor health fairs, teach parenting skills to teen parents, make presentations on teen pregnancy prevention to school-age youth, help youth access health care, provide referrals to health care providers, and develop social supports for teen parents. *National service programs are operated with members of AmeriCorps, Learn and Serve America, and the National Senior Service Corps, who work collaboratively with school districts, universities, churches, health departments, national non-profits, and community-based organizations.*
- Healthy Start Program: HHS continues to support the Healthy Start Program, which has demonstration projects underway in 22 communities nationwide to **reduce infant mortality in the highest-risk areas and to improve the health and well-being of women, infants and their families**. Among a broad array of services provided, thousands of teenagers participate in prevention programs exclusively designed for them that encourage healthy lifestyles, youth empowerment, sexual responsibility, conflict resolution, goal setting, and the enhancement of self-esteem. A comprehensive evaluation is ongoing and results are expected in 1997.
- The Home Visiting Services Demonstration: In September 1994, HHS launched this new grant program that is currently operating in three sites. Under the demonstration, paraprofessional home visitors provide first-time teenage parents on welfare with instruction and supportive guidance related to family planning, parenting skills, health care for themselves and their children, and child support. The visitors also facilitate the teenagers' participation in the required education and employment-related activities.

Promoting Personal Responsibility Among Young People

President Clinton has made personal responsibility a central part of his message to young people, urging young people not to get pregnant or father a child. Estimates indicate that over half the mothers who receive Aid to Families with Dependent Children were teenagers when they had their first child. To prevent welfare dependency in the first place, teenagers must get the message that staying in school, postponing sexual activity, and preparing to work are the right things to do.

By supporting welfare reform that promotes work, demands responsibility, and toughens child support enforcement activities, President Clinton has sent a message that, "Nobody should get pregnant or father a child who isn't prepared to raise the child, love the child, and take responsibility for the child's future."

Welfare Reform: The President supports welfare reform that sends a clear message to minor parents seeking assistance: to get help, you have to live with a responsible adult, you have to stay in school, and you have to prepare for work. Congress has endorsed the President's proposal requiring unmarried teen mothers to live at home and stay in school in order to qualify for assistance. Congress also supports the Administration's efforts to establish "Second Chance" homes, or adult-supervised group homes, as alternative living situations to help teen parents break the cycle of welfare dependency.

Strengthening Child Support Enforcement: In 1995, the Administration collected a record \$11 billion in child support from non-custodial parents, an increase of 40% since 1992. From 1992 to 1995, paternity establishments have also risen by over 40%, to an estimated 735,000. This increase includes, for the first time, paternities established as part of the Clinton Administration's in-hospital paternity establishment program.

President Clinton proposed a comprehensive child support enforcement plan as part of his welfare reform legislation. The plan would streamline paternity establishment; require new hire reporting; make child support laws uniform across state lines; computerize state-wide collections to speed up payments; and require states to revoke drivers' and professional licenses to parents who refuse to pay child support. Both House and Senate have adopted these provisions--changes that should increase child support collections by \$24 billion over the next 10 years. In addition, in 1995 President Clinton signed an Executive Order to crack down on Federal employees who owe child support.

State Welfare Reform Demonstrations: The Administration has approved state welfare reform demonstrations to a record 35 states that include various provisions affecting minor parents. Nineteen states have authority to implement provisions linking AFDC benefits to the school attendance of minor parents. Seven states have received waiver authority to require minor parents to live with their parents or guardians or in an adult-supervised setting. A comprehensive evaluation will be conducted for each of these demonstrations.

Teen Pregnancy Prevention As Part Of A Comprehensive Approach to Youth Policy

The Clinton Administration has worked to address the high rate of teen pregnancy by confronting the complex economic and social factors often behind these high rates. We have stressed the importance of investing in young people and in the communities where they live in order to offer them positive alternatives to early parenting and sexual behavior. Critical to this effort are Administration initiatives to invest in early childhood and adolescent development, to provide equal educational opportunities for our children and youth, to invest in distressed urban and rural communities, and to create more jobs.

Researchers have documented correlations between poor academic skills and early childbearing; high dropout rates, illiteracy, a history of physical and/or sexual abuse, and poor employment prospects are all risk factors for early childbearing. Research has also shown that the risk factors for teen pregnancy, violent behavior, delinquency, and drug use are similar and that comprehensive programs focused on changing behaviors related to alcohol, drugs and teen pregnancy -- such as focusing on raising self-esteem -- have an impact.

Following are examples of programs and initiatives in this area that the Administration supports:

LEARNING MORE ABOUT YOUTH AT-RISK

- National Adolescent Health Survey: Teens have been a significantly understudied sector of the population. In 1994, the National Institutes of Health began funding a new 5-year study known as Add Health, the first comprehensive study of the determinants of adolescent health. Using a national sample of 7th through 12th graders, Add Health examines the personal, familial, peer-related and community related influences on health behavior, taking a more **comprehensive look at the health of our nation's teenagers** in order to provide a better understanding of the complex forces that promote good health for our young people and those factors that put youth at risk.
- Preventing Youth Violence in Public Housing: This year, HUD and CDC have awarded a \$550,000 grant to collect and develop information on youth violence prevention research. The intent is to disseminate existing information on successful programs to Indian and Public Housing authorities so that they can make more informed choices about prevention programs, which offer alternative services and activities for youth that can play a major role in preventing teen pregnancy as well.

- Comprehensive Strategy and Guide for Implementation: In December of 1993, the Department of Justice published a *Comprehensive Strategy for Serious, Violent, and Chronic Juvenile Offenders*, following up with a *Guide* to implementing the *Comprehensive Strategy* in June of 1995. Studies on the causes and correlates of delinquency, which used large random samples of inner-city, high-risk youth in three sites, provided the research underpinnings for these publications. All three studies showed that **chronic violent delinquent offenders have higher rates of dropping out of school, gun ownership for protection, gun use, gang membership, teenage sexual activity, teenage parenthood, and early independence from their family.**

Comprehensive Strategy and its *Guide* for implementation provide an alternative to increasing reliance on the criminal justice system by calling for the establishment of a **coordinated system of prevention** and graduated sanctions programs that provide a continuum of care for each child.

- Review for Practitioners: *Family Life, Delinquency, and Crime: A Policymaker's Guide--Research Summary*, was completed in May of 1994 by the Department of Justice. Its findings indicate that **family is one of the most powerful socializing forces for young people**, and can therefore seriously impact children's behavior.
- Parenting Initiative: The Department of Justice completed research work in 1993 under a grant to the University of Utah and the Pacific Institute for Research and Evaluation. This four-year major parenting initiative resulted in a document entitled *Effective Parenting Strategies for Families of High-Risk Youth (December 1993)*, which identified a representative group of 25 programs as potentially the most promising. The research findings underscore the **importance of a family-focused approach to prevention and intervention of youthful problem behavior.**

EXPANDING OPPORTUNITIES FOR YOUTH AT-RISK

- SafeFutures: In September 1995, the Department of Justice created the SafeFutures Program, a five-year program which will provide approximately \$8 million per year to six jurisdictions for a comprehensive and coordinated **delinquency prevention and intervention program for at-risk and delinquent youth.** Several programmatic components allow the four cities, one rural jurisdiction and one tribal government, to address teen pregnancy and receive support for specific counseling and education services. These include support for family strengthening activities, mentoring, specific services to at-risk and delinquent females, and general delinquency prevention activities.
- High Risk Youth Demonstration: HHS supports the High Risk Youth Demonstration program, which funds **innovative and effective model programs for preventing alcohol and drug use among high-risk youth.** One component of the program targets the specific needs of females from 12 to 20 whose use of substances often occurs with special factors (e.g. sexual abuse and domestic violence) that underlie or contribute to women's addictive problems. Every component of the program is evaluated.

- School Health Programs: The CDC has established a national framework to support school health programs that are locally determined and consistent with community values. Programs in all 50 states and 18 major cities are designed to help young people avoid those risk behaviors that result in HIV infection, other sexually transmitted diseases, and unintended pregnancies. CDC's Youth Risk Surveillance System provides information about the prevalence of behaviors practiced by youth that put their health at risk, and states, cities, and CDC use this information to more effectively target and evaluate school health programs.
- Youth Development Initiative: Started in 1994 under the Departments of Veterans Affairs and Housing and Urban Development, the purpose of this initiative is to address the problem of violence in low-income communities by providing young people aged 13 to 25, with access to education and employment opportunities and supportive services. Offering these positive alternatives and services to youth to reduce violence are shown to be effective for affecting other teen behavior as well, such as sexual behavior that could lead to teen pregnancy.
- Youth Fair Chance: In July 1994, the Department of Labor implemented the Youth Fair Chance program, funding seventeen sites. Youth Fair Chance is a community-based program that targets money directly into **high poverty areas where youth problems are greatest**. Working in cooperation with local service providers, these sites use in- and out-of-school components to provide a variety of services that focus on youth problems, like teen pregnancy, unemployment, drug and gang involvement, and dropping out of school. Some of the sites utilize AmeriCorps volunteers.
- The Community Schools Youth Services and Supervision Grant: Through this new program established in 1994 under the Crime Bill, HHS provides matching grants to communities with significant poverty and juvenile delinquency for **after-school, weekend and summer recreation and education programs**. The program includes an evaluation component.
- Family Planning: In the face of strong opposition, the President has proposed budget increases for the federal Family Planning Program each year and successfully maintained the program. Among other reproductive health and education services, this program makes family planning information and contraception available to millions of women who might not otherwise get reproductive health care.
- 4-H Youth Development Program and Children, Youth and Families at Risk Initiative: The Department of Agriculture, through the Cooperative Extension System, funds these important initiatives serving young people. These programs work with communities to implement effective research-based programs which address a broad range of issues and needs, including teen pregnancy, child abuse, infant mortality, community crime and violence, and child care.

- Safe and Drug-Free School Act: Passed in 1994, this act responds to the continuing crisis of violence and drugs in our schools by **supporting comprehensive school-and community-based drug abuse and violence prevention programs**. Local school districts in high need areas are coordinating violence and drug prevention programs with comprehensive school health education programs.
- Comprehensive Services for Teenage Parents on Welfare: In 1994, HHS funded these grants, which supported development of programs providing **comprehensive services to meet the personal, physical and social needs of teenage parents**, as well as aiding the cognitive, physical and emotional development of their children. They were implemented in conjunction with mandatory participation requirements for education and employment-related activities.

