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TEENAGE PREGNANCY: THE ECONOMIC AND SOCIAL COSTS

HEARING

BEFORE THE

SUBCOMMITTEE ON EDUCATION AND HEALTH

OF THE

JOINT ECONOMIC COMMITTEE CONGRESS OF THE UNITED STATES

ONE HUNDRED SECOND CONGRESS

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TUESDAY, NOVEMBER 24, 1992

CONGRESS OF THE UNITED STATES,
SUBCOMMITTEE ON EDUCATION AND HEALTH,
JOINT ECONOMIC COMMITTEE,
Washington, DC.

The Committee met, pursuant to notice, at 9:18 a.m., in room 2359, Rayburn House Office Building, Honorable James H. Scheuer (Chairman of the Subcommittee) presiding.

Present: Representative Scheuer.

Also present: William Buechner and David Podoff, professional staff members.

OPENING STATEMENT OF REPRESENTATIVE SCHEUER, VICE CHAIRMAN

REPRESENTATIVE SCHEUER. This is a Subcommittee of the Joint Economic Committee. We have a broad ranging mission looking at the economy of our country and the things that impact it.

When Governor Bill Clinton was elected President on November 3, it seemed to me that we ought to be on the eve of a revolution in reproductive rights, facilities, services and reproductive research, and that at long last the needs of young women in our society for contraceptive care and for a total concern for their reproductive privileges is long overdue.

Since we are on the brink of this true revolution, it would be helpful for the guidance of the Congress and to be helpful to the President, to have a hearing and think about this subject, and to advise both the Congress and the President.

Just consider these facts: Every 21 seconds a 15- to 19-year-old woman becomes sexually active for the first time. Every 64 seconds an infant is born to a teenage mother, truly children having children. Between 1986 and 1990 adolescent childbearing increased 16 percent, from 38.4 percent to 44.6 percent.

Every year more than a million teenagers become pregnant. Every year a million girls become pregnant, and half of these pregnancies result in the birth of a child, a half million cases, 500,000 children having children.

The vast majority of these children are born into families headed by a single mother—the most poverty-stricken group in America—the type of family that is least able to nurture and raise a young infant to maturity with all of the life support, the caring, the love, the nutrition, the rich exposure to life's exciting possibilities, the education and skills training that they need.

These women are not yet ready to have families. Only a third of teenage mothers have a high-school degree, compared to 25 percent of mothers 25

and over. Only half of pregnant teenagers know enough to seek early prenatal care, compared to 85 percent of older mothers.

Many of these young women and their families will spend much of their lives in poverty. The Congressional Budget Office recently reported that half of all adolescent mothers begin receiving Aid to Families With Dependent Children within five years after having their first child, while three-quarters of unmarried adolescent mothers will go on AFDC within five years of their first child.

As I said before, a new President is going to take office on January 20, with a mandate from the American people to change this Nation's direction from its utterly sterile and empty posture relating to young girls and their reproductive needs to something much fuller, much more rich and much more relevant. We have a number of witnesses before us this morning who are going to present some ideas for dealing with this problem of teenage pregnancy.

I am sure that the hearing record of this morning will be brought to President Clinton's attention. We hope and are confident that he will take it to heart and act on it, many of these suggestions emanating from this morning's witnesses.

Where teenage pregnancy results from ignorance of family planning methods, the challenge for the new administration would be to help with better channels of information for young people as to where they can seek help in meeting their reproductive needs.

Where pregnancy results from lack of convenient family planning services and from lack of appropriate family planning technology, then the challenge is to create more and better institutions for family planning and to support the research in order to give us a broader array of contraceptive technology, so that in that full array, there will be something appropriate for a young girl.

Where teenage pregnancy results from immaturity or a lack of responsibility, the challenge is to find ways to support the efforts of families and social institutions to raise our Nation's children to be mature and responsible adults.

Where teen pregnancy results from despair that life offers no alternatives—no job prospects, no income, no respect, no hope—the challenge then is to provide opportunities for better education, job training, employment and advancement for both young men and women.

The Subcommittee is very fortunate to have a distinguished set of witnesses here this morning to address the issue of adolescent pregnancy and what to do about it.

Our first witness is Dr. Jocelyn Elders, Director of the Arkansas Department of Health, and who has served Governor Clinton in this capacity for the past five years.

She will then be followed by Governor David Walters of Oklahoma, who has taken a strong interest in this subject through the Southern Governors Association's Center on Adolescent Pregnancy Prevention.

Then we will follow with a panel of four expert witnesses.

Because this hearing was not announced or planned until after election day, it was very difficult to round up Members to come here. They are all back in their district celebrating, I suppose, and preparing for the new congressional session. Because I am the sole Member here—and it may be because I have retired and I am not running for re-election, that may be the

reason why I am here and the Members of the Committee who have been elected are back home preparing for the new session—because I am chairing this hearing, I don't have to share time with other colleagues for questioning, so I may do some questioning while you are all speaking, or after each witness while the questions are fresh in my mind.

I do want to interject at this moment my deep appreciation and enormous admiration for the gentleman sitting at my right and at your right, one of the leading staff experts, Bill Buechner. Bill had a right to feel that the demands on his time after the election were going to be a little less than they had been in a hectic session. But when he and I discussed this hearing, he was enthused, full of pep, vim and vigor, and he totally agreed that this hearing was important, timely and significant, and he threw himself into it with total concern and dedication.

I want to say what a great pleasure it has been working with him over the past many years. We all owe him a debt of gratitude. He has done some great things for his country. He did a cost-benefit study of the GI Bill of Rights after World War II which validated what an important payoff the Federal Government got for providing young men and women with postsecondary education—an enormous payoff. It is such a good investment that it is hard to see how we can fail to do it.

This is especially relevant at a time when we do not have a skilled, competitive, viable work force that can compete successfully in global commerce with the work forces in the developed world. It is urgent for us to complete the mission and the challenge of producing a competitive skilled work force. Two thirds of all of the jobs that are available in New York City, right now, for young people require some postsecondary education.

Now, that has not been true in the past. We had one very visionary president who, in 1948, produced a report on postsecondary education. His name was Harry Truman. At that time he recommended that we ought to have two years of assured, paid-for education beyond high school; in effect, that we should extend our education system from K through 12 to K through 14. Now, if you will add some kind of inflation factor to that K through 14—not inflation, but a way of increasing the demands of society for skilled persons from 1948 to 1992—I think you could easily say, if Harry Truman had been writing that report today, he would say let's have four years of postsecondary education as an entitlement.

It was Bill Buechner who gave us the sophisticated understanding of what an enormous payoff there would be to our society in moving in that direction. I hope that the new Clinton Administration will give deep thought to Bill Buechner's study and the enormous potential for our country toward giving each young person an entitlement to go through 12 plus four years of education, starting from kindergarten. Of course, he had a hand in doing a cost-benefit analysis of the Head Start program, too. That, also, has a tremendous cost-benefit, from $7 to $12 back to the government for every dollar that we invest.

So what he is suggesting and what I firmly endorse is that we restructure our education system so that it is K minus two to K plus four. In other words, two years of an enriched free-school program, plus 12 of elementary and secondary education and four years of postsecondary education, to give us the

skilled, dynamic work force which our country urgently needs and which we owe to our young people.

I want to express this profound debt of gratitude and my respect and affection for this wonderful man, Bill Buechner.

I also want to introduce David Podoff. He has been a trusted staff member on the Joint Economic Committee staff for years, and I want to express my appreciation to him.

All right, let's get on with the hearing and Dr. Joycelyn Elders who served Bill Clinton as Director of the Arkansas Department of Health for the last five years.

Dr. Elders is a native of Shaw, Arkansas, and has had a distinguished career in medicine. After graduating from the University of Arkansas Medical School in 1960, she worked as an intern pediatrician at the University of Arkansas Medical Center.

She became a professor of pediatrics in 1976, receiving board certification as a pediatric endocrinologist in 1978. Based on her studies of growth in children and the treatment of hormone-related illnesses, she has written 188 articles for research publication. Dr. Elders has had a scholarly background and has been in the thick of things in the last five years as Director of the Arkansas Department of Public Health.

We are delighted to have you with us. Please take such time as you may require.

STATEMENT OF JOYCELYN ELDERS, DIRECTOR, ARKANSAS DEPARTMENT OF HEALTH

DR. ELDERS. Thank you, Mr. Chairman. It is a real pleasure for me to be here.

I want to thank you for myself and for all of the young people in this country for holding what I consider a very important session to discuss the social costs of teenage pregnancy. This is a subject with which I have been fighting long and hard since Governor Clinton appointed me as the Director of the Arkansas Department of Health.

I might add that Governor Clinton has stood beside me the entire time since I first dumped him in an ocean of Jell-O, from sitting around a conference table where I said that we were going to reduce teenage pregnancy in Arkansas. The way we were going to do that was by health education, school-based clinics. Then I was asked, were we going to provide condoms at school? My response was yes, but I was not going to put them on the lunch plate. You can imagine that since then Bill Clinton has had to swim in that ocean of Jell-O by my side.

Perhaps Governor Walters knows that. He has also testified, speaking to the National Governors' Conference, that he and I had been working on this problem for so long that when we started his hair was black and I was an albino, just to give you an idea.

We are delighted that you are holding this important investigation. As you know, the problem of teenage pregnancy serves as a barometer of our society, of how well we are doing and how much we are investing in the future. We know this subject is important. It is important because too many of our bright young people are becoming parents before they become adults.

You previously stated that more than one million young people each year become pregnant. There are over 500,000 births, 400,000 abortions and 135,000 miscarriages every year in this country. Each year in America, 1 in 10 girls will have a pregnancy before the age of 20, and 6.7 out of 10 black girls will have a pregnancy before the age of 20. Eighty-two percent of these are unplanned.

We are behind every other industrialized country in the world. In fact, our teenage pregnancy rate is twice as high as the next industrialized country, seven to eight times higher than countries like Japan.

REPRESENTATIVE SCHEUER. Would you object if I asked you a question?

DR. ELDERS. No, not at all.