LIFELONG LEARNING: INVESTING IN OUR YOUNG PEOPLE

"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; January 25, 1994**

Under the Clinton Administration, the Department of Education has launched a number of initiatives that address teen pregnancy prevention through improved schooling for disadvantaged students, coordination of health and social services, and school-to-work opportunities to increase economic self-sufficiency. Drop-out prevention and drug-free schools and communities programs address risk factors that are the same or related to those leading to teen pregnancy.

Specific initiatives started or expanded include: **The Goals 2000: Educate America Act, Improving America's Schools Act, Title I Program; 1994 School-To-Work Opportunities Act; and Head Start.**

EMPOWERING COMMUNITIES TO SOLVE PROBLEMS

The Clinton Administration has worked hard to encourage investment in distressed communities, to create jobs and to help these communities rebuild themselves by designing initiatives like the **Empowerment Zones and Enterprise Communities** and **The Community Development Banking and Financial Institutions Act.**

file
teen preg'cy

A NATIONAL CAMPAIGN TO REDUCE
TEENAGE PREGNANCY

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

(202) 857-8531 Office, (202) 728-0232 Fax

FAX TRANSMISSION

TO: Melanne Vervcer

DATE: 1/12/96

FAX NUMBER: 456-6244

FROM: Sarah Brown

TOTAL PAGES INCLUDING COVER SHEET: 9

MESSAGE:

make folder
teen pregnancy

A NATIONAL CAMPAIGN TO REDUCE TEENAGE PREGNANCY

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

(202) 857-8531 Office, (202) 728-0232 Fax

MEMORANDUM

TO: CAROL RASCO

FROM: SARAH BROWN

DATE: JANUARY 12, 1996

RE: THE NATIONAL CAMPAIGN TO REDUCE TEENAGE PREGNANCY

The purpose of this memo is to update you on our progress in organizing a private sector initiative to reduce teenage pregnancy and to suggest some ways in which the White House and the President could help in launching the effort.

Progress to Date

Mission. The purpose of this effort is, quite simply, to reduce teenage pregnancy. Other related issues such as early or unwed childbearing, unintended pregnancies among women of all ages, or the need to address the poverty and other circumstances that lead too many of our young people to engage in a variety of high-risk behaviors, are equally important and have come up in our discussions with a number of people. Nonetheless, we think defining the mission in terms of reducing adolescent pregnancy will help to sharpen the focus of this effort and resonate best with the public. We intend to set some benchmarks against which we can measure our success, such as reducing the teenage pregnancy rate by one-third over the next ten years or making sure that at least half the states and large cities have organized state-level coalitions before that time.

Leadership. We have made every effort to recruit a diverse and prestigious governing board for this effort and very much appreciate the help that the President, the First Lady, and your staff have provided in securing the active participation of a number of individuals. Firm commitments to serve have now been secured from Katharine Graham, Charlotte Beers, Hugh Price, David Hamburg, Andrew Young, and Nancy Kassebaum. Likely prospects, based on conversations with them or their staffs, include Whoopi Goldberg, Tom Kean, Warren Rudman, and Judy McGrath. Invitations are out to Harvey Golob, Felix Rohatyn, Steve Case, Sam Nunn, and Gloria Estefan. The First Lady has sent letters to Oprah Winfrey and Everett Koop and I will be following up with calls very shortly. Jane

Fonda and Irving Harris have not yet been officially invited to join the Board (for reasons we can discuss) but I plan to talk to them next week. We think the initiative is gaining momentum and that more people will say yes but even if we had to start with a board consisting of just the above six committed people, we would be in good shape.

Organization. Because most members of the governing board will not be able to devote significant amounts of time to this effort, and because we want the effort to be as active and as broad-based as possible, we are setting up a set of task forces organized around the major challenges of the campaign: organizing/supporting community coalitions, involving the media, supporting existing programs, learning more about what works, clarifying public values, raising funds for the effort, and involving teenagers themselves (in an advisory capacity). Each committee will be chaired by a very knowledgeable and committed person who has the ability to lead that portion of the campaign. Our current candidates include Kathleen Sylvester (community coalitions), Jody Greenstone (media), Marion Howard (existing programs), Kristin Moore (research on what works), Bill Galston (public values) and David Hamburg (fundraising). In addition to their work in organizing their committees, these individuals will serve on the board and will also meet more frequently as an executive committee which the Chairman of the Board, or his or her designee, will chair. (At present, no obvious Board chair has emerged but we hope to have this resolved before the Jan. 30 meeting.)

In addition to the core Board members and the task forces, the Campaign will have an Executive Director (a position which Belle has asked me to consider filling), a small staff, and a number of "affiliated" organizations and individuals.

Funding. Following the meeting with the President on Oct. 5, we sought and secured funding for the planning phase of this initiative from four different sources. We have had some conversations with various individuals (e.g., Warren Buffett) or organizations (e.g., the Mott Foundation) about longer-term funding but will need to work more on this once a good planning document -- that can also serve as a proposal -- is in hand, the nucleus of the Board has been recruited, and the credibility of the effort as a long-term, bipartisan effort has been established.

Consultations. One of our most time-consuming but worthwhile activities during the planning phase has been holding meetings and individual consultations with a wide variety of people with experience, or a strong interest, in this area. A list of our meetings and individual consultations is attached. What we have learned from these discussions will be reflected in the detailed prospectus that I am now writing.

Prospectus. The prospectus will lay out in some detail the mission, structure, agenda, budget, and rationale for the Campaign. A first draft will be available in less than a week and will be shared with a small group of reviewers including you and your staff. It will then be revised and sent out to all those attending the January 30th meeting that David Hamburg is hosting at Carnegie. A briefing book will be sent to all participants and will include the materials listed in the attached table of contents.

January 30 Meeting. All of the original participants in the October 5th White House meeting have been invited to this meeting along with some new faces. The major purpose of the meeting is to brief the group on our plans and ask for their feedback. We hope that you will be able to attend and say a few words on the President's behalf, but we will certainly understand if your schedule doesn't permit this.

White House Involvement

We think the President can take a lot of credit for catalyzing this initiative and provide much-needed leadership on the issue through the use of the bully pulpit, the convening power of the White House, and administration support in the form of research and data, legislative action, and funding. In short, this effort can be a model of a public-private partnership in action and a means of rebuilding the components of a well-functioning civil society (churches, voluntary organizations, and all kinds of community-based initiatives). For now, we lay out our more specific recommendations with respect to the 1996 State of the Union address and a White House event to launch the Campaign.

The 1996 State of the Union. We understand that some consideration is being given to including something about our initiative in the State of the Union address and stand ready to work with you and your staff on the details. As an example of what the text might say, we have drafted the following:

The state of the union is closely linked to the state of the American family. And nothing could be more tragic than children who are brought into the world by parents who are too young to take on the most serious responsibility that any individual ever undertakes. Yet more than two out of every five girls is pregnant before their twentieth birthday with the result that we have the highest teenage pregnancy rate in the industrialized world. Last year I challenged parents, local communities, churches, and leaders all across our country to get involved in the battle against teen pregnancy. This year, I am happy to report, that my call has been answered. A diverse and bipartisan group of Americans has come together and is about to launch a National Campaign to Reduce Teenage Pregnancy. They have set a goal of reducing the teenage pregnancy rate by one-third over the next ten years. I will be meeting with the leaders of this effort on, following their progress, and lending my own and my administration's support to this critically important task.

Presidential Launch of the Campaign. We expect to launch the campaign as soon as possible after the January 30th meeting at Carnegie. However, we need time to a) clear the schedules of the a very busy and over committed group of Board members, b) secure funding and hire some staff for at least the first year of operation, and c) prepare a press release and public relations strategy. With these tasks in mind, we recommend a March launch date with an event at the White House at which the President would bless the initiative by meeting with members of the Board and saying a few words about the importance of the Campaign.

These are all ideas that we would be happy to discuss further with you and your staff. We also hope that we can brief the President at some point as you and Belle earlier discussed.

cc: Jeremy Benami
Janet Abrams
Melanne Verveer
Debbie Both

Attachment A.

CONTACTS MADE DURING PLANNING OF THE CAMPAIGN TO REDUCE TEEN PREGNANCY

Group Meetings

November 16, 1995, meeting of media people, hosted by People Magazine, attendees included:

Peter Bahouth, Turner Foundation
Anna Maria Cugliari, Advertising Council
Pat Fili-Krushel, ABC Daytime
Jane Fonda, Turner Foundation
Gwen Lipsky, MTV
Ann Moore, People Magazine
Nancy Rubin, Former Official, Corporation for National Service

December 8, 1995, meeting of program directors hosted by Advocates for Youth, attendees included but not limited to:

Gloria Primm Brown, Carnegie Corporation of New York
Patricia Canessa, The Arts of Living Institute
Denise Chuckovich, Multnomah County Health Department
Marge Pruitt Clark, Advocates for Youth
Dana Green, Young People's Health Connection
Kristy Hellum, Teen Outreach Project
Marion Howard, Grady Memorial Hospital Teen Services Program
Darhyl Jasper, Alexandria Health Department
Tom Klaus, Young Women's Resource Center, "It Takes Two"
Maxine Orey, Jackson-Hinds Health Center
Bonnie Parker, HiTops
Ernest Robinson, Teen Peer Education Program
Jan Stanton, Ounce of Prevention Fund
Lori Villarosa, Charles Stewart Mott Foundation
Deidra Wilson, CHOICE

December 12, 1995, meeting of experts on teen pregnancy hosted by Child Trends, attendees included:

Chris Bachrach, Demography & Behavioral Sciences Research
Gloria Primm Brown, Carnegie Corporation of New York
Jacqueline D. Forrest, The Alan Guttmacher Foundation
Douglas Kirby, ETR Association
Brent Miller, Utah State University
Kristin Moore, Child Trends
Freya Sonenstein, Urban Institute
Felicia Stewart, U.S. Department of Health and Human Services
Barbara Sugland, Child Trends
Kathleen Sylvester, Progressive Policy Institute
Lori Villarosa, Charles Stewart Mott Foundation
Laurie Zabin, Johns Hopkins University

January 26, meeting of community outreach people, attendees invited include:

Peter Bahouth, Turner Foundation
Dennis Barbour, AHRP
Gloria Primm Brown, Carnegie Corporation of New York
Joy Campbell, South Carolina
Debra Delgado, Annie E. Casey Foundation
Robert Dugger, Tudor Investments
Donna Fishman, Minnesota
Barbara Huberman, Advocates for Youth
Jenny Knauss, Illinois Caucus on Adolescent Pregnancy
Jim Marks, Center for Disease Control
Linda Rigsby, Lenore, South Carolina Programs
Sharon Rodine, Oklahoma
David Saltzman, The Robin Hood Foundation
Felicia Stewart, Department of Health and Human Services
Kathleen Sylvester, Progressive Policy Institute
Lori Villarosa, Charles Stewart Mott Foundation
Genie L. Wessel, University of Maryland School of Nursing
Gail Wilson, California Wellness Foundation
Barbara Ziegler, Charlotte-Mecklenberg

Meetings and Consultations with Individuals Since October 5

Peter Bahouth, Turner Foundation
Kimberly Barnes-O'Connor, Senator Nancy Kassebaum
Charlotte Beers, Ogilvy and Mather
Elayne Bennett, Best Friends
Doug Besharov, American Enterprise Institute
Kathy Bonk, Communications Consortium
Warren Buffett, Chairman and CEO of Berkshire-Hathaway
Jim Burke, Partnership for a Drug Free America
Brad Butler, former CEO of Procter and Gamble
Marge Pruitt Clark, Advocates for Youth
Anna Maria Cugliari, Commitment 2000
Annette Cumming, National Board of Planned Parenthood
Debra Delgado, Annie E. Casey Foundation
Francie de Peyster, Center for Disease Control
Jody de Sarno, National Family Planning & Reproductive Health Association
Ken Duberstein, Duberstein Group
Rob Dugger, Tudor Investments
Sharon Edwards, consultant
Jane Fonda, Turner Foundation
William Galston, University of Maryland
David Gergen, U.S. News and World Report
Christine Chambers Gilfillan, MCJ Foundation
Patrick Chaulk, Annie E. Casey Foundation
Katharine Graham, Washington Post
Irving Harris, The Harris Foundation
Joan Henneberry, Colorado Family Planning Association
Nancy Hoit, consultant
Leslie Boney, Director of Community Involvement in Governor's Office of North Carolina
Sol Hurwitz, Committee for Economic Development
Jane Johnson, Planned Parenthood
Lisa Kaeser, Alan Guttmacher Institute
Tom Kean, Drew University
Betty King, Annie E. Casey Foundation
Fran Kissling, Catholics For A Free Choice
Julia Lear, Georgetown University
Gwen Lipsky, MTV
Ginna Marston, Partnership For A Drug Free America
James Marks, Center for Disease Control
Bronwyn Mayer, Child Welfare League of America
Rebecca Maynard, University of Pennsylvania
Inca Mohamed, Ford Foundation
Susan Moses, Harvard School of Public Health
Sol Price, The Weingart Foundation

Meetings and Consultations with Individuals Since October 5 cont.

Sally Quinn, Washington Post
Nancy Rubin, former Corporation for National Service Official
David Saltzman, Robin Hood Foundation
Vicki Sant, The Summit Foundation
Reverend Kenneth Smith, The Chicago Theological Society
Mark Smith, Kaiser Foundation
Kathleen Sylvester, Progressive Policy Institute
Vin Weber, Clark & Weinstock
Cliff Wharton, former Deputy Secretary of State
Gail Wilson, California Wellness Foundation
Jay Winsten, Harvard School of Public Health
Tim Wirth, State Department

Meetings or Consultations prior to October 5

Dennis Bakke, AES
Eileen Bakke, Mustard Seed Foundation
Angela Blackwell, Rockefeller Foundation
Gloria Primm Brown, Carnegie Corporation of New York
Joe Califano, CASA
Michael Carrera, Children's Aid Society
Dr. Marion Wright Edelman, Children's Defense Fund
Dr. Henry Foster, "I Have a Future"
David Gardner, Hewlett Foundation
Peter Goldmark, Rockefeller Foundation
David Hamburg, Carnegie Corporation of New York
Marion Howard, Teen Services Program in Atlanta
Barbara Huberman, Advocates for Youth and head of North Carolina program
Linda Lader, Renaissance
Sister Mary Rose McGeady, Covenant House
Ann McLaughlin, former Secretary of Labor
Bill Miliken, Cities in the Schools
Dick Munro, former head of Time, Inc., chairman of Points of Light Foundation
Paul Offner, Senate Finance Committee
Karen Pittman, Administration person, formerly w/ Children's Defense Fund
Alice Radosh, NY Teen Pregnancy Campaign
Peter Richardson, Smith-Richardson Foundation
John Robson, former Deputy Secretary of Treasury under the Bush Administration
Jeannie Rosoff, Alan Guttmacher Institute
Janine Selendry, Horizon Communications
Secretary Donna Shalala, Department of Health and Human Services
Lori Villarosa, Charles Stewart Mott Foundation
Andrew Young, Co-Chairman of 1996 Summer Olympics in Atlanta

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Adolescent Sexuality and Public Policy: A *Liberal* Response

Lainie Friedman Ross University of Chicago, USA

Abstract. Conflicting U.S. statutes exist governing adolescent sexuality. While parents are allowed to remove their children from sex education, they cannot prevent their children from procuring medical care and contraception without parental awareness or consent. I argue that specialized consent statutes—statutes which empower adolescents to seek confidential reproductive and sexual health care—are an inappropriate solution to adolescent sexuality because (1) they empower individuals whom we otherwise believe are not ready for autonomous decision-making; (2) they endorse deception, which is the wrong message to be sending to our children; and (3) they are illiberal in that they circumvent parental decision-making authority to promote a particular conception of the good life. I argue that we should rescind these statutes and return these decisions to the family.

[Author Profile]

Lainie Ross is Assistant Professor in the Department of Pediatrics and the MacLean Center for Clinical Medical Ethics at the University of Chicago. She is a practicing pediatrician. In November 1995, she successfully defended a dissertation entitled "Health Care Decision Making for Children," and will receive a Ph.D. in Philosophy from Yale University in May 1996. Her main interests are pediatric ethics and ethical issues in genetics. Correspondence should be addressed to Lainie Friedman Ross, M.D., University of Chicago School of Medicine, MacLean Center for Clinical Medical Ethics MC 1057, 5841 S. Maryland Ave., Chicago, IL 60637, USA (E-mail: LROSS@MEDICINE.BSD.UCHICAGO.EDU).

Acknowledgments. I thank Walter Glannon, Ann Dudley Goldblatt, Robert E. Merrill, Jeffrey Oak, Mary Mahowald, Leslie Moore, Jacqueline Peterson, Julie Rothstein, John Ross, David Schmitz, Sara Swenson, and Joanna Zolkowski-Wynne for reading earlier drafts of this paper. I also thank three referees for *Politics and the Life Sciences* for their thoughtful comments. *Editor's note:* Commentaries and a response by the author will appear in the August 1996 issue of *PLS*.

There is a contradiction between the purported acceptance of diverse lifestyles by our *liberal community*¹ and present-day U.S. policy regarding contraceptives for *minors*.² In a liberal community, it is presupposed that adults have a special insight into their own conception of the good life that they can pass on to their children. Yet, recent legislation and court decisions in the United States usurp parental power on health care issues pertaining to adolescent sexuality and reproduction.

Consider the following scenario: The Joneses are devout Catholics. Their third daughter, Jane, is 14 years old. Jane, who has become sexually active with her 18-year-old boyfriend Eric, asks her pediatrician for prescription-requiring oral contraceptives. Jane knows that her parents disapprove of premarital sexual activity, and that birth control is strictly prohibited by their religion. Genuine respect for different values would require that we respect the Jones's decision to raise their daughters according to strict Catholic doctrine. They have simplified this for us by enrolling Jane in a Catholic parochial school that does not teach the students about human sexuality, birth control, and abortion.

We cannot argue that the parents' strict prohibition against premarital sexual activity and sex education is a form of neglect. On the contrary, the Joneses are offering their children a coherent, viable lifestyle—a lifestyle that they believe would be threatened by such education outside the context of marriage. And yet, the Joneses cannot fully shelter their daughters because sexuality is pervasive in the mass media and literature. The Joneses recognize this risk, and expend much energy in monitoring their children's exposure to television programs and movies that address sexuality. Nevertheless, if Jane is truly bent on obtaining the facts about human sexuality, she can go to the public library!

A liberal community is and must be tolerant of various lifestyles. As such, our laws allow parents to remove their children from sex education in the public schools, as well as to send their children to private schools in which sexuality is either intentionally omitted from the curriculum or, if addressed, taught as a moral and not a biological issue. And yet most states also have specific statutes (specialized consent statutes) that allow Jane and her pediatrician to discuss contraceptives and allow for Jane to be given a prescription for birth control pills—all without parental consent, even without parental notification. That the laws are inconsistent in the way that they respect various lifestyles is not surprising: different policies were set by different people with different agenda.

Although Jane Jones is a hypothetical person, realize that patients like Jane are relatively common in pediatrics. And realize that Jane may come to my office alone, or she may come with a parent under some pretense (e.g., back pain) and then announce her real intention (her desire for oral

contraceptives) when her parent leaves the room. In this article, I consider—both from the private doctor-patient relationship and from the public context of the larger liberal community—whether specialized consent statutes are a moral response to Jane and her parents.³

Specialized Consent Statutes

In a liberal community, parents have the legal right to raise their children according to their own values, and to make major educational, religious, and social decisions for them. Within the context of health care, parents in a liberal community are presumed to be the child's proxy voice for minor as well as serious conditions.⁴ In general, physicians can neither examine nor treat a child without parental consent; if they do, they can be charged with battery and assault. There are two important exceptions. First, physicians can treat a child when a life-threatening emergency exists even if parents are unable or unwilling to give their consent. Second, the state does not require parental permission if it has a substantial compelling interest, such as with universal vaccinations (which it can actually require for all citizens, both children and adults—*Jacobson v. Massachusetts*, 1905).