REPRESENTATIVE SCHEUER. These statistics that you have given us are extremely significant. I would like you to explain to us why there is such an incredible divergence in the experience of various industrialized nations. Is it because the natural rate of sexual activity varies that widely? Or is it because of the way society perceives its young people and the assistance the society gives them in coping with their sexuality?

DR. ELDERS. From all the data I reviewed and I know about, the sex activity is no different between our young people and those children in other countries.

In Sweden they may even be more sexually active than our young people. The difference is that they educate their children. They believe in being open and talking about it. Not only is their pregnancy rate lower, but their abortion rate is far lower than ours.

Yet, we do not teach our children, nor do we make preventive services available for our children. I feel that we moralize about the issue and try to legislate morals rather than teaching our bright young people responsibility.

REPRESENTATIVE SCHEUER. And giving them the services they need.

DR. ELDERS. Making the services they need available where they are.

REPRESENTATIVE SCHEUER. Okay. Please proceed.

DR. ELDERS. Thank you. As you may or may not know, 82 percent of the children born to our children are unplanned. Eighty-two percent of all the children born in America, regardless, are unplanned. Sixty-four percent of our tenth graders admit to being sexually active.

REPRESENTATIVE SCHEUER. Those children are how old?

DR. ELDERS. They are probably 16, I would say.

Seventy-five percent of our 19 year-old women are sexually active, and 86 percent of our 19 year-old men admit to being sexually active. So our children are sexually active as documented by the pregnancies, as documented by sexually transmitted diseases.

One in six of our teenagers will have a sexually transmitted disease—every year—more than three million. AIDS is rising most rapidly in our teenagers.

REPRESENTATIVE SCHEUER. In the heterosexual community?

DR. ELDERS. In the heterosexual community and obviously rising much more rapidly in the black community in our poor black males. We are about to lose a whole generation of young black men because of our failure to respond to their ever-increasing needs.

We know that these children—50 percent of the women become pregnant before the age of 18—will never finish high school. Only 2 percent will go on to college. Many of the children they have will be members of what we now call the 5-H Club. Representative, that is children that are hungry. Every night in America, three and a half million children go to bed hungry.

Many of them are homeless. We think of the homeless as the people that we see on the streets or the alcoholics and drug addicts. A third of those are children. We think that many of them are helpless. The group in our society now who are least likely to have insurance or health care is our children. Up to 30 percent of school-aged children have no health care. Many of them are hugless. They have nothing to love them. Many of them end up hopeless, with nowhere to go. I feel that because of our failure to respond, we have created this problem in our society.

Sixty-four percent of the young women who become teen parents have been abused at some time in their lives. Eighty-four percent of those less than 14 who become pregnant are sexually abused often by somebody in their own home.

We do not have laws to protect these children. Many say, well, what if the 14 year-old is lying? Mr. Chairman, I do not feel a 14 year-old who is pregnant can lie. She had to be abused by somebody.

These children born to children are far more likely to be low-birth weight, have multiple complications for the rest of their lives and require repeated care. They are children who are twice as likely to have problems in school and do poorly, and many of them are far more likely to end up themselves to be teenage parents. In fact, we know that 50 percent of the children born to children will themselves be teenage parents.

Ninety percent of our young men in prison between the ages of 17 and 35 were born to teenagers who didn't know how to parent. It costs $30,000 to build one prison cell, and the average cost of keeping someone in prison is $35,600 dollars a year.

We often say we do not have the money for these things, but we have the money for the things we put first. It is apparent we have not put our children first.

In this country, we spend $26 billion for AFDC, WIC and Medicaid for families started by children. What we pay for with this $26 billion is for poverty, ignorance and enslavement. This has increased from $16 billion in 1985 to $26 billion in 1991. We have seen an increase in the percentage of pregnancies in our very young teenagers—16 percent increase in the country, 18 percent increase in the South. In the South our outlay for AFDC, WIC and Medicaid has increased more than 60 percent, from $3.2 billion to $5.7 billion.

Many of these children will grow up in poverty. Our poverty has increased in children from one in seven being poor in 1970 to one in five poor in 1990. If they are in Arkansas, it is one in four. If they are minorities—regardless of the minority—it is one in two. This, to me, is a major problem.

We know that families that were started by teenagers in 1988 will cost taxpayers—just all children born to teenagers—an average of $16,450—each one—over the next 20 years. If they are on Aid to Families with Dependent Children, it will cost more than $37,500, or $5.9 billion over the next 20 years.

How can we make sure that we begin to address these problems and reduce the many things that we see happening to our children?

First of all, I think we need to look at the government outlay for prevention of teen pregnancy. We find that if we consider all the programs——Title 10, Title 20, and Title 5 and state funds——funds for family planning has, in fact, decreased more than a third over the past 10 to 12 years.

REPRESENTATIVE SCHEUER. Does that take into account the effect of inflation?

DR. ELDERS. It has decreased 66⅔ percent, and we take into effect inflation.

REPRESENTATIVE SCHEUER. That is a very important figure to have on the records. That is a two-third decrease in real dollars out of what we are spending on adolescent pregnancy care.

DR. ELDERS. We spend less than 2 percent of what we spend on prevention. We do not invest in preventing the problems from coming about. So, what must we do about it? What are some of the things that I feel we can do to make a difference?

First of all, I feel that we must invest, as you have just said more elegantly than I can, in education. We have to invest in early childhood education for all of the children. We say that we want them to enter school ready to learn.

Mr. Chairman, I want you to know that only 18 percent of the children on Medicaid have any early childhood education, not even Head Start, whereas 85 percent of middle- and upper-income children have early childhood education.

REPRESENTATIVE SCHEUER. Just to illustrate that point, I want you to know that I am a Head Start kid. You may ask how could you be a Head Start kid when you helped write it in 1965—when I first came to Congress in 1965.

I had a preschool program. We didn't call it kindergarten or pre-kindergarten, but a rose of any other name would smell as sweet. I am suggesting that middle-class families have enabled their children to benefit from an enriched pre-school education regardless of what they called it. So the kids who came from homes like yours and mine had educational benefits, they got the experience of good pre-school. Whereas, the kids who were educationally disadvantaged, the kids who needed it the least, got it the most, and the kids that urgently needed it the most got it the least.

So, today, with all the rhetoric we have heard about President Bush wanting to be an education President, less than 25 percent of the kids who were a desperate education risk have a pre-school slot in a Head Start program, whereas more than 75 percent of the kids who urgently need it don't get it.

That is not a fair or just society. That is a dumb society. That is a society that cannot figure out where its own economic best interest is. It infuriates me that that should be the reality today after 12 years of the last two administrations. That is one of the reasons I am so exhilarated to be alive and kicking in the beginning of the Clinton era.

DR. ELDERS. I certainly could not agree with you more.

The other thing that I feel we must do, we must invest in comprehensive health education programs in schools. I have been saying from kindergarten to 12th grade, but the people in prep school tell me, Dr. Elders, it has to be from birth to 12 years.

We have AIDS programs, cigarette and tobacco programs. If we had a comprehensive health and education program in our school from kindergarten to 12th grade, we would not need all the specialty programs. It has to be age appropriate, and we must build on it and make it a part of our educational system if we want to make a difference.

REPRESENTATIVE SCHEUER. I have often thought that instead of having an AIDS prevention or drug prevention or tobacco prevention program, what we ought to have is a self-esteem program. Make those kids feel good about themselves and they wouldn't be destroying their life prospects with drugs, alcohol, tobacco, AIDS, or anything else. I cannot think of a better self-esteem project than the kind of educational enrichment starting in school and traveling throughout their elementary and secondary years, the kinds of program that you are discussing.

DR. ELDERS. I would certainly agree with you. I also feel that we have to educate their parents. I also tell people that we hire electricians to screw in light bulbs, we get licensed plumbers to unstop our commodes, and we do nothing to help the people who take care of the most important resource that we have, our children.

REPRESENTATIVE SCHEUER. The Head Start program, as it is presently constituted, in its updated 1992 form, does spend a lot of time bringing the parents into the education process and teaching them how to be competent, nurturing, supportive parents in the whole spectrum of needs that the young people have. That is only an additional reason why some kind of Head Start program deeply involving parents should be made available to each kid who needs it.

DR. ELDERS. I could not agree with you more. We have been talking about pregnancy prevention, but we know with Head Start, they are 50 percent less likely of becoming a teenage pregnancy. I think we all know the real value of these programs.

The other thing, we have to start teaching our young males to be responsible. We have allowed many of our young males to feel that they donated a sperm and that is being a father. We have to teach them to be responsible.

In Arkansas it took 12 pieces of legislation, but we are going to deduct 7 percent of their salary from the top of the young man's. We put their social security number on the birth certificate when the child is born so that we can address that issue.

Another thing we have been involved in is comprehensive school-based health services. One fifth of our population is in school every day. We can provide primary health services for children in school for approximately $100 per child. Of course, you know the cost of health insurance or health care. We feel that this has made a very big difference, especially for our children in poor areas.

In one of our very small schools for which we received a federal fund, 7 percent of the children were on free lunch, so you know they were all poor. The pregnancy rate was 59 percent. In three years we had no pregnancies, no abortions and no dropouts because of this school-based clinic program in our program.

The other thing that I feel we must begin to do, we must make contraceptive services available where the children are. We must improve

contraceptives, as you said previously, and we must deal with the problem of child abuse where 8 to 10 to 12 percent of our young people have been abused.

Lastly, we must offer our bright young people hope for the future. The hope is there. We passed a piece of legislation where children who had a B or above average and were good citizens had their tuition and books paid at a state-supported school. It is far cheaper to pay for college than it is to pay for prisons.

For the past five years, I feel I have been out there dancing with the bear. As we always say in Arkansas, when you are dancing with the bear, you can't sit down; you have to wait until the bear gets tired. I want you to know that I have been looking for some new partners to stand in for me. I am glad you are having this opportunity, because it gives us the opportunity to get new partners.

I am pleased Bill Clinton will be the President, because I know that he understands the problem I am talking about and understands what we need to do for our most viable resource, our children.