Nevertheless, all fifty states have specialized consent statutes that—although varying in scope—give adolescents some autonomy to seek and consent independently to the diagnosis and treatment of drug and alcohol abuse, contraceptive counseling, and/or the procurement of contraceptives (Holder, 1985). Some states even allow minors to consent to abortions without disclosure or consent from their parents. The statutes were designed to encourage adolescents to seek health care for problems that they might deny, ignore, or delay if they had to get parental permission.

The purported purpose of the specialized consent statutes is laudable: to encourage early, responsible sexual health care for adolescents. But the empirical data do not support the claim that adolescents will seek medical care for sexual and reproductive issues if they are assured complete confidentiality. Despite the inception of the specialized consent statutes in the 1960s, adolescent pregnancy and sexually transmitted diseases (STDs) are on the rise.⁵ And the data suggest that most adolescents (especially those younger than 16 years) do discuss these issues with their parents.⁶

Is this a case in which a few "bad" cases have produced "bad" laws? That is, were the specialized consent statutes written to protect the rare adolescent whose parents might harm or threaten to harm her were they to learn that she had a sexually transmitted disease or that she went to a physician for birth control? Were the statutes written without concern for the vast majority of

parents who are both able and willing to guide their adolescents' medical care and who consider this role integral to their child-rearing rights and responsibilities?

I am deeply troubled by specialized consent statutes and believe they are an inappropriate response by a liberal government. A liberal community must accommodate families that hold a wide spectrum of attitudes toward sexuality, and it must realize that these families may seek to structure the experience of their children according to these values. A truly liberal community would allow the Joneses to prevent Jane from procuring all contraceptives and from aborting a fetus, if conceived. But we do not want adolescents having children. So we allow adolescents to get birth control because we agree with them that they are not ready to be parents, and we are willing to override their parents' role as medical decision-makers in order to prevent what we perceive to be a greater tragedy. That is, the specialized consent statutes support those particular conceptions of the good life that approve--or at least condone--responsible adolescent sexual activity. These statutes allow sexually active adolescents to circumvent parents who belong to subcommunities that discourage or forbid premarital sexual activity by their members. These statutes, then, circumvent parental decision-making authority without parental awareness of being excluded.

To minimize adolescent pregnancy, the specialized consent statutes, allow, if not require, Jane's physician to collude with Jane if she insists upon deceiving her parents.⁷ This collusion leads to multiple moral difficulties. First, as Jane's pediatrician, I have developed relationships of trust with both Jane and her parents. What happens when Jane's parents discover the birth control pills? If they confront me and Jane, there is nothing to say but that I believed it was in Jane's best interest. But I have lost their trust, and rightly so. I have also made it clear that I do not respect their religious beliefs; and, since the law stands behind me, my action suggests that members of the larger community also do not respect their religious beliefs. Second, what happens if Jane has a medical complication? A sexually transmitted disease that leaves her infertile? Or an uncommon but serious medical complication from the pill, such as a stroke? How do I explain to Jane's parents that Jane understood and consented to these risks, and that she and I believed that their consent was unnecessary and undesirable, even though they are the parties who will remain responsible for the physical, emotional, and economic hardships that result? And third, what does this mean for Jane herself? She has learned that a physician, an authority figure, is willing to serve as an accomplice in deceiving her parents. What are we teaching our adolescents when they find persons in authority willing to help them deceive their parents? What does it teach these adolescents with regard to the respect owed to any adult, least of all a deceitful doctor or a duped parent?

There is more to our illiberal policy. As the health care system now stands, our classic suburban middle-class adolescent would find it difficult to go to a doctor without her parents' knowledge. The visit is expensive, and to maintain absolute secrecy, the insurance company cannot be billed. Even if the doctor agrees to see the adolescent free of charge, a month's supply of oral contraceptives costs \$15-25. And then the nondriving suburban adolescent must get to the doctor's office, which is not accessible by public transportation. In effect, then, the law gives increased confidential access to oral contraceptives only to poor adolescents who live in inner cities, who can go to a hospital clinic, and who can get free care and medicine with their state Medicaid card. So the policy tends to disproportionately disempower welfare parents who are already politically impotent. I wonder whether the laws would be overturned if physicians were treating large numbers of children whose parents had more political clout?

The Failure of Arguments for Specialized Consent

Those who support the specialized consent statutes offer several pragmatic and moral justifications. The first pragmatic position is compelling: Given the fact that adolescents can be and frequently are sexually active even when birth control and other sexual health services are relatively inaccessible, they should be given the opportunity to be responsible for their sexual activity. The pragmatist does not need to concede or refute whether the availability of such services increases the number of sexually active adolescents. Rather, he or she must argue only that the number is sufficiently large, even when such services are unavailable, as to portend a public health crisis. I accept the pragmatist's position thus far. But the argument makes two assumptions that must be fleshed out: (1) that adolescents are competent to make health care decisions, and (2) that a policy that grants adolescents autonomy will achieve greater sexual responsibility than would a policy that requires parental involvement.

Consider if the two assumptions are false. If the first assumption is false—that is, if adolescents are not competent to make health care decisions—then the statutes are misdirected. If adolescents are incapable of giving informed consent in the area of sexual and reproductive health services, then the statutes unfairly hold them responsible for such measures. If the second assumption is false—that is, if granting autonomy to adolescents does not produce greater sexual responsibility—then the argument for extending autonomy fails. Since parents have presumptive responsibility for their minor children, even if the children are competent, legislation should override the parents' responsibility only if it can

be shown that the policies will promote adolescent well-being *significantly better* than a policy based on parental responsibility. The state should not override parental authority on any issue in which the state is only slightly more effective than parents *unless* the state is able and willing to take responsibility for the myriad of other concerns of its adolescent citizens; otherwise, state intervention inadvertently risks undermining parental authority in other realms—realms in which we both need and want enduring parental commitment. Thus, unless granting adolescent autonomy will promote significantly better sexual and reproductive health care for adolescents, the state must defer to parental authority.

Is the first assumption valid? Are adolescents competent to make health care decisions? The data support the claim that adolescents make decisions as competently as adults do in medical case scenarios designed by psychologists (see Grisso and Vierling, 1978; Weithorn and Campbell, 1982). But does this competency necessarily apply to actions in real life? Despite their knowledge regarding auto safety, adolescents account for a disproportionate number of fatal car accidents. And despite their ability to repeat the facts about the transmission of AIDS and other sexually transmitted diseases, adolescents tend to overlook long-term consequences. The result is that adolescents are quickly becoming a high-risk group for sexually transmitted diseases, including AIDS (DiClemente, 1993). Thus, if competency is understood as the ability both to choose *and* to act to promote one's own interests, then the claim that adolescents are competent is not persuasive.

The second assumption—that specialized consent statutes will promote significantly better health care for adolescents in the realm of sexual and reproductive services than if adolescents required parental involvement—is also unpersuasive. Despite the confidentiality assured by specialized consent statutes, adolescents typically delay seeking sexual and reproductive health care for almost one year after they become sexually active (American Academy of Pediatrics, 1990, citing Zabin and Clark, 1981). Of course, if parental involvement would cause adolescents to delay such services indefinitely, then the statutes achieve significantly better results. Proponents of these statutes need to present empirical evidence that adolescents will seek earlier and better care if they are assured complete confidentiality. Since such data do not exist, the presumption ought to be in favor of parental involvement.

A second pragmatic reason to favor adolescent autonomy in sexual and reproductive health care is the concern of domestic violence. The position is that some adolescents seek sexual and reproductive health care without parental knowledge because these adolescents fear potential parental abuse. They fear physical or emotional abuse if their parents were to find out that they are sexually

active. But many of these adolescents who claim to fear such parental actions have never been abused. That is, they believe that their parents would be so outraged that they would harm them even when their parents have never harmed them previously. There are no data to support their fears. Should the law be written to deal with the few potentially unfortunate cases? I would prefer legislation that included parents in procreative decisions for their sexually active children through the age of emancipation. In the rare event that a parent becomes abusive, I would dispose of this case to the system that deals with abused and neglected children.

A third pragmatic reason to support adolescent autonomy is that this position avoids conflict. Some adolescents want to act without their parents' consent because they know that their parents' religious convictions condemn premarital sexual activity and birth control. But why do we permit these adolescents to seek medical help when we do not allow them to get sex education against their parents' beliefs? That is, if parents can remove their children from sex education classes because we supposedly respect their traditional lifestyle, then why do we allow physicians to go behind their backs and prescribe birth control to their daughters? And would anyone suggest that, to avoid conflict, we should not tell parents when their adolescents are failing in school? Surely, poor grades are common and are a major cause of intrafamilial strife. The pragmatic arguments are weak at best. The empirical data that presently exist do not justify the policy.

The moral argument in support of the specialized consent statutes is based on the moral claim that competency should entail autonomy. This claim is the prevailing moral justification for denying physicians the right to act paternalistically towards competent adult patients. However, whether competency is necessary and sufficient to give children the right to make autonomous decisions is more ambiguous. The argument ignores the fact that parents are responsible, not only for responding to the child's *current* identity, needs, and interests, but also for shaping the child's *future* identity, needs, and interests. Granting autonomy to competent children should serve both their current selves and their future identities. Parents must be able to justify restricting a child's present-day autonomy in order to enhance his or her overall or long-term autonomy. I will return to this point below.

The moral argument that competency should entail autonomy depends on two assumptions: (1) that the competency of children is not morally different from the competency of adults, and therefore that competent children and competent adults should be treated similarly; and (2) that competency is necessary and sufficient to justify autonomy. Both of these claims can be refuted.

Let us consider the first assumption. There is a large and growing movement that claims that competent children should not be treated differently from their competent adult counterparts. These

advocates are known as child liberationists, and they are found in both academic circles (see, for example, Cohen, 1980; Harris, 1982) and the White House (see Rodham, 1973, 1979). Child liberationists differ on when children should be emancipated, depending on how they define competency. One group uses a minimum rationality test: as long as an individual has some minimal capacity to get what she wants, she should be deemed competent to make her own decisions. A second group uses a thicker notion of competency that includes the ability to make informed, intelligent, and voluntary decisions that can take into account both short-term and evolving long-term interests.

Laura Purdy offers a compelling argument on why competent children should not be treated the same as their competent adult counterparts. First, she rejects the minimal competency argument on the grounds that society should not use a least common denominator as its standard for competency:

Even liberationists, after all, lament the mistakes and immorality of adults. It seems to me that instead of asserting children's right to be equally silly and weak, it would be at least as plausible to argue for the overriding importance of helping children develop the self-control and other enabling virtues necessary for living more satisfying and moral lives. (Purdy, 1992:78)⁸

Purdy is in favor of granting *all* competent adults, even minimally competent adults, the right to self-determination on the grounds that the right to make autonomous decisions has intrinsic value. Even if a minimally competent adult might benefit from guidance, the intrinsic value of acting autonomously often outweighs the benefits of guidance. Children, on the other hand, have a great potential for improving their capacity to make decisions that reflect their best interests, and therefore Purdy is willing to restrain present-day decision-making authority in order to enhance overall decision-making authority (Purdy, 1992:55-84).

When children are competent according to the thicker notion of competency, Purdy is still willing to restrict their autonomy. Purdy argues that the knowledge and skills that individuals need for genuine autonomous choice are accumulated only gradually and are developed, in part, by practicing these skills in areas of lesser import (e.g., young children should be free to choose between equally nutritious cereals). Purdy maintains that children, by contrast with their adult counterparts, have a great potential for *improving* their knowledge base and their skills of critical reflection and self-control. By adulthood, however, most individuals will have developed the skills and obtained the necessary background knowledge to use their autonomy to achieve their own goals, and those who have not are not likely to benefit from a longer training period. Thus, at some point an individual must be allowed to live her own life, provided that she has attained some minimal level of competency (Purdy, 1992).⁹ For children, on the other hand, we can and should aspire to higher goals.

The second assumption holds that competency is necessary and sufficient to justify autonomy. I believe, for two reasons, that competency is necessary but not sufficient. First, granting autonomy to children may actually be autonomy-restricting over a lifetime, and so we can justify restricting a child's autonomy now to give her greater overall autonomy. An example helps to clarify this point. If Jane enjoys great sexual freedom now, she may suffer several cases of pelvic inflammatory disease, which may cause her to be infertile. This condition may prevent Jane from becoming a parent when she is psychologically prepared to do so. Or she may contract an incurable sexual disease (preferably herpes and not AIDS) that will limit her sexual expression as an adult. Both of these conditions, then, have long-term consequences to which Jane may not give adequate attention during her adolescent years. Thus, we can justify withholding autonomy from adolescents in the short run in order to promote their potential for greater lifetime autonomy in the long run.

Second, I favor continued proxy decision-making authority by the adolescent's parents on the ground that her parents have a valid third-party interest in her development and activities, even after she has achieved a significant level of competency. In general, parental decision-making authority serves both the children and the parents. It serves the needs and interests of the child to have autonomous parents who will help her to become an autonomous individual capable of devising and implementing her own unique life plan. It also serves the adults' interests in having and raising a family according to their own vision of the good life. This freedom does not automatically stop when the child becomes competent. If anything, parents then have the opportunity to try to inculcate their beliefs through rational discourse, instead of through example, bribery, or force. While children are still dependent upon their parents for emotional, economic, and material support, the parents' interest in their children must be balanced against the competent children's interest in acting autonomously. In contrast, the present-day specialized consent statutes give unilateral responsibility to adolescents who can still benefit from adult guidance, and thus deny the parents' enduring interest in educating and guiding their competent children according to their own values.

For Rescinding Specialized Consent Statutes

There are several reasons why we ought to rescind specialized consent statutes. First, these statutes send adolescents the wrong message. They teach adolescents that their decisions regarding sexuality are unrelated to other aspects of their lives. Consider that parents dictate what schools and church their children attend and the activities in which their children may participate, but these same

children have legal sanction to ignore parental discretion in the area of sexuality. Consider that these children cannot consent to a throat culture without parental permission,¹⁰ but they can authorize their physicians to perform a pelvic examination.

Second, specialized consent statutes affirm the adolescents' attitude that their sexuality is solely a private matter. It is not. Adolescent sexual activity has numerous public consequences for which adolescents are ill-prepared to accept responsibility. Adolescents have a responsibility to themselves to delay sexual gratification until they are emotionally and psychologically prepared; they have a responsibility to their partners to practice safe sex; and, finally, they have a responsibility to their community to avoid parenthood until they are both emotionally and financially capable of caring for a child.

Third, our laws give parents decision-making authority for their children because parents are best situated to decide and to act upon what is in their children's best interest, and because parents are financially and socially responsible for them. This is, or ought to be, no less true of their medical care with regard to sexual health issues.

In arguing against specialized consent statutes, I do not deny the need for a public commitment to prevent and treat the unwanted consequences of adolescent sexual activity. In that vein, specialized consent statutes are on the mark: they affirm the community's belief that the cost of unwanted adolescent pregnancy and untreated sexually transmitted diseases is too high. But the implementation of these statutes entails moral hurdles for the ethical physician: collusion against parents, disrespect for parental conceptions of the good, and a disregard for the adolescent's need for further parental guidance.

I am committed to the prevention and treatment of the unwanted consequences of adolescent sexual activity, but I want parents involved in their adolescents' care. When parents are involved, I am able to call the house to discuss laboratory results instead of asking my nurse to pretend to be a classmate and see if the adolescent is available. Similarly, when the parents are not excluded I am able to call the house if an adolescent fails to follow up for her reevaluation after treatment for a sexually transmitted disease. Follow-up is improved when parents are involved because both the parents and the child are looking out for the adolescent's welfare. Parents have a responsibility for the well-being of their children, and they can fulfill that responsibility only if they are aware of their children's needs.¹¹

A serious objection to rescinding the specialized consent statutes and requiring parental authorization for prescription-requiring contraceptives is that it is unrealistic: the result is a pregnant

adolescent (and we all know what we think of this option). But the fact is that over one million adolescents become pregnant yearly--and most of these adolescents are unmarried and their pregnancies are unplanned--which suggests to me that the present statutes are not working. A pediatric colleague suggested that I was missing the point.¹² She argued that adolescents get pregnant for many reasons, and not necessarily by mistake. Some hope that a child will strengthen relationships with their boyfriends; some seek legal emancipation from their parents; and others seek a child who will love them unconditionally. She argued that these "selfish" reasons were no less true of adult women. She asked why I condemned one and not the other.

My response is liberal in the classic sense of the term: I do not believe it is my prerogative, nor the prerogative of the liberal community, to decide what is or is not a good reason for having children. However, I do believe that the right to procreate entails responsibilities. Is an adolescent as capable as an adult woman of coping with the emotional, physical, social, and financial costs of a child? The data suggest she is not. For example, adolescent parents are less likely to graduate from high school, which involves significant social and financial costs. But even more worrisome is the impact on their children. Children of adolescent parents often have more behavior problems and are at greater risk for significant morbidity and mortality from accidents. In the long term, they are more likely to be high school dropouts, adolescent delinquents, as well as adolescent parents themselves (Juszczak, 1992).

Presently an adolescent mother is legally emancipated from parental authority and accountability. These adolescent mothers are legally allowed to leave home, get their own apartments, drop out of school, and receive welfare. And they will get additional state support by having a second child. What would the consequences be if adolescent motherhood did not emancipate Jane, but instead legislation held Jane's parents accountable for their grandchild until their own daughter was old enough for emancipation? Or should the Joneses be unwilling to care for their granddaughter, what if the child were to be placed in foster care until her mother was able to take care of her? Would this serve as a deterrent to adolescent pregnancy? My goal is not to penalize adolescents who unwittingly become parents, but to discourage adolescents from viewing parenthood as a means to early independence. I would like to help adolescent parents learn the skills that they will need to care for themselves and their children. They need parenting skills as well as vocational skills. And this requires more, not less, schooling; more, not less, adult guidance.¹³

I told my pediatric colleague that it is she who is missing the point. The liberal community must not be neutral with respect to adolescent pregnancy and parenthood. We must reemphasize the

emotional, physical, and yes, the financial obligations of parenthood. Adolescent sexual activity and pregnancy are not just private moral decisions, and neither physicians nor the community at large should act as if they were. As a pediatrician, I should not pretend that Jane's pregnancy has positive aspects in addition to the negative. Jane, her parents, and I should all anguish over how to deal with this most unfortunate consequence of her sexual activity.

Another objection to rescinding specialized consent statutes is the greater negative impact such action would have on adolescent females versus adolescent males. It was pointed out to me that this article claims to be about adolescents, but it is really only about female adolescents.¹⁴ According to this objection, the specialized consent statutes are a part of the whole package that ensures *all* women the right to procreative freedom and control over their own bodies. To rescind specialized consent statutes would be to diminish women's autonomy in the sexual and reproductive arenas.

This argument fails because it is over-inclusive. Nothing in my proposal detracts from the sexual and reproductive rights that must be guaranteed to all adult women. I believe that adult women *must* have full control over their own bodies—and such empowerment entails public support for family planning clinics, pregnancy-related services including abortion services and prenatal care, rape-counseling programs, and public clinics that treat sexually transmitted diseases and counsel patients regarding HIV. But this commitment does not prevent me from distinguishing between adult women and female adolescents. The independent minor will still be protected under the emancipated minor statutes. My position is only that adolescents who live at home with their families must involve their families in their health care.

I mean no harm to either female or male adolescents by urging rescission of specialized consent statutes. In general, females need more sexual and reproductive health care than males, but that reality involves responsibility as well as privilege, for only females have the capacity to conceive and bear a child. That this biological fact gives female adolescents less sexual freedom as children (and as adults, at least in our contemporary culture) is surely outweighed by the fact that these same individuals have greater reproductive opportunities as adults.¹⁵

Public Policy Implications

Given my great respect for parental autonomy and family privacy, I favor existing policy that allows parents to remove their children from sex education courses, but I also favor rescinding specialized consent statutes. Sexuality and sexual expression are private matters to be decided upon

by individuals and their intimates, and not to be imposed by the state. This position does not mean that I would encourage parents to exclude their children from sex education classes: liberal institutions other than the family share responsibility for educating our youths. But parents have the right and responsibility to select the means and scope of those other institutions' teachings.