I would like to close with an old Greek saying which says, children for the most part are the most valuable resource we have, and when we find that there are old men planting trees under whose shade they know they will never sit, then our society grows great. Today, I feel that in this conference and in this Subcommittee, we are planting trees for the most valuable resource we will ever have to sit under. Thank you.

[The prepared statement of Dr. Elders starts on p. 41 of Submissions for the Record:]

REPRESENTATIVE SCHEUER. Dr. Elders, thank you for your brilliant and inspiring testimony. We are very grateful to you.

I have a few questions. During your five years as Director of the Arkansas Department of Health, how were your ideas of preventing teenage pregnancy been affected by the Federal Government?

DR. ELDERS. We feel the Federal Government has very frequently gotten in the way.

I didn't know all the rules and policies. When I became health director, I said I was too old to learn them. So I told my department to make the rules fit what I do. So, in many respects, we bent a lot of rules to the absolute breaking point in order to do some of the things we needed to do for our most valuable resource.

One of our rulings relates to Medicaid, Mr. Chairman. In our society, we go up to 185 percent of poverty to pay for pregnant women and children. I support that. I am not opposed to that. But in my state, we only go to 29 percent of poverty for family planning. I told one of the members of your committee that the Medicaid rules could only have been designed by a white male slave owner who said that we want to have bigger, better, healthier slaves rather than planned, wanted children. We don't need any more slaves now.

I think it is for Medicaid to support reproductive help. Even if they want to write in no abortions, that would help. I think I was convinced by legislation in Arkansas to pass a law for funding for all women 10 to 25 who want it. It makes good sense. Economically, it would save us billions of dollars.

REPRESENTATIVE SCHEUER. I am absolutely delighted to hear you say that. As soon as Norplant was employed, I thought, wow, this will provide a breakthrough for women in this country to control their own fertility. I thought the cities and states would be clamoring to get Norplant passed, an absolute, assured availability to young people, but, unfortunately, it has not happened. Why hasn't it happened? Is it cost?

DR. ELDERS. It is cost. It costs approximately $500 at a single shot. Insurances, some of them are now beginning to pay.

In Arkansas, we only go to 29 percent of poverty, so we didn't have the money. Many of our legislators are wanting to sign on so that we can get enough money to pay for Norplant. We have over 3,000 young women on the waiting list, and you know how long they will stay on the waiting list. We will need to send them to prenatal care next time.

REPRESENTATIVE SCHEUER. You are absolutely right. There ought to be a federal policy addressing Norplant.

DR. ELDERS. I certainly think so. When I talked with Mr. Waxman, and I also talked with Mr. Kennedy, they said that the governors didn't want it. We were talking about changing it from pregnancy to reproductive health. They said the governors did not want it changed, but I felt we, perhaps, did not sell the governors enough.

REPRESENTATIVE SCHEUER. I hope you will get Governor Clinton's ear and explain to him the importance of Norplant. It amounts to reversible sterilization. A woman can become sterilized at will, at her own timing and convenient.

DR. ELDERS. Absolutely.

REPRESENTATIVE SCHEUER. It seems to me that is an absolute Godsend, and our society is a fool if we don't make it available. I would indeed say that around the world there are areas where that is just as appropriate as in America.

In sub-Saharan Africa, you have an area of the world where people's production goes up about 3½ percent a year. Food production goes up about 1½ percent a year. It doesn't take a nuclear scientist to notice that there is a 2 percent drop in availability of food the first year or thereafter.

It may not be as important in the first few years, but by the fifteenth year that comes around you have a 20 percent reduction in food availability. You can see it on TV now with terrible pictures of Somalia which tear your heart out. It is the interlockable problem created by an imbalance between more people and not enough food.

I know from my own experience in over 20 years of scrutinizing family planning programs in Africa, when they open up a family planning program in a little center, women walk through the hot sun for hours and hours and hours. If you come there around noon, the line stretches out to the horizon, to infinity. Such is their desire to control their own fertility.

Somehow or other, the donor nations of the world, the OECD—Organization of Economic Opportunity and Development—which relates to the well-to-do developed countries and is located in Paris, they have done a shameful job in mobilizing the resources of the developed world to provide family planning facilities for the young women of sub-Saharan Africa, especially. I think the figure is that for $6 billion or $7 billion a year, we could provide

contraceptive services for the entire world. Then we would not see those pictures on the television that disgrace the concept of human rights.

Let me ask you, have federal policies been supportive of or hostile to your efforts to reduce teenage pregnancy?

DR. ELDERS. I would describe them more as hostile. When we changed some rulings, we had to go through a lot of investigation, a lot of threats. So I would describe them as more hostile. I feel that I won, but it was only because I was willing to fight back, I think.

Things like the gag rule—the only thing that ruling ever did, Mr. Chairman, was punish the young and the poor and the ignorant. We already know that everybody else could go to their doctors and do what they wanted, and they did not have to deal with the gag rule.

Who are the people coming to the family planning clinics? It is the young, it is the poor—poor women are increasing all the time—and the uneducated. So the rules were hostile to our young, our poor and our uneducated.

REPRESENTATIVE SCHEUER. As Director of the Arkansas Department of Public Health, what would you find helpful in terms of assistance and attitudes coming from the Federal Government. Let's be specific.

DR. ELDERS. All right. First of all, I think I would get rid of the gag rule. I think President-elect Clinton said he would get rid of that.

REPRESENTATIVE SCHEUER. I think by dusk on January 20 you will see the gag rule becoming history.

DR. ELDERS. That would be very helpful.

The other thing that would be very helpful would be to really fund family planning. I think that is the longest continuing resolution in the history of government.

REPRESENTATIVE SCHEUER. I take it you mean funding the availability of Norplant. So whatever we need for contraceptive services. We have a lot of men in line for vasectomies whom we can't do because we don't have the money. We have only one third of the funding that we need for family planning services. It would be helpful to us to change the immediate aid ruling to extend it to reproductive health as opposed to just pregnancy. That may not sound huge, but I think they would make all the difference in the world, with the availability of women to control their reproduction.

REPRESENTATIVE SCHEUER. Well, Dr. Elders, you have been an inspiring and eloquent witness. I can't thank you enough for joining us this morning and expressing your points of view toward the new world that is upon us and the challenge for the Clinton Administration. I thank you.

DR. ELDERS. Thank you. We are grateful for your holding this conference.

REPRESENTATIVE SCHEUER. We will now hear from Governor David Walters of Oklahoma, who has taken a strong interest in the study of teenage pregnancy from the Center on Adolescent Pregnancy Prevention.

We are delighted to have you with us, Governor Walters. Please take 10 minutes and summarize your views, and I am sure we will have questions along the line.

STATEMENT OF THE HONORABLE DAVID WALTERS, GOVERNOR OF OKLAHOMA

GOVERNOR WALTERS. Thank you. It is an honor to participate in this hearing, and my congratulations to you as you go forward in a new chapter in your life.

It is great to follow Dr. Elders. Her leadership in our neighboring state has spanned a decade. Each time I hear her I come away inspired, as I know you are.

I am David Walters, Governor of Oklahoma. I am pleased to be here today as the lead governor to the Southern Regional Project on Infant Mortality, which recently authored a report on the public expenditures and investments associated with adolescent childbearing. The author of that report, John Schultz, is behind me. He did a very fine job.

REPRESENTATIVE SCHEUER. I would ask unanimous consent at this point to put the report that you just mentioned into the Congressional Record. There being no objection, it is so ordered.

[Material supplied for the record starts on p. 48 of Submissions for the Record:]

GOVERNOR WALTERS. The rate of babies born to teenage mothers is raising steadily in the South and in the nation. Not surprisingly, the public costs for supporting these families started by adolescents are on the rise as well.

In 1981, Southern states spent over $5.7 billion to support families begun by adolescents. Included in that figure are the three largest public programs for families in need: $2 billion for Medicaid, $1.5 billion for food stamps, $2.2 billion for Aid to Families with Dependent Children. Even in Washington, this sounds like and is a lot of money.

By my estimation, the $5.7 billion figure is conservative. We have not begun to estimate the cost of remedial education, job training and the day care needs of the adolescent mom. With the recent increase in babies born to adolescents, the federally-mandated Medicaid expenses for pregnant women and infants, and the growing number of families requiring public assistance, the price tag for adolescent childbearing is skyrocketing. In four years, our region's expenditures jumped 60 percent, from $3.5 billion to $5.7 billion. Some Southern states' expenditures actually doubled.

In Oklahoma, 1991 outlays totaled $219 million, up 62 percent from $135 million in 1987. Imagine if we had these funds for prenatal care for drugs for AIDS patients, for parents and teachers programs, for expanding Head Start, for programs for our increasing elderly population.

The burden of too-early parenthood is not just a personal one. With an incomplete education and inadequate work-force skills, teen moms are less likely to be self-sufficient than their nonparenting peers, and consequently, more likely to rely on public financial and medical assistance. The costs extend well beyond the young family and into our public pocketbook.

I do not mean to suggest that these public programs are inappropriate or should be abolished. It is not in our best interests to abandon our most vulnerable populations. I do believe, however, that we need to take a good hard look at our spending priorities.

Mr. Chairman, the familiar adage, "an ounce of prevention is worth a pound of cure," is particularly relevant to this discussion. You have heard evidence that we are paying for the pound of cure, but we have only begun to

make wise investments in the ounce of prevention. In the same year that the South expended $5.7 billion to support the consequences of adolescent pregnancy, investments to prevent too-early childbearing amounted to $110 million.

REPRESENTATIVE SCHEUER. Let me ask a question here. You governors are pretty pragmatic people. You are pretty bottom-line oriented. How come governors and mayors didn't pick up on this, this thought that you have just expressed, the enormous cost-benefit calculus supporting preventive evidence, even absent any federal leadership in the field, and we have had none for 12 years?

Why do you think governors, themselves, didn't say that it is going to pay us royally, there is going to be an enormous payoff for providing prevention services.

GOVERNOR WALTERS. Mr. Chairman, it is not an uncommon problem, I would say, in not only state and municipal governments, but even in the Federal Government, for us not to focus clearly on good investments. We still struggle trying to find the money to rehabilitate prisoners within our correction system when we know that it pays great dividends. We still struggle to find the money to fund Head Start or to fund prenatal care, and so it is not just isolated to teenage pregnancy. But I think Mr. Schultz' work, in terms of developing this report, helping us as governors, and hopefully congressional leaders and others, focus very clearly on the fact that we spend two cents on the dollar when it comes to prevention for the cost of these programs.

I am not sure that we have torn into Medicaid, AFDC and the other programs as carefully as we have now so that we can bring greater focus to that. My hope is, with the new Administration and their interest in having an investment budget, that that will be infecting the rest of the country's attitude towards budgeting, that we will all pay more attention to wise investments in the future.

The $110 million, as I said, is virtually pocket change compared to the 5.7 billion, and as I just said, it represents two cents on the dollar of our expenditure for prevention, compared to the cost of families started by adolescents.

As a businessman, I believe in true investments that reduce long-term outlays. And for my money, that would mean programs that help school-aged children delay parenting until they have completed high school, until they are self-sufficient, until they are emotionally and financially capable of raising a family. Eight out of ten adolescent moms did not plan early parenthood, as Dr. Elders said.

We face a serious, costly social problem that is not only undesirable to the general public, but to the young people it directly affects as well. I would suggest that we have a mandate to prevent our youth from facing the life-altering costs and course of unintended pregnancy.

The question was posed to me, "What recommendations do I have for investments that could reduce the incidence of teen pregnancy?" I am glad to offer my own philosophy which is grounded in research and a little common sense and a few hours with health advisors who do their best to educate. There is no singular solution, they contend.

To be successful, our interventions must be multifaceted responses to a large number of causes and reasons why pregnancies occur among adolescents. To combat ignorance, counter misinformation, and dispel myths,

communities should provide accurate information about human sexuality and reproductive health.

I strongly believe that parents have the primary responsibility for shaping values and attitudes about sexuality. But they clearly are in need of help. Classroom-based health and sexuality education programs do increase knowledge.

In Oklahoma, we will soon implement a comprehensive health education curriculum, with defined learner outcomes with segments on family life and health and other topics such as AIDS prevention.

By building interpersonal skills to manage their sexuality responsibly, we empower our young people to resist peer pressure, to make smart, healthful decisions. The most powerful evidence of effective programs we have comes from classroom-based curricula that pulls students from behind their desk and gives them the opportunity to rehearse and practice skills needed to avoid sexual pressures.

Provide health care and family planning resources for sexually-active teens. It is not uncommon for public health nurses to discover through in-take that adolescents are sexually active, not using birth control, and not planning a pregnancy. Too often adolescents' medical and preventive health care needs are neglected.

In Oklahoma, we are making them a priority by establishing special clinic hours, employing professionals who will work well with teens, and promoting services to make sure they know what is available.

Finally, and this is our greatest challenge, we must link students to the future and give them the sense that they have other options besides early parenthood. So many of our young parents are not motivated enough to avoid the potential consequences of unprotected sexual activity. Students who have lost interest in school and have low expectations for success most often fall prey to the early parenthood trap. We need to raise their expectations and regain their interest in learning.

We don't ask, Mr. Chairman, for more dollars. I don't want a bigger deficit or a bigger national debt. We ask for new priorities. I am proud to say that many of our Southern States have taken great strides to make adolescent pregnancy prevention a priority. Their efforts serve as good examples for the country.

West Virginia and Tennessee, for example, employ adolescent pregnancy specialists statewide to assist communities in their prevention efforts.

I mentioned Oklahoma's attempt to bring adolescents into the public health doors. Georgia has committed a fair portion of its maternal and child health block grants to school-based services in hopes of advancing their school's health status. Florida's comprehensive and well-funded school health program is a national model; communities across that state are given funding to ensure a basic level of services to all students.

We in Oklahoma, as well as Georgia, Kentucky and North Carolina, have established state grant programs that provide communities greater flexibility in responding to local needs by providing funds for innovative projects.

Despite all these efforts, we cannot attempt to match the need. Mr. Chairman, we need the help of Congress to make this a national priority. Your leadership in creating a federal family planning initiative those many years ago has generated a public health response to fight unintended pregnancy, not just

among teens, but among all women. It is one of our greatest prevention resources. But as you know, those Title X funds continue to buy us less and less when we are required to achieve more and more.

Given the limited resources and the myriad of socio-health problems facing our communities, including substance abuse, low-birth weight, infant mortality, and HIV infection, the public health community is forced to make hard choices about spending priorities. We have stretched our public health dollar as far as possible. And unfortunately, adolescents are paying the consequences. There simply are no federal resources to address the health information and service needs of our children in adolescents.

I am hopeful that this new Administration and new Congress will make young people a national priority. Empowering them with accurate information, accessible health resources, and a sense of their future is our greatest hope for curbing the number of pregnancies to our Nation's adolescents. It is our greatest hope for reducing the number of families started by young people not even out of high school, and it is our greatest hope for reducing the exorbitant cost associated with supporting those families.

Thank you for this opportunity, Mr. Chairman.

[The prepared statement of The Honorable Mr. Walters, together with attachment, starts on p. 45 of Submissions for the Record:]

REPRESENTATIVE SCHEUER. Thank you for your very thoughtful statement.

GOVERNOR WALTERS. You are the only elected official on the panel this morning. So let me ask you a political question. Americans tend to be very conservative about teenage sexuality. And frequently they are hostile to the notion that teenagers are sexually active or ought to be sexually active, and because they are likely to be sexually active, they need family planning information.

How do you deal with voters who are hostile to the concept of giving family planning information and even services to teenagers?

GOVERNOR WALTERS. Very carefully. It is a political risk. It is an element of great sensitivity among many of our constituents. It is something that you simply have to break down the traditional barriers by providing good information.

Dr. Elders provided lots of good information this morning. The statistics are undeniable. The surveys are undeniable. The transmission of sexual diseases is undeniable. Our pregnancy rates are undeniable. And so I think when you counter the emotion of the arguments with the simple facts, that what we are doing apparently doesn't work, whether it is in the home or in the school or in our health clinics, that what we have done in the past needs to change, generally the public—at least the public that I have dealt with—begins to appreciate the need for change. And that, of course, is where we start.

We have to have them appreciate the need for a change before we can implement really any program. So it is incumbent on us to have just this type of hearing, to have publications produced by the Southern Infant Mortality Group, to hold press conferences.

John came to Oklahoma, and we connected up to radio stations all across the Nation and did interviews and tried to make it publicly available to plow the same ground that Dr. Elders has been plowing now for many, many years in Arkansas and doing it very, very effectively. But she is right, she needs some more partners to dance with the bear.

REPRESENTATIVE SCHEUER. You can't afford to sit down. You had a problem in Oklahoma, and apparently you have surmounted the problem. Have you had to change the programs in order to gain voter approval in ways that have prepared their effectiveness? What kind of compromise have you had to make to get your voter mandate?

GOVERNOR WALTERS. Well, I would say that we have had to do a number of different things in order to attack the problem. And it may just be a statistical aberration, but we were the only state in the Southern States to actually have a decrease in the teenage birth rates during the period of time that John studied. And we have gotten there by doing a number of different things.

We have adolescent health clinics in many of our counties that we especially fund. We have matching grants for many of our programs, as we mentioned, which has really helped. We won't fund the community unless there is strong community involvement. We have found very innovative programs that have proven to be successful. We established a training program that principally concentrates on self-esteem, so whether we bring in parents or teachers or Boy Scout leaders, or whoever, we bring them together and train them, and that seems to have had some impact.

We have now trained over 5,000 individuals who have branched out around the state. I would say, if we have made political compromises because of the sensitivities involved, it is that we have not been as strong as Dr. Elders has been, as Arkansas has been in getting school-based clinics established in our schools.

It does make lots of sense that you put the programs where the children are, which would be in the schools, and we have not been able to climb that wall yet and have, instead, begun to develop adolescent health clinics in our county health facilities and making it widely known that those services are available.

REPRESENTATIVE SCHEUER. Are they conveniently enough available so that almost any young person in the state will find one?

GOVERNOR WALTERS. Not yet, to be honest with you. In our state, we have 15 out of 77 counties, so clearly they are not widely available. We are beginning, I believe, through the school health curriculum, to establish a foothold within the schools to provide both—kind of the cultural acceptance of health education—and treating the health needs of children in schools.

So our comprehensive health education program, which was passed as part of a major education reform in our States, I think will begin to help us provide that information that is so important in getting acceptance for the need for change.

REPRESENTATIVE SCHEUER. Governor, you know and I know that the science and art of telecommunications, of communication by a politician with his constituents, has been revolutionized, and Governor Clinton is an example. He had a whole smorgasbord of approaches to communicating with people at the grassroots level, far more than did President Bush or other politicians in the years gone by: The town meetings, his travels by bus, his foray into neighborhoods in Washington, an incredible variety of means of connecting with people.

It doesn't seem to me that we have matched this creativity and inventiveness in our efforts to communicate with young women, young couples, and try and pass on to them some understanding of how important it is for them to

defer pregnancy to a point in their lives where it makes sense, the very criteria that you have given us.

What prospects do you see? Of these breathtaking new means of communicating between politicians, politically and their constituents, what possibility is there that these can be applied to improving the communication between our society and these young people and giving them the message that you articulated?

GOVERNOR WALTERS. I think it has tremendous potential, and we have seen just a glimmer of great hope in our state. My wife, Rhonda Walters, has led a group called Healthy Futures in our state, which is a revitalized group that was involved in the Robert Woods Johnson Foundation Grant a few years ago.

This group decided that they were going to attack the problem of a too-high percentage of our children not being inoculated, of the health issues surrounding maternal and infant care. And so what they did, under my wife's leadership, was to raise private dollars. Then they went to the television stations and asked them to contribute a certain amount of time, so if they bought one ad, they asked for three or four, in some cases, five ads for free, not at 2 a.m. in the morning, but during prime time.