Since I accept the liberal position that adolescent pregnancy and adolescent parenthood are public crises, how can I justify my policy proposals? Morally, I believe that parents should be allowed to remove their children from sex education courses that conflict with their moral beliefs—it is the responsibility and prerogative of parents to teach their children their own values, including their values on sexuality. Parents play a leading role in the formation of their children's sexual identity, their sexual attitudes and mores, and the manner in which they give their sexuality expression. Pragmatically, I would also add, sex education has not worked. Sex education has not been shown to change risky behavior (see, for example, Cromer and Brown, 1992; Durbin et al., 1993; Ku, Sonenstein, and Pleck, 1992).

I am also against prescribing birth control to Jane without parental notification because I am morally uncomfortable with the deceit that it entails. I respect Jane's parents' right to lead a more traditional lifestyle and to inculcate this lifestyle into their children. This is not to deny that Jane's parents have a responsibility to fulfill Jane's basic needs and interests and to help Jane develop into a mature autonomous adult. It is only to deny that her parents are obligated to expose her to a wide range of possible ways of life, or that they must permit her to participate in activities at odds with their moral conception of the good. On the contrary, if parents want to inculcate certain traditional lifestyles—be they Amish, Hasidic, or Catholic—then they need to restrict their children's exposure to their own ways of life. A truly liberal community must tolerate non-liberal but legitimate (i.e., non-abusive, non-neglectful) lifestyles.

Unfortunately, some adolescents who are sexually active are unable or unwilling to discuss their decision with their parents. The public goal of preventing and treating the unwanted consequences of adolescent sexual activity applies to these adolescents as well. A liberal community can devise statutes that keep present-day over-the-counter birth control easily accessible to all individuals, even minors. And, in fact, the Supreme Court held in *Carey v. Population Service International* (1977) that state laws restricting the availability of over-the-counter contraceptives to minors were unconstitutional. I concur with the Court's decision.

How can I justify allowing adolescents to obtain non-prescription birth control without parental notification and yet advocate parental consent for prescription-requiring contraception?¹⁶ To a great

extent my response is pragmatic: a policy that makes over-the-counter birth control easily accessible to all individuals, even minors, is neither an attempt to override parental moral values nor a statement condoning adolescent sexual activity. Rather, the decision to have barrier method birth control available to all adolescents is consequentialist: the costs of denying adolescent sexual activity are unwanted adolescent pregnancy and diseases, which are a larger community burden than we are willing to accept. But my response also has a deontological basis: the adolescent's procurement of over-the-counter contraceptives does not require deception by medical providers and does not entail that medical providers undermine parental authority.

Some have argued that adolescents have a constitutional right to procure prescription-requiring contraception from family planning clinics without parental notification. The proponents base their position on the repeal of the "squeal rule." In 1970, Congress enacted Title X of the Public Health Service Act, which provided for voluntary family planning projects. In 1978, Title X was amended "to encourage family participation." The Department of Health and Human Services promulgated the "squeal rule" in 1981, which sought to require family planning projects that received federal funds to notify a minor's parents within ten days that she had been given contraceptives.

I believe that this interpretation is misguided. In both court cases in which the "squeal rule" was struck down, it was overruled on the ground that the rule was inconsistent with congressional intent (*State of New York v. Heckler*, 1983; *Planned Parenthood Federation of America v. Heckler*, 1983). Neither decision discussed whether parental notification or parental consent requirements violated a minor's constitutional rights.¹⁷ If family privacy and autonomy are the important ideals that the courts have claimed them to be,¹⁸ then we must respect the different lifestyles that different families promote.

Conclusion

Specialized consent statutes were designed to empower adolescents with respect to their sexual identity. But to do this, the statutes permit or even encourage adolescents to circumvent their parents and the guidance they might offer. These statutes also permit physicians to collude with these adolescents. I have argued that the statutes are inconsistent with the respect owed to parents within a liberal community. The liberal response to the unwanted consequences of adolescent sexual activity requires a set of policies consistent with liberal goals and values. I favor laws that allow parents to decide upon the nature of their children's sexual education and laws that require parental involvement

in the procurement of medical care pertaining to adolescent sexual activity. I also favor laws that allow sexually active adolescents who refuse to involve their parents to have access to over-the-counter barrier methods of birth control. These latter laws enable adolescents to avoid the unwanted consequences of their decision without legitimizing disrespect for parental authority by other institutions. It is a liberal community's way of avoiding a lose-lose solution in a no-win situation.

Notes

1. By "liberal community" I refer to a political democracy in which there is limited government and institutional guarantees of basic rights and personal liberties. A liberal community can be either liberal or conservative, depending on where it places the boundaries between the public and private spheres. In general, we tend to think of family and domestic life as private and economic and political spheres as public. The distinction is not so clear-cut, as many feminists have shown (see, for example, Nicholson, 1986; Okin, 1989). Although the dichotomy is too rigid, the distinction is nevertheless important, as we tend to tolerate greater state supervision and intrusion in the public sphere. Whether a liberal community is liberal or conservative depends, in part, on the extent and type of state involvement it tolerates in the different spheres.
2. By "minors" I refer to all individuals under the age of 18, which is the current legal age of emancipation. The specific age at which emancipation should be granted is a political and not a moral question. I do not argue for any particular age. Rather, I believe that the age should be chosen by societal consensus, and may differ in different cultures and different epochs. My arguments are germane regardless of where the line is drawn. (I do favor line-drawing versus a case-by-case evaluation because I know of no value-free standards on which to judge individual cases.)
3. This article does not address the issue of abortion, nor should the reader extrapolate my position on the role of parental consent and/or notification from my arguments regarding contraception and the treatment of sexually transmitted diseases. Although I do not believe that a fetus is a moral person, the fetus does add further complexities to the public and private dimensions of adolescent sexual activity that require a separate analysis. I leave this project for another day.
4. By "parents" I refer to those adults who are intimately involved in their child's upbringing. That is, I use the term morally and not biologically. I would not respect the decision-making authority of uninvolved caretakers regardless of their genetic or gestational relationship to the child. In this hypothetical case, both of Jane's parents are responsible for her upbringing, and *either* parent can be the child's proxy voice. I thank Ann Dudley Goldblatt for asking me to clarify this point.
5. To be accurate, the increased number of pregnancies among adolescents today may be more a reflection of the larger number of adolescents who are sexually active than a rise in the rate of adolescent pregnancy (see DeAngelis et al., 1987). Regarding the data on STDs, see Washington, Sweet, and Shafer, 1987.
6. These data were culled from a variety of studies that were summarized and discussed by the Council on Scientific Affairs of the American Medical Association (1993). Of note, the council's emphasis was to show that other adolescents stated that they would avoid medical care if parental notification were required, but as the authors of a corollary article in the same issue of *JAMA* note: "what adolescents say they will do (i.e., regarding forgoing care) may be different from what they actually do" (Cheng et al., 1993:1406).

7. Technically, the statutes do not require physicians to deceive parents, because physicians are under no legal obligation to provide a specific service or treatment requested by a minor if it conflicts with their moral principles (Council on Long Range Planning and Development, 1990:1). Nevertheless, the point still stands that if the physician confidentially gives Jane the prescription that she requests, then the physician effectively has colluded with Jane in deceiving her parents.
8. Purdy defines "enabling virtues" as "a certain class of skills, habits and goals that . . . help us get what we want," which includes such traits as rationality, diligence, and the desire for excellence (Purdy, 1992:45).
9. Again, this is not to deny that adults can also improve their decision-making ability to better reflect their own interests, but only to acknowledge that at least part of the value of autonomy is in its use. That is, the capacity to make autonomous decisions is valued because it allows one to act according to one's own beliefs and judgments. It acknowledges that at some point an individual must stop preparing for an autonomous life and just live it.
10. I realize that this is also changing under the mature minor statutes which allow "mature" adolescents to consent to much of their own medical care (Sigman and O'Connor, 1991). Nevertheless, this freedom is not commonly sought when the issue is not sexual, reproductive, or psychiatric. Rather, in general, parents are an important influence in their children's decisions, and adolescents tend to seek their support and advice in most other matters (see Hendry et al., 1992). In addition, adolescents are often willing to conform to parental influence (see Scherer and Reppucci, 1988), particularly female adolescents (Gilligan, Lyons, and Hanmer, 1990).
11. In discussions with families regarding adolescent sexual activity, I have met a number of parents who have asked me to prescribe birth control for their children if their children request it, and then to respect their children's confidentiality. Although they hope that their children will be able to discuss these intimate issues with them, they are more concerned with their child's well-being and the avoidance of unwanted consequences. The policy that I propose to replace the specialized consent statutes would in no way prevent parents from giving physicians such pre-approved authorization.
12. I thank Joanna Zolkowski-Wynne for pressing me on this point.
13. In no way do I mean to deny Eric's and his family's responsibility for his and Jane's child. I would endorse a policy that required Eric's financial support and encouraged his social participation. Men as well as women must be responsible for their sexuality. I have focused on the Joneses because I am Jane's pediatrician and I frequently do not know the young man and his family.
14. I thank Sarah Swenson and Leslie Moore for pressing me on this point.
15. Consider, for example, that the single or lesbian woman can procreate by artificial insemination, whereas paid surrogate mothers for single or gay men are often illegal. At the other end of the spectrum, the pregnant woman has the final right to decide whether to carry a

child to term. If abortion were illegal, this part of my argument would be weaker.

16. I thank Robert E. Merrill for insisting that I address this issue directly.
17. This legal issue is discussed by Mnookin and Weisberg, 1989 and Wardle, 1989.
18. See, for example, *Meyer v. Nebraska*, 1923; *Pierce v. Society of Sisters*, 1925; *Wisconsin v. Yoder*, 1972.

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File
Teen
Pregnancy

Reducing Teenage Pregnancy

A Handbook for Action

March 1996

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Kids Having Kids

A Synthesis of Project Findings

Each year, nearly one million teenagers in the United States—approximately 10 percent of all 15- to 19-year-old females—become pregnant. About one third of these teens abort their pregnancies, 14 percent miscarry, and 52 percent (or more than half a million teens) bear children, 72 percent of them out of wedlock. Of the half a million teens who give birth each year, roughly three-fourths are giving birth for the first time. Even more striking, more than 175,000 of these new mothers are 17 years old or younger. These young mothers and their offspring are especially vulnerable to severe adverse social and economic consequences. More than 80 percent of these young mothers end up in poverty and reliant on welfare, many for the majority of their children's critically important developmental years.