The stations were interested in this and began to become very active, and now we have 100 percent participation of all the stations in our State. Then we proceeded to take both that soft money contributed and the hard private dollars contributed and ask the Federal Government to match that with Medicaid dollars to help us advertise "two by two, take care of your baby now"—all kinds of jingles.

We had a little rock band parity with little kids that were singing about healthy programs. It has had a remarkable impact. We have had a 30 to 40 percent increase in the inoculations to our state.

Young women—we have advertised to prevent smoking and drinking during pregnancy. Young women, it is reported coming into our health departments and into our schools, and teachers and others now report a remarkably changed attitude, because we spent in a small state, without the expenditure of additional dollars on our part, just by being creative, about a million dollars on advertising. It works. It worked in the campaigns; it works on these issues.

The thing that we do not do enough of on adolescent pregnancy prevention is just that, and I hope in time that we are able to expand our program. But if HCFA, or if those that manage Medicaid——

REPRESENTATIVE SCHEUER. You better spell out HCFA.

GOVERNOR WALTERS. Health Care Finance Authority. If those that managed those programs, which are so essential to our health, would also recognize the importance of investing in advertising and prevention, and would provide that match. If we are able to raise the funds or get contributed funds, then we could advertise on this as well. Imagine if you had peer to peer, put a teenager on TV, talking about the difficulties of engaging in early sexual activity and what it means in terms of a change in their life course, I think it would have enormous impact. I don't think adults talking on TV are going to do much, but peer to peer advertising, I think, has a lot of potential. And we can do that if we can have some encouragement and perhaps some match will do it anyway, but we won't do nearly as much of it.

REPRESENTATIVE SCHEUER. How about one-on-one peer group involvement with the target group we are talking about?

GOVERNOR WALTERS. It is very effective. We have funded some grant programs in our state from some communities that have that kind of peer-to-peer counseling. And it is effective. It is hard to explode it to where you are dealing with the great numbers of people that you need to touch, and that is the advantage of telecommunications and advertising.

But I think, as I said in my testimony, it really is going to take a wide variety of solutions. We ought to have a table that has 20 columns in it and determine which states do which things. There ought to be 20 different programs that all of us can model and look to.

REPRESENTATIVE SCHEUER. Take from column A and column B?

GOVERNOR WALTERS. Right. So, in determining which ones are the most effective, which is the advantage of having a southern group on infant mortality, we can now learn from other states' mistakes. If they spin their wheels or spend their money doing something that doesn't work, well, we know that now and we can try to copy those things that are most successful.

REPRESENTATIVE SCHEUER. Assuming that President-elect Clinton comes out with some kind of program encouraging postsecondary education, what would you think of some kind of requirement for those kids who benefit from government aid going to college? Some kind of requirement for them to relate on a one-to-one basis with teenagers—males as well as females—in a one-to-one relationship explaining to them the importance of delaying childbearing to a point in their careers where it is appropriate and makes sense, and will enhance their happiness and life prospects?

GOVERNOR WALTERS. I think the educational trust proposal that the President-elect has made is very exciting. The idea that we offer that kind of educational prospects to our entire population and recognize that investment, and equally exciting is the opportunity to pay for that or pay it back by voluntary services, making available what you just described as an option in that.

I am not sure you would want to mandate each and every student that volunteers to pay it back in that range, but whether they are working there or with community law enforcement or security or health care, it would certainly be an attractive option to make available.

REPRESENTATIVE SCHEUER. Well, Governor, I can't thank you enough for your fine testimony. We very much appreciate it.

GOVERNOR WALTERS. Congratulations to you as you enter your next chapter.

REPRESENTATIVE SCHEUER. Thank you. All right. Now, we will go ahead with our panel of four witnesses. Perhaps, you would all want to come to the witness table. Jane Johnson, Vice President of the Planned Parenthood Federation; Dr. Martha Burt, Senior Fellow of The Urban Institute; Jeannie Rosoff, President of the Alan Guttmacher Institute; and the Reverend Michel Faulkner, Minister for Youth and Director of Community Outreach of the Calvary Baptist Church in New York City.

It is a great pleasure for me to welcome all of you to this hearing. I want to say a special word about Jeannie Rosoff. I have been in Congress 26 years, 13 terms, and at the very beginning of my congressional service, Jeannie Rosoff was a very young woman in Washington, but deeply experienced in the whole matter of reproductive rights, family and the like. She took me under her

wing and helped guide me, and with her advice and counsel, I coauthored with Senator Joe Tidings the bill that ultimately became the current Title X. Is that correct, Jeannie?

Ms. ROSOFF. You forgot one person, George Bush.

REPRESENTATIVE SCHEUER. Yes, and George Bush was a very important supporter of ours. He was an active member of the Wednesday Breakfast Group in Congress, which was the liberal enlightened group of Republican members. We could always count on him for help.

As a matter of fact, I have in my file a newsletter from the Population Crisis Committee of January 1971, a picture of me and Senator Joe Tidings and Congressman George Herbert Walker Bush—an enthusiastic supporter of family planning—to such a degree that Congressman Wilbur Mills, chairman of the House Ways and Means Committee called Bush, "Rubbers Bush"—such was his enthusiasm for family planning services.

It was Jeannie Rosoff who guided me and extended her wisdom and counsel. As a very young woman, she had a very high degree of wisdom and insight, and she guided me through a quarter of a century of contributing to quite a wide variety of measures in the field of family planning and reproductive rights. I want to pay tribute to you, Jeannie Rosoff.

Ms. ROSOFF. We have learned together.

REPRESENTATIVE SCHEUER. We have learned a lot together, but you were ahead of the learning curve, you were ahead of me on the learning curve at all points in our joint experience, and you always interpreted and made your experience and your insights meaningful to me. And I ascribe much, if not most, of the confidence I have been responsible for in family planning to you. So your guidance, concern and patience, I am very, very grateful to you, Jeannie Rosoff.

Now, we will go ahead with all of the testimony. We will start out with Jane Johnson, Vice President of the Planned Parenthood Federation. I am going to try and limit each one of you to ten minutes, and then during the course of that ten minutes, we will have some questions.

STATEMENT OF JANE JOHNSON, VICE PRESIDENT OF AFFILIATE DEVELOPMENT AND EDUCATION, PLANNED PARENTHOOD

Ms. JOHNSON. Good morning, Mr. Chairman. I am Jane Johnson, Vice President of Affiliate Development and Education for the Planned Parenthood Federation of America. I have spent my life as a trained social worker trying to improve the lives of women, children, and families. Prior to my 23-year association with Planned Parenthood, I was a counselor. And I have also managed social service departments at teaching hospitals in Michigan, Alabama, Oklahoma, Wisconsin, and New York City. I also worked in child welfare in Georgia.

I am appearing today on behalf of more than 30,000 volunteers and staff who operate the 169 Planned Parenthood affiliates throughout the country.

REPRESENTATIVE SCHEUER. If you would get to the point, we don't have unlimited time. If you would give us your thoughts on the problems and the challenges ahead and what we can hope for in the Clinton area.

Ms. JOHNSON. The thing that I want to thank you for, Chairman Scheuer, is the opportunity to speak on this issue, and before I go any further in my statement, I want to thank you for the dedication you have given over the years to the issues of family planning.

I am particularly pleased that you did not have the conversion that our President had. Your presence as a true advocate on family planning will be very much missed on Capitol Hill.

For 75 years, Planned Parenthood has been concerned with the social and health repercussions of early and unintended pregnancy. In 1989, we rededicated our commitment to reducing teen pregnancy by launching a new initiative we have called: First Things First. The goal of First Things First, and one that we believe is very much improved by the election of President-elect Clinton, is an ambitious one, which is to reduce by half, by the year 2000, the number of adolescents who become pregnant and give birth annually.

It borders on scandal in the United States that a million teenage girls become pregnant, 500,000 give birth. Little can more profoundly undermine the well-being of the society than the premature, unprepared formation of families by youngsters who are often struggling to get through their adolescence.

Think about it. Five hundred thousand young teen mothers a year, five million in ten years. Let's put that number in perspective. There are approximately half a million persons in Seattle, Washington; El Paso, Texas; Denver, Colorado; Cleveland, Ohio; New Orleans, Louisiana. Imagine for a moment that during a one-year period, half of these cities' productivity was slashed. Half of their bus drivers, doctors, nurses, teachers, dry cleaners, taxies, restaurants, stopped functioning or came to a halt.

Stop functioning and coming to a halt is what happens to half, 50 percent, of the adolescent girls when they become pregnant and deliver a child. Half of them stop functioning in their occupations, they stop going to school. But unlike the cities, these youngsters are without skills, dependent, and bizarrely expected to resume the most difficult occupation on the planet, to perform with success parenting.

Not only is there a high degree of dysfunction and disintegration in these young families, there is the corollary loss of two, and often more, productive citizens. It is estimated that nearly $20 billion is spent annually to support families begun by adolescents.

The personal costs of too-early childbearing are often devastating—perpetuating poverty, hopelessness, and the abandonment of school and productive work. And the cost to society is far-reaching. The vast resources spent by government for the most part are not directed to preventing too-early childbearing, but in attempting to repair its consequences.

The First Things First that we hope the government will emulate is designed to help adolescents avoid the pitfalls of early sexual involvement, because sexual involvement interrupts and even ends personal development in adolescents.

First Things First offers guidance and materials to participating community organizations. Our strategies include: Recognizing the family's role as primary sexuality educators by providing assistance to parents and caretakers in communicating with children about sexuality. Highlighting effective programs that involve, educate and provide services to adolescent men, whose role in sexual decisionmaking has been often neglected.

A centerpiece of First Things First is its reliance on adolescents to help design and implement the programs and efforts that can prevent the early, unintended pregnancy and childbearing that plagues them. Ironically, Mr. Chairman, while some apparently find that it does not ask too much for

adolescents to perform adequately as parents, their demonstrated potential for helping to resolve their own dilemmas is effectively ignored.

We call on the government and the private sector to follow our example to assure that all programs designed to stem the tide of adolescent pregnancy and childbearing include an adolescent perspective. Professional expertise is critical, but without the unique perspective of adolescents themselves, it is doubtful that any program can succeed. Not only is their understanding fresh and unique, but the acknowledgment of their fundamental resourcefulness achieves the empowerment so many of them have been denied.

We professionals wring our collective hands as we note that teenagers are initiating intercourse at earlier ages, and one-third of them use no form of birth control at all during first intercourse. I am persuaded by the adolescents who advise us that, with support, expectation, and information, adolescents are capable not only of altering their own behavior, but also impacting the behavior of their peers and that of their younger siblings.

We also promote the involvement of caring adults to supplement the nurture and guidance usually available for mature families. Unless the government can mandate parental affects, guidance and wisdom, it is destructive of the goal to reduce adolescent pregnancy and childbearing to mandate parental involvement in adolescent reproductive decisionmaking.

A key component of First Things First is to the recognition that to reduce adolescent childbearing, intervention must begin in early childhood. Unless children are nurtured and affirmed in their early years, the chances are greatly reduced that later interventions will be of much use.

Traditional programs for involving and serving adolescents must be expanded, and innovative programs begun. First Things First will do this, but it also will work with communities to assure small children love, security, and proper care.

Bottom line of all of this is that Americans must face the reality of adolescent sexual activity. Fifty percent of unmarried women and 60 percent of unmarried men aged 15 to 19 have had sexual intercourse.

These are the hard truths. For over a decade, our only national effort addressing teen pregnancy has focused solely on promoting abstinence. I urge Congress to expand the Adolescent Family Life program into a more comprehensive approach.

The task facing us, Mr. Chairman, is a tough one, but it is of fundamental importance to the welfare of our children and the future of our Nation. It merits the energy and resources it will require.

First Things First acknowledges the right of every child to accomplish first things first—by securing an education, obtaining physical and emotional maturity, and developing life goals before assuming the responsibility of parenthood. Each year, the reality of too-early parenthood cruelly denies almost a million U.S. teens the rights to first things first, and changes their lives forever. We think that American children should reach their adulthood without having parenthood in their childhood.

Thank you, Mr. Chairman.

[The prepared statement of Ms. Johnson starts on p. 70 of Submissions for the Record:]

REPRESENTATIVE SCHEUER. I think you said it all in that last sentence. Let me just pose some questions to the whole panel. I probably should have done this before your remarks.

What have we learned in the last decade or two about helping young people control their fertility? What have we learned about the diffusion and distribution of family planning information and services? What have we learned about the need for new contraception technologies?

What have we learned about acceptability of the way and the means that we deliver family planning services and counseling? What have we learned about the way we provide incentives? Should we provide incentives?

What kind of incentives for young women, to young couples to control their sexuality in order to defer childbearing? In effect, what have we learned since the days when others put together that piece of legislation, from 1967 to 1970, and up to 1992? That is a period of over two decades.

MS. JOHNSON. I think what we have learned, and I will certainly defer to my colleague, Jeannie Rosoff, as you pointed out very well, has helped us learn what we have learned, and prove what we have known. The one thing that is clear, we have known, Jeannie knew, I knew, Planned Parenthood knew, health care providers knew, the importance of information services, support.

We would have been, I have no doubt, in terms of being on the cutting edge of new technology, if we had not run into a buzz saw of antireproductive health attitudes in this administration.

What we have learned is that if we don't provide services, if we don't provide information, if we don't give young people what they need, they will continue to have unintended pregnancies. We already know that many of them will be assisted if we have reality-based education in the schools and not provide them disinformation, as some curricula that this Administration supports does.

We know that if clinics are available to them, if resources are available to them—you talked earlier today about Norplant. We started providing Norplant in our clinics in February of 1991. By the end of this year, we will have inserted 30,000 Norplants, many of them in adolescent women with generally very good results.

It is interesting that this is a method that has been more available to low-income persons simply because Medicaid covers this cost in most states, in fact all states—apparently not adequately in some states. But the tragedy is that it is too costly really for a lot of working poor.

But we have learned, we have continued to learn. But when important organizations like AGI, who help us learn more, find that they don't have access to the kind of resources necessary in a situation which we are running up against a lot of problems, what we should have known, what we could have known better, we had a setback. But my judgment is that we are in a new place, in a new environment, and we have an excellent chance to move forward.

REPRESENTATIVE SCHEUER. Well, I am very much impressed that you are using Norplant on as wide a scale as you are. It is my understanding that Norplant, which was developed in, among other places, China, widespread experimentation with Norplant—Jeannie, am I wrong?

MS. ROSOFF. I think it was tested in China, but no more than in other places.

REPRESENTATIVE SCHEUER. Is it being used widely in China now?

MS. ROSOFF. Not as far as I know.

REPRESENTATIVE SCHEUER. Well, it seems to me that in terms of the horrendous costs that we have documented being produced by early, unwanted, out-of-wedlock adolescent pregnancy, if you calculate the cost to society per child—and I don't mean the infant, I mean the mother—and you do a cost benefit calculus for that $500 investment in Norplant, that would free that young woman of worry about unintended pregnancy until she had completed her education, completed her training, had grown to maturity, hopefully had acquired a husband, a supportive and nurturing husband.

I think you would find on a very hard bottom line financial analysis that that investment in Norplant was trivial to society in comparison to the savings.

MS. JOHNSON. That has been true, really, of the legislation you talked about, Title X. And, again, Jeannie can address the issue of cost benefit of dollars put in family planning. So any failure that we have had to pursue aggressively, strong family planning financing, certainly has not done anything for the economic well-being of this country.

REPRESENTATIVE SCHEUER. It has been very deleterious for the economic well-being of the country.

Thank you very, very much, MS. JOHNSON. We are very grateful for your testimony.

Now, we will hear from Dr. Marcia Burt, Senior Fellow of The Urban Institute. Please take ten minutes and express your views to us.

STATEMENT OF MARTHA BURT, SENIOR FELLOW, THE URBAN INSTITUTE

DR. BURT. I am actually going to try to express some facts. I am very delighted to hear virtually everybody citing the public cost of teenage pregnancy, while there were some studies from which I actually took off that did rather detailed and expensive estimates of the cost of teenage pregnancies.

In 1985, I was asked by the Center for Population Options to develop a method that practically anybody could use to develop estimates of costs for local jurisdictions, states or for the country as a whole, and at that time I did the country as a whole part.

What I want to do is describe the three different types of cost estimates and what are included in them. There are several graphs in my written testimony that will make rather clear what I am talking about.

I estimated three different kinds of public costs. The first of those is a one-year cost. It is based on welfare dependency, Aid to Families with Dependent Children, and the programs that are tied to that. Medicaid and food stamps, which almost 90 percent of people on welfare get. Actually, the actual calculation is that slightly over half of the families on welfare—whatever the current age of the mother— were begun by the birth to a teenager.

And it is very simple to calculate. You take the total cost of AFDC, the total cost of Medicaid to those on AFDC, the total cost of food stamps to those on AFDC, multiply by .53, and unless you have any better data for your state or jurisdiction, you come up with an answer and that answer is displayed on Table 2, Figure 2 or Exhibit 2.

In 1985, which was when I calculated it, it started out at about $16.7 billion for the country as a whole. It has not gone down since then. Since 1985, the Center for Population has been making these calculations every year.

The latest calculation, which was for 1990, was $25.1 billion, and you can see how it has gone up. The big jump between 1989 and 1990 was, in part, related to the number of people in poverty, because that will increase the number of people on AFDC.

Case loads are pretty constant through 1985 through 1989, and then between 1989 and 1990, they went up. What that means is, you can expect the 1991 figures to be significantly higher as well. Another part of that jump is the increase in medical costs. So there were big Medicaid increases in that 1989 to 1990 inspection as well.

The second kind of cost I calculated is a little bit harder to explain. Exhibit 1 tries, to the best of my ability, to paint a picture of the differences between these two costs. The second kind of cost is the cost for a single birth to a teenager who begins a family, a first birth. It begins a career that is basically a career of a family that may be or may not be on welfare, may or may not incur any public costs, but the expectations built into that 20-year projection are for a certain period, additional childbearing and for a certain probability of receiving public support.

The costs that are involved in these are AFDC, food stamps, Medicaid, the administrative costs to those programs which are not in the first category, and an estimate of public housing costs and social services costs as well. They are projected over a 20-year period, and they are discounted back to what you would have to put aside today in order to pay for that family. It deals only with first births because that is the beginning of the family.

There are, of course, other births to teenagers while they are still teenagers, but that is calculated in the expectation of having a second child within a couple of years and so on.

That cost of a single birth is in Exhibit 3. It is in thousands and not terribly impressive. It is not nearly as impressive as the billions. It starts at $13,900 for a single birth on average to a teen. If you are talking about a 14-year-old, the costs are higher. If you are talking about a 19-year-old, the costs are lower, but this is average.

REPRESENTATIVE SCHEUER. That is roughly $14,000 a birth?

DR. BURT. Correct, per family.

REPRESENTATIVE SCHEUER. Is that cost to society?

DR. BURT. That is the AFDC, food stamps, Medicaid, social services and housing costs, over a 20-year period. It goes up to about $18,000 by 1990. These costs are as low as they are because, although we all have the public image of every teenager instantly going on welfare and staying there forever, in fact, that is not what happens to a lot of them.

In the teen years, there is about a one-third probability in any given year, there is only one out of three of them that will be on welfare during a given year. By the time you hit 20, you are going down to one out of five, and then way down by the time you are 30.

The image of the teenage parent as the one who gets on welfare and stays there forever is the sort of public bugaboo, but it is not the reality for a great number of families begun when they are teenagers. Nevertheless, included in

my written testimony is an estimate of what it would cost if they do go on immediately and stay on forever, and that is somewhere in the $40,000 per family range over the 20-year period.

REPRESENTATIVE SCHEUER. Where there is a teenager who does go on welfare?

DR. BURT. Immediately goes on welfare and stays there for 10 years.

REPRESENTATIVE SCHEUER. Let me ask, these figures range from about $14,000 in 1985 to about $18,000 in 1990, going up to $40,000 when the teenager does even up reasonably and promptly on welfare, and stays there for a considerable period of time.

DR. BURT. Right.