Due to their weak educational and skill levels, low rates of marriage, and inadequate support from nonresident fathers of their children, young mothers face significant challenges in trying to provide for their children. Partly because of their young age, very few of these mothers complete high school before their first child is born. More than 80 percent of those who are 17 or younger when they have their first child are

unmarried. Fewer than half of them will get married within 10 years. Only a small minority of the unwed fathers of the children born to adolescent mothers provide any ongoing economic support for their children.

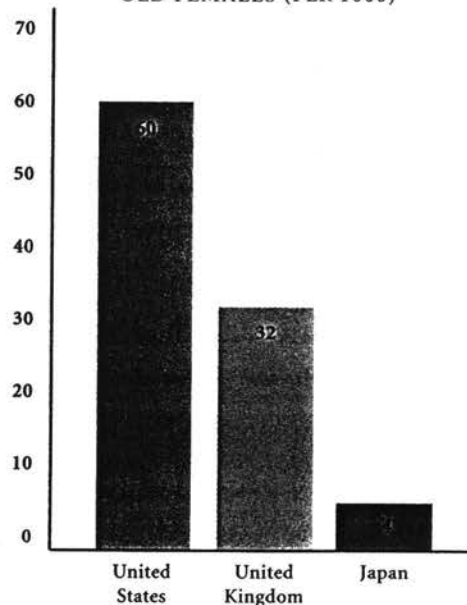
Much of all this seems to be a uniquely American phenomenon. The teen birthrate in the United States is the highest of any industrialized nation, nearly twice as great as the next highest, the United Kingdom, and more than 15 times that of Japan. In addition, in 1988, the last year for which comparative data are available, a teenager in the United States was twice as likely to have an abortion as a teenager in the United Kingdom, the industrialized country with the next highest abortion rate. American teens were more than 13 times as likely to have an abortion as Japanese teens.

The public focus on adolescent childbearing as a major social issue has been fueled by three social forces. First, child poverty rates are high and rising. Second, the number of welfare recipients and the concomitant costs of public assistance have risen dramatically. And third, among those on welfare we see a much higher proportion of never-married women, younger recipients, and recipients who have long average durations of dependency. Adolescent childbearing has both contributed to and been affected by these trends.

To better understand the full costs and consequences of adolescent childbearing, the Robin Hood Foundation commissioned some of the nation's leading scholars to research the issue. Working in teams on seven coordinated stud-

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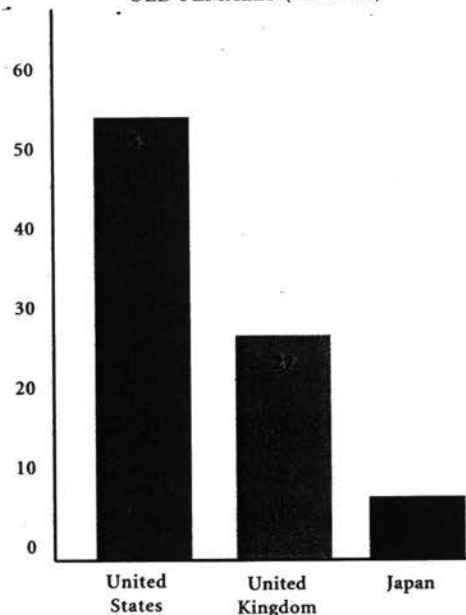
BIRTHRATE FOR 15- TO 19-YEAR-OLD FEMALES (PER 1000)



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ies, the scholars explored the costs and social consequences of teen childbearing for the young mothers, their children, the fathers of their children, and the entire nation. An additional study of previously researched childbearing trends informed and helped round out this set of reports.

ABORTION RATE FOR 15- TO 19-YEAR OLD FEMALES (PER 1000)



The scholars focused their research on the roughly 175,000 adolescents a year who have their first baby at the age of 17 or younger. Still school age, unlikely to be married, and even less likely to be prepared for parenthood, these young mothers highlight the dimensions of the teen-pregnancy and -parenthood problems in this country. The researchers compared these young mothers with women who delay their first births until the age of 20 or 21, which is still two to three years younger than the national average age of women having their first child. The researchers chose this comparison group in the belief that a delay in childbearing until the early twenties is a long enough delay to make a meaningful difference in the life options of the young mothers and their children, and is potentially attainable through aggressive teenage pregnancy-prevention options. The teenage mothers are referred to as "adolescent mothers" throughout this report, distinguishing them from older teen mothers. Those who are 20 or 21 when they have their first child are referred to as "later childbearers."

To develop an understanding of adolescent childbearing itself, researchers attempted to untangle the pathway of early

parenting from an intricate web of social forces that influence the life course of the mothers, including the behaviors and choices leading to their adolescent parenting. The researchers began by examining the gross differences in outcomes between adolescent mothers and women who delay childbearing until the age of 20 or 21. They then applied statistical controls to apportion this overall difference into as many as three categories. First, they looked for the portion of the difference attributable to background factors such as race, ethnicity, socioeconomic class, and parents' education. Second, they accounted for the portion of the difference due to factors *closely linked* to adolescent childbearing but often difficult or impossible to measure directly—factors such as motivation, self-esteem, peer-group influence, and the impact of community.

All of the studies were able to break out these two sets of components. Two of the studies went further and isolated the effects of adolescent childbearing itself on outcomes. One accomplished this by using the randomness of miscarriages, which force a delay in the timing of the first birth. The other study utilized the fact that a woman who has more than one child is necessarily older when she gives birth to her second child. Scholars, therefore, were able to separate the effects of early childbearing from the effects of other factors that are correlated with early childbearing.

The full study is to be published in October of this year by the Urban Institute Press under the title *Kids Having Kids: Economic Costs and Social Consequences of Teen Pregnancy*. The following summarizes the scholars' major findings.

THE NATIONAL CAMPAIGN TO PREVENT TEEN PREGNANCY

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

SUMMARY

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

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

What the Campaign will do:

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

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

Origins and history: The initiative was stimulated by President Clinton's challenge issued in his 1995 State of the Union address that "parents and leaders all across the country ... join together in a national campaign against teen pregnancy to make a difference." A follow-up meeting was held at the White House with a group of private citizens in October to discuss what might be done. Following that meeting, a serious private-sector planning effort was initiated around the ideas generated at the meeting. In his 1996 State of the Union address, the President once more talked about the seriousness of the issue and mentioned the current private-sector initiative as one very positive response.

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

For further information: To get on the mailing list of the new organization, or if you have other questions, please write to Sarah Brown, The National Campaign to Prevent Teen Pregnancy, 2100 M Street, N.W., Suite 500, Washington, D.C. 20037. FAX: 202-331-7735.

TEENAGE PREGNANCY PREVENTION:

THE ADMINISTRATION'S NEW \$30 MILLION INITIATIVE

President Clinton is seeking an additional \$30 million in his FY 1997 budget to help communities prevent teenage pregnancy.

By providing \$1 million in new resources to each of approximately 25 communities with high teenage pregnancy rates, HHS anticipates being able to expand significantly the knowledge about what works and what does not work.

The new resources will be used to build on the Department of Health and Human Service's on-going partnership with local communities, focusing especially on those that have a solid infrastructure to launch new strategies. While other Departmental programs are making significant contributions in the area of teenage pregnancy prevention, these additional dollars will be concentrated on comprehensive pregnancy prevention interventions and on evaluation. The funds will help communities with their plans to provide opportunities for young people to take responsibility, increase their life skills, and become contributing members of adult society.

The funding will support a wide variety of community-initiated approaches to preventing teenage pregnancy that incorporate the five principles of promising strategies. These approaches include abstinence-based activities, school health, family planning, alcohol and drug abuse prevention and referral for treatment, academic tutoring, literacy training, drop-out prevention programs, career and college counseling, mentoring, job skills training, apprenticeships, part-time paid work, community service programs, and local media campaigns. The funding can also be used to ensure coordination of services and fill in gaps in services.

Funded communities will involve many sectors of the community, including parents, schools, businesses, voluntary organizations, media, law enforcement, and religious organizations, as well as the health and social services sectors.

Because assessment and learning are key goals for the additional dollars, \$5 million will be set aside for evaluation and technical assistance. This will allow further refinement of the principles of promising strategies so that communities can make decisions based on as much knowledge as possible.

PREVENTING TEEN PREGNANCY:

Promoting Promising Strategies

A Guide for Communities

PRINCIPLES OF PROMISING STRATEGIES TO PREVENT TEEN PREGNANCY

Teenage pregnancy remains a profound problem, and President Bill Clinton has called for a national campaign to reduce it. Real solutions lie at the grassroots level, with families, communities, and young people themselves. Communities must develop tailored approaches to meet their own needs, resources, and values.

Since 1993, the Department of Health and Human Services has supported a variety of approaches to help communities develop comprehensive strategies. Based on research and experience, we believe that successful community efforts incorporate the following five key principles:

**Parental and Adult
Involvement**

Parents and other adult mentors must play key roles in encouraging young people to avoid early pregnancy and to stay in school.

Abstinence

Abstinence and personal responsibility must be primary messages of prevention programs.

Clear Strategies for the Future

Young people must be given clear connections and pathways to college or jobs that give them hope and a reason to stay in school and avoid pregnancy.

Community Involvement

Public and private sector partners throughout communities, including parents, schools, businesses, media, health and human services providers, and religious organizations, must work together to develop comprehensive strategies.

Sustained Commitment

Real success requires a sustained commitment to the young person over a long period of time.

These principles are reflected in teen pregnancy prevention programs the Department supports, including the demonstration programs of the Centers for Disease Control and Prevention and the Office of Population Affairs. They will be the basis for funding decisions of the new \$30 million teenage pregnancy prevention initiative proposed by President Clinton in the 1997 budget.