REPRESENTATIVE SCHEUER. At a cost of $500, would you say that Norplant would be an extremely desirable investment for society to avoid these costs, which range from $8,000 to $40,000 in a family?

DR. BURT. Right. The dark part of all of these charts is the savings that you could expect by postponing all these teen births until the mother is at least 20, and it is about 40 percent of the total cost. People do not immediately, once they turn 20 without a baby, go down to a zero probability of ever receiving welfare or being supported.

The people who are having babies and using public support also have a lot of other things going on in their lives, which are part of why they are having babies in the first place, in terms of low hopes, low education, low-labor market participation, low school completion and so on, which also predict, even in their later years, some probability of being on welfare, hence the 40 percent issue.

But yes, in the abstract, Norplant would be a very, very wise investment, although the feedback on a lot of Norplant stuff is that they also cost a lot to take out, and teenagers may want them to begin with and then five months later meet a wonderful man and decide that they want them taken out.

A lot of family planning clinics are beginning to report back that they are getting a lot of requests to take them out as well as to put them in—they have side-effects and so on. So I think that what you need is good counseling. You cannot just pop it into somebody without explaining what they should expect by it and the meaning of that decision, because then you are going to be spending a lot of money to take it out, as well.

REPRESENTATIVE SCHEUER. Is the $500 cost of a Norplant insertion good counseling?

DR. BURT. If you are talking about private docs, often no. If you are talking about family planning clinics, usually yes. It is critical to have it, because people often do not recognize some of the side-effects that may happen to them that they may not like. They may not really be thinking in a five-year stretch.

I mean, in terms of new technologies, there is also going to be Deprovera, which is a three-month decision instead of a five-year decision. It means a more frequent return, but it also gives a woman more control in shorter periods of time.

REPRESENTATIVE SCHEUER. It gives them control over a shorter period of time without the necessity of taking out Norplant.

DR. BURT. That is right.

REPRESENTATIVE SCHEUER. But Norplant is truly a reversible sterilization procedure, and it is totally reversible?

DR. BURT. Oh, there is no question about that. I think the issue is whether people will reverse it short of the five years.

REPRESENTATIVE SCHEUER. Let's say a young woman 14 or 15 years old gets Norplant that provides five or six years of protection.

DR. BURT. If she keeps it in.

REPRESENTATIVE SCHEUER. And let's say that at 18 she decides to get married, and she has a supportive husband and she wants to have a family. Surely she is not going to delay or hesitate about taking Norplant out for the purposes of becoming pregnant.

DR. BURT. No, and that would be a very successful scenario, where you have avoided all the public costs and an unwanted pregnancy.

REPRESENTATIVE SCHEUER. What is the cost of taking it out?

DR. BURT. About $350.

REPRESENTATIVE SCHEUER. Let's say, between the cost of taking it out and the cost of Norplant—the cost of a thousand dollars—it seems to me, by almost any calculus, you would want to make, even if a woman has Norplant only for a couple of years before she takes it out, it is an absolutely terrific investment for society.

DR. BURT. There is no question about that, and if society does invest in it, it would be a very great benefit. At the moment, a lot of family-planning clinics are having to raise money to take it out when an uncounselled person, who has had it put in by a private doctor, comes in and wants it out. So, at the moment, it is an issue. It would not be an issue if that public support was there to allow people to go either way.

REPRESENTATIVE SCHEUER. By any test of logic, Norplant is still a terrific public investment.

DR. BURT. Absolutely.

REPRESENTATIVE SCHEUER. But what you are saying is that we better have a reevaluation of the financial processes by which we have been inserting Norplant and then taking it out at a later time.

DR. BURT. Correct.

REPRESENTATIVE SCHEUER. From any vantage point of overall logic and rightness, from the point of view of our society, I don't see how you could question a thousand-dollar investment, with an average cost of $5,000, right?

DR. BURT. Right.

REPRESENTATIVE SCHEUER. That is a pretty straight line down there.

DR. BURT. Definitely.

REPRESENTATIVE SCHEUER. With an average cost of $5,000 per single out-of-wedlock birth.

DR. BURT. An average cost, I think, is up to $18,000.

REPRESENTATIVE SCHEUER. No, no, I am talking about the savings.

DR. BURT. The potential savings, right, right.

REPRESENTATIVE SCHEUER. And plus the single-birth cost of anywhere from $14 to $40,000.

DR. BURT. Right, right. Exhibit 4 puts all the people who had their first birth in a given year together for cohorts and gives us the total cohort cost,

which are back in the billions. So you are at $5.2 billion for 1985, up to $7.2 billion for 1990.

Back to Exhibit 1. Each of the bars going across is a different cohort, and so every year you are doing that again—you are starting another 20-year trajectory. So the 1985 cohort is now in its seventh year, but the 1986 is only in its sixth year.

The single cost cuts through that, picks up everybody whenever they started; the single cohort cost gives you a 20-year projection. And I think these numbers are striking enough.

I know one of the consequences for local jurisdictions that have calculated them, who haven't cared very much about doing any prevention before that, is that they look at it and say, my God, we are going to be spending a million dollars on our 14 children who have had babies this year, and we are going to do the same next year and the same next year. And all of a sudden, they start looking at the real benefits of prevention.

I want to say one thing that is not fact—well, I guess it is fact, but it is of a different variety—and that is what Europeans have done that I think we have not done. They have separated three different things. They have separated out knowledge, morality, and health care. They provide health care for everybody, so there is no question about access to the means of preventing pregnancies if you want to.

They have education in the schools, so people have knowledge and they have said, some more explicitly than others: Morality, parents, is your problem. We urge you, we encourage you, we pray that you will talk to your children about what they should and should not do, but the State's function is to give them information and to give them medical care so that they and their children will be healthy. And I think that is what we haven't done. We haven't managed to separate those functions, and we are caught in a perpetual head-in-the-sand dilemma, because we are so totally schizophrenic on the subject of sex.

[The prepared statement of Dr. Burt, together with attachment, starts on p. 72 of Submissions for the Record:]

REPRESENTATIVE SCHEUER. In Europe, where they have been much more successful in helping their young people cope with their teenage sexuality, have the various church groups, *per se*, opposed programs of knowledge in the schools, the widespread and convenient availability of family planning counseling and services?

DR. BURT. Not even in France.

REPRESENTATIVE SCHEUER. How about Italy, how about Spain?

DR. BURT. Jeannie, those weren't in the study that I know of, but——

MS. ROSOFF. The sex education picture in Europe is very mixed. Except for the Scandinavian countries, I think the situation is fairly similar to that of the United States. What I think is very different, and I will give you just one example of the German parliament—after the two Germanies came together— there was a big issue between the East German abortion law and the West German abortion law. And the parliament passed an abortion law that fell somewhere in between, but it was accompanied by a decision by the government to pay for all birth control devices for teenagers under national health insurance at full cost, which was an exception from the normal way of dealing with drugs in which there is some kind of deductible.

REPRESENTATIVE SCHEUER. Did they use Norplant in Europe?

MS. ROSOFF. In some countries. I think since there has been a lot of attention to Norplant, let me second a little bit about what was said before. Number one, if you ask what we have learned in the last 25 years we have learned that people are very strange and they have all sorts of strange ways and habits and preferences, and there is no birth control method which is acceptable by everyone. And I don't mean religious differences, I mean just people have fears.

There are some women who will not take the pill, even though it has been proven to be safe. There are women who will be terrified of having something under their arm, which is tantamount to surgery. So, to just say that this is a wonderful method and everybody should get it, I think, is a great oversimplification.

The other problem, which has to do with removal, is very complicated. For example, even if a woman can get the device under Medicaid, Medicaid pays for it and Medicaid is generous. If she is no longer in Medicaid—and hopefully in a couple of years she won't be—she then has no way of getting it out, except paying for it out of pocket.

Most women on Medicaid six months ago are not suddenly wealthy and capable of coughing up the surgical fees six months later . The second point is that it is not that easy to take out. And not so many people——

REPRESENTATIVE SCHEUER. You mean, not so many of the technicians know how to insert it as know how to take it out.

MS. ROSOFF. Yes. And women move a lot around the country. You might be living in New York where it is very easy, and then move to South Dakota where it is not so easy. So the problems, I think, are much more complex than they appear to be on the surface.

As a matter of fact, as you probably know, we are engaged in a two-year study just to look exactly at that question. To see one, who can get it, because I think there is a triage system that, because the device is so expensive, Medicaid agencies and public health agencies just give it to certain women, maybe not older ones who would need it. But that is the whole problem of mobility and removal.

And also the question of individual preferences. There are women who will say I will never tolerate an IUD because I can't stand the idea of this thing floating somewhere in my body. Other women will say I will never take hormones. And I think we just have to accommodate this. And just as teenagers are not all alike, all men and women are not all alike either.

REPRESENTATIVE SCHEUER. I take it that you are suggesting that we need more research to increase the choices available?

DR. BURT. And more options.

REPRESENTATIVE SCHEUER. Yes. Let's get back to you.

DR. BURT. I am finished with the money. The charts and the savings speak for themselves. You can expect about 40 percent just from delaying teenage pregnancy until the woman reaches at least the age of 20.

Obviously, if we were also investing in education and in job opportunity creation and more job training, and so on, you would reduce the probabilities even further, and you would see much less public dependency.

I also talk from the point of view of a researcher in order to try and answer your question about what have we learned about what is effective. There are several things that we have learned about the delivery of contraceptive services. Information is critical. If they don't know what they need, if they think that if they do it standing up, they won't get pregnant, then they are not going to come in for care.

REPRESENTATIVE SCHEUER. Wait a minute, hold the phone. How do we get that information to them? Is it through the schools?

DR. BURT. Through every possible available means where kids are, through schools, Boy Scouts, Girl Scouts, through any possible youth activity, youth centers. Put it on TV. If you can have anti-abortion stuff on TV, you should be able to have this stuff on TV.

REPRESENTATIVE SCHEUER. Well, I have tried very hard for a number of years to get the television stations to accept ads for condoms. They won't do it. They will have 19,000 examples a year shown on television of sexual intercourse, but they don't like to deal with the consequences of sexual intercourse.