PROMISING STRATEGIES

CHILDREN'S AID SOCIETY'S ADOLESCENT PREGNANCY PREVENTION PROGRAMS

Approach: Comprehensive, Multi-Faceted

Short Description: This program looks beyond sex education to the whole child, offering youngsters a variety of opportunities and a broad-spectrum of services as well as positive role models. The seven major components of the program include: career awareness; family and sex education; medical and health services; mental health services; academic assessment and homework help; self-esteem through the performing arts; and fostering lifetime participation in individual sports activities. The Children's Aid Society has another program in Harlem which, in addition to the above, guarantees youth in the program who graduate from high school or get a General Equivalency Diploma admission to New York City's Hunter College.

Goals of the Program: The primary goal of the program is to assist youth in avoiding unintended pregnancy and making responsible sexual decisions.

Location: 10 New York communities and 17 cities across the country

Population Served: Youth ages 10 through 20

Early Findings: For the six New York City sites employing this model, early data show--

- ▶ Participants have educational aspirations that are higher than those reported in national samples of high school students.
- ▶ Participants have better outcomes four years after entering high school when compared to the New York City public school Class of 1994.
- ▶ Participants have substantially lower rates of alcohol use when compared to national samples of adolescents in the same age group.
- ▶ Participants are less likely to be sexually active, and those who eventually do become sexually active are more likely to have used contraception when compared to national samples.

TEEN OUTREACH PROGRAM

Approach: Life Options

Short Description: The Teen Outreach Program, sponsored by the Association of Junior Leagues and the American Association of School Administrators, combines curriculum-based, facilitator-guided, small group discussions with volunteer service in the community. Issues addressed in the small group discussions include: self-understanding, communication skills, human growth and development, parenting issues, and family interaction. Some health and sex education is included. Facilitators serve as mentors and link youth to volunteer activities.

Goals of the Program: The program seeks to prevent early pregnancy and encourage school achievement.

Location: Nationwide and in Canada, mostly located in schools

Population Served: Youth ages 11 through 19

Early Findings: Early data show a reduction in teenage pregnancy as well as in school suspension and drop-out rates. The volunteering and classroom curriculum appear to be working although greater site volunteer hours and older students were associated with more positive outcomes.

POSTPONING SEXUAL INVOLVEMENT

Approach: Abstinence and Delayed Sexual Initiation

Short Description: The Postponing Sexual Involvement Curriculum, developed by the Emory University School of Medicine and Grady Memorial Hospital Teen Services Program, provides teens with the skills they need to resist peer pressure and early sexual involvement. The curriculum offers a clear message that favors abstinence and postponing sexual involvement, but also provides information about contraception. Skill-building exercises conducted by slightly older peer educators are key elements of the program.

Goals of the Program: The program provides youth with basic factual information and decision-making skills related to reproductive health. Teenagers in the program gain skills to deal with social and peer pressures that lead them into early sexual involvement.

Location: Atlanta, GA and other sites nation-wide.

Population Served: Youth ages 13 to 14

Early Findings: Compared to non-participants, a significantly smaller proportion of youth participating in the program reported being sexually active by both the 12- and 18-month follow-up periods, even though a slightly higher proportion of the participants had been sexually active before receiving the program's curriculum. The effect on delayed first sexual activity was true for both male and female participants. The impact on delayed sexual activity among females was particularly strong. In addition, the evaluation also found higher contraceptive use among those program participants who were sexually active.

I HAVE A FUTURE

Approach: Life Options and Opportunity Development

Short Description: “I Have A Future” is a community-based intervention that uses a comprehensive set of activities to expand life options for high-risk youth living in public housing projects. The focus of the program is on abstinence, community, and self-esteem. The three parts of the program include: equipping adolescents with the basic information they need about health, human sexuality, and drug and alcohol use; providing a comprehensive array of adolescent health services, with a focus on abstinence and a very strong emphasis on parental and community involvement; and assisting young people to enhance their life-options through activities that improve their job skills, self-reliance, values, and self-esteem.

Goals of the Program:

- ▶ developing a replicable community-based, life-enhancement program that promotes a significant reduction in the incidence of early pregnancy and child bearing among high-risk adolescents;
- ▶ improving knowledge, attitudes and behaviors related to personal health and human sexuality; and,
- ▶ enhancing the ability of high-risk adolescents to overcome environmental barriers to attaining the skills necessary to pursue meaningful employment and educational opportunities with the promise of upward mobility.

Location: Public housing projects in Nashville, TN

Population Served: Youth ages 10 through 17

Early Findings: Those who participated in the program had fewer pregnancies, higher self esteem, fewer self-reports of delinquent behaviors, and a greater sense of a promising future. Preliminary analyses of the I Have A Future Program have also found positive effects on intermediate outcomes such as pro-social attitudes, sexual and contraceptive knowledge, self-esteem, perceived life options, and psychosocial maturity, when comparing the active participants to the comparison group of youth from two other public housing projects.

QUANTUM OPPORTUNITIES PROGRAM

Approach: Life Options and Opportunity Development

Short Description: The Quantum Opportunities Program (QOP), a four-year demonstration program launched in 1989 was designed to test the ability of community-based organizations to improve the lives of low-income high school students. The project used Opportunities Industrial Centers in five communities to deliver an intensive package of services to youth during the four years of high school. Services included educational activities, community service activities, and development activities to help youth learn more about health issues, arts, careers and college planning.

QOP was a relatively small national demonstration program. At each site, there were 50 students--25 randomly assigned to the project and 25 to a control group. The young people received small stipends for participating in and completing approved activities. The program also established accrual accounts to collect matching funds that youth could use for additional training or education after they graduated from high school. Staff members were also given financial incentives to meet the program's participation goals.

The Ford Foundation and the Department of Labor are currently funding replications of the program.

Goals of the Program: To test the ability of community-based organizations to "foster achievement of academics and social competence among high school students from families receiving public assistance."

Location: Philadelphia, PA; Oklahoma City, OK; San Antonio, TX; Saginaw, MI; and Milwaukee, WI. (Milwaukee was later dropped from the study)

Population Served: Students entering the 9th grade

Early Findings: QOP made significant improvements in the lives of participating youth over a two-year period. Results compiled one year after the program was completed show significant differences between QOP participants and control group members. Specifically, QOP members were more likely to be high school graduates, more likely to be enrolled in secondary schools, less likely to be high school dropouts, and less likely to have children. They were also more likely to be involved in community service, to be more hopeful about the future, and more likely to consider their lives a success.

ADDITIONAL RECENTLY AVAILABLE RESOURCES

Beginning Too Soon: Adolescent Sexual Behavior, Pregnancy, and Parenthood.

A 1995 two volume report reviewing recent research and describing interventions and evaluations written by Kristin Moore, Brent Miller, Barbara Sugland, Donna Ruanne Morrison, Connie Blumenthal, Dana Gleib, and Nancy Snyder of Child Trends, Inc. for the Office of the Assistant Secretary for Planning and Evaluation (ASPE) in the U.S. Department of Health and Human Services. Copies available from Child Trends at 202-362-5533 or from ASPE at 202-690-6461. Also available at the Internet address <http://aspe.os.dhhs.gov>

The Best Intentions: Unintended Pregnancy and the Well-Being of Children and Families.

A 1995 report by the Institute of Medicine. Copies available from the National Academy Press at 800-624-6242.

Great Transitions. The 1995 concluding report of the Carnegie Council on Adolescent Development funded by the Carnegie Corporation of New York. Copies available from the Carnegie Council on Adolescent Development at 202-429-7979.

Sex and America's Teenagers. A 1994 report by the Alan Guttmacher Institute. Contact the Alan Guttmacher Institute at 202-296-4012.

Trends in the Well-Being of America's Children and Youth. A 1996 report written by Child Trends, Inc. for the Office of the Assistant Secretary for Planning and Evaluation (ASPE) in the U.S. Department of Health and Human Services. Copies available from Child Trends at 202-362-5533 or from ASPE at 202-690-6461. Also available at the Internet address: <http://aspe.os.dhhs.gov>

The National Campaign to Prevent Teen Pregnancy. The National Campaign to Prevent Teen Pregnancy is a private, nonpartisan organization newly established to support and stimulate actions to reduce teen pregnancy. To contact the Campaign, write to The National Campaign to Prevent Teen Pregnancy, 2100 M St., N.W., Suite 500, Washington, DC 20037.

HHS Programs That Fund Community-Based, Comprehensive Teen Pregnancy Prevention Strategies

- Community Partnership Programs for the Prevention of Teen Pregnancy
Centers for Disease Control and Prevention
For information call: 770-488-5136
- Adolescent Family Life Program
Office of Population Affairs
301-594-4004

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THE NATIONAL CAMPAIGN TO PREVENT
TEEN PREGNANCY

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

DIRECT DIAL: 202/857-8531

FAX: 202/728-0232

3/28/96

Dear Melanne,

I wanted to make sure that you and the First Lady received a copy of this update. It shows, I think, that we are hard at work building the new organization, although the amount of work still in front of us is truly overwhelming.

Your support and help have been very important in our having come this far. Please know how grateful we are.

With kindest regards,

Sarah Brown

THE NATIONAL CAMPAIGN TO PREVENT TEEN PREGNANCY

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

CAMPAIGN UPDATE

March 1996

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

Board established and officers elected:

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

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

Task force chairs elected:

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

Staff appointed:

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

Fundraising:

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

Future plans:

Immediate plans include at least the following:

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

Staying in touch:

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

Attachments: Board Roster
One page summary of the Campaign

THE NATIONAL CAMPAIGN TO PREVENT TEEN PREGNANCY

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

SUMMARY

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

THE NATIONAL CAMPAIGN TO PREVENT TEEN PREGNANCY

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

BOARD MEMBERS

(As of February 22, 1996)

Chairman

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

President

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

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

William Galston, School of Public Affairs, University of Maryland

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

Whoopi Goldberg, actress

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

Irving B. Harris, Chairman, The Harris Foundation

Barbara Huberman, Director of Training, Advocates for Youth

Nancy Kassebaum, U.S. Senator

Dr. C. Everett Koop, former Surgeon General

Judy McGrath, President, MTV

Jody Miller, Senior Vice President for Operations, Americast

Kristin Moore, Executive Director, Child Trends

Hugh Price, President, National Urban League, Incorporated

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

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

Campaign Director

Sarah Brown, former Senior Study Director, Institute of Medicine