DR. BURT. Absolutely, unless you are Murphy Brown. I think we have learned that availability, access and comfort are critical. Where you get service has to be friendly with teenagers, has to be used to dealing with teenagers, has to be close to where teenagers are, has to be cheap or free. It has to be at the right time or be in school so that they can go during school.

It really helps if the people are familiar to them. Even if the facility is not literally in the school, if the staff of that facility are involved in health education classes in school, if they are known people with whom teenagers are comfortable, they will come for services. If they are shunted aside and told to shut up, and so on, you will have a hard time.

Another thing we absolutely learned is that follow-up drastically increases the success rate. If you keep after kids, if you ask them if they are happy with their method, that all helps. Privacy should be essential so that they can go there without having to tell their parents and without all the other kids in school knowing what they are doing.

We have also learned, completely separate from family planning, per se, that developing protective environments and peer cultures that have a hope for the future is very effective. So, yes, you are talking about exclusively in these environments. I am thinking of one that is a public housing project right now, but there are others as well where there are curriculum models for talking about family life education responsibilities, et cetera.

There are also many other opportunities, entrepreneurs clubs, there are ways of tutoring, ways to get them to stay in school and do right and have 150 kids like you who will not laugh at you when you do that. You can change environments, even the worst environments, if you give kids a protective other way to be that has some other kind of future. It helps more if the future is realistic so you can say there are jobs out there.

I think we have learned that, in spite of the fact that we have had no funding for research into these issues. I think it is absolutely critical that the cancellations of major research projects, which look at people's sexual activity to find out where it would be possible to intervene and on what grounds people might be able to listen, should go forth. If you don't have the information, you are really flying blind.

We all have anecdotes. We do have some pretty old research actually on program effectiveness. We don't have a lot of new research on program effectiveness.

REPRESENTATIVE SCHEUER. Thank you very, very much, Dr. Burt.

Jeannie Rosoff, long-time guide, please proceed.

STATEMENT OF JEANNIE I. ROSOFF, PRESIDENT, THE ALAN GUTTMACHER INSTITUTE

MS. ROSOFF. I am pleased to be here this morning. It is only tempered by the fact that I am jet-lagged from coming back from Japan where I was, interestingly enough, asked to talk about the subject of teenage pregnancy.

The point there is that, even though the rate of teenage sexual activity in Japan is only half of that in the United States, it is growing rapidly with all the consequences we can mention.

My own institution has done studies in Europe and Latin American. This is a problem which is really worldwide. It is not so much that teenage young men and women are having sex much earlier, but that they marry much later. It used to be, if you are pregnant at age 17, last year of high school, you hasten the marriage a little bit and everything was okay. It is no longer okay.

We expect young men and women to have long and expensive educations in order to be able to support themselves—not only men, but also women—and to marry later, hopefully, to have more stable marriages. So we have now a period between the normal initiation of sexual activity and that of marriage, which is quite long. As a result, I think for the United States and for most other countries, the problem is as anxiety provoking as it is here.

We have to accept the fact that the teenage years are the transition to sexual activity. This is something that adults, I think, find hard to face. As parents, I think we like to keep our children young as long as possible and children as long as possible. I think this issue is particularly difficult to face.

We don't have that much problem discussing whether they should stay in school and whether they should go to college, but when it comes to boys and sex, we become tongue-tied and paralyzed. Our children are not comfortable talking about this with us, since they don't think we could be there in the same condition.

REPRESENTATIVE SCHEUER. Are we more tongue-tied in this country than parents are across the length and breadth of Europe?

MS. ROSOFF. In general, that is true. The point I make about sex education in Europe is also true, that most school districts are like the United States, very regionalized and localized and, therefore, their practices vary outside the Scandinavian country.

The discussion of sexuality, not only among teenagers but among human beings, is more open and frank and more acknowledged by government. The fact that the government takes note in the midst of a debate on abortion, that some teenagers should be able to get contraception, I think, is a powerful signal that your government thinks it is very important for you not to get pregnant in your teens.

This is the highest authority in the land saying, I don't think this is good for you. I think that must have an impact on how people think on this issue. This is also a national health system which makes sure that you really have access to a physician.

I know that I am in front of the Economic Committee, so I should be talking about money. But I think that there is, in this case, too much talk about money, because the issue folks are focusing on—teenage pregnancy and childbearing—is teenage sexual activity.

It is possible to be a teenager and have sex and find it pleasurable, and maybe also have emotional feelings about it. But, nevertheless, its consequences will not be long-lasting and its consequences may be nil. However, you can also get pregnant and then the choices, unfortunately, are only two: To have an abortion or to have a baby.

One third of all abortions in the United States are to girls under 20, so it is not a rare and unusual experience. But mention was made this morning about somebody who said, even if we don't have anything to do with this, well, unfortunately, it is one of the most common resolutions of teenage pregnancy. And whether we want to ignore it or not, I think it makes all our remedies somewhat skewed to the portion of the population which is usually, of course, the poorest and the ones that cost us the most money, and they usually end up having the babies.

That does not mean—and I want to stress this—that there is fundamental opposition to abortion among poor people. I know that their rate of abortion is quite high, in some cases going beyond the general population. They tend to have pregnancies more often, and they tend to have more abortions and more births. For us to think simply in terms of this portion of the population for whom the consequences are severe and who for the society's consequences are severe, I think is scuzzing the whole problem.

We cannot address and segregate that population, if you will, as if they did not exist in the United States. They were not exposed to the same background and the same aspirations as we are.

What's interesting about minority teenagers is that when they are 14 or 15, their aspiration to go to college is higher than better-off people, but in fact they don't get there. I think it is the problem of poverty, which I think is very serious, and we need to address it as a poverty program, and then there is the problem of teenage sex and how we feel about it.

I acknowledge the discomfort and particularly the political discomforts that this creates, but I don't think solutions are possible until we face this issue very squarely. I do think that we have found, and there is tentative research which shows this, that it is possible under certain conditions to postpone the initiation of sexual activity. I think the longer we can postpone it, the better.

I would deal with this for the emotional reasons for the young women and men involved, maybe for religious reasons, for reasons that younger teenagers do find it harder to obtain and use contraception well. Whatever we can gain, whether it is six months, a year, or two years, I think this is all to the better. I think we should do a lot of research on this. I think it would aid the public comfort.

I was asking, for example, the Japanese, their particular problem with teenage pregnancy, and really they were saying, well, you know, nobody is uncomfortable as soon as kids go to college. They are already out of the house. We don't know what they are doing and it is fine. It is really when they are around and under foot that we really have a concern.

I think the American public would feel a lot more at ease if they felt when their children started to have sex that they be out of the house. But I think

they are then mature and can take care of themselves. So I think postponing the activity is important.

REPRESENTATIVE SCHEUER. Do European countries, in their sex education programs, have the kind of priority concern for deferring sexual activity?

MS. ROSOFF. Not very much. As a matter of fact, most European countries have the same sexual behavior that we do except for Sweden, which is earlier. We are in the middle range of France, England; Canada seems to be a little later.

The average age of sexual activity by girls, because we only know about girls in this country, basically is a little under 18. It is not the 11- or 12-year-old. These are rarities. The numbers are too large, but they are still rarities in this country.

REPRESENTATIVE SCHEUER. Why is the onset of sexual activity earlier in Sweden?

MS. ROSOFF. I don't know. They have very free attitudes about sex. That is clear. Sweden and the Netherlands are the two probably best known examples of that. I think they know it is going to happen. They think there is nothing wrong with it. Their parents are not upset. They have contraception available. They think that is the thing to do,and it becomes part of the culture.

REPRESENTATIVE SCHEUER. The teenage sexuality?

MS. ROSOFF. Yes, the sexuality. The pregnancy is viewed as a catastrophe, as it is in this country.

DR. BURT. It is viewed that sex is fine. You have sex with people you care about, and if you care about them, you protect them.

MS. ROSOFF. I think it is a different attitude. We mentioned Japan, because it is fresh in my memory. What is interesting there is that, in fact, it is the only country in which the teenage sexual activity of men is studied as much as the teenage sexual activities of women. And given the fact that Japanese activity is not particularly kind to women in general, I think this is a new twist.

REPRESENTATIVE SCHEUER. How do you account for it?

MS. ROSOFF. I would have to go back when the jet lag is over.

I want to conclude on one point, some of which is in fact a question of cost. We have heard a lot about the problem of adolescent pregnancy and childbearing, but I think there is a more hidden cost and that is the cost of sexually-transmitted disease.

As we know, in some sexual transmitted disease, the old fashioned ones we knew about 20 years ago are treatable. I am talking about Syphilis and Chlamydia. But a lot of the new diseases are not treatable and will have life consequences, particularly cancer. They are very often without symptoms, particularly in women, so they are not easily detectable and may be dormant for a long time and have long-term economic consequences.

We don't know what they are, but we do know that they are particularly harmful to women and have long-term consequences for women; and, in some cases, for the babies that they will bear. We know very little. There has been almost no research done on this topic. I think that is something importantly needed.

I am not talking about HIV, which is obviously the most terrible and devastating, but the diseases most of you never heard of, such as chlamydia, which are basically silent diseases in women, and they have very serious, long-term consequences.

Finally, as I say, hope is not lost. Perhaps, if our institutions are failed in many ways, I think young people, there are I think some hopeful signs. For example, in only five years, the proportion of the young women and their partners who use contraception at the first intercourse went from 52 percent to 65 percent.

In 35 years that's a very substantial increase. The proportion using condoms in the same period went up from 23 to 47 percent. Forty-seven percent of young women who don't want to get pregnant are now using a contraceptive method. So that clearly is a response. Both the parents, the school, the media, somebody is doing something, and it has had effect in a very short time.

The down side of this—and this goes back to the question of education—is that young women, women particularly between the age of 20 and 24—so we are not talking about teenagers, but even younger women teenagers—are by and large poor users of contraception. It is not that they don't use well. They forget. They don't use it at the right time. The methods are not easy to use, and many women are fearful of side-effects.

Therefore, I would think that there is a considerable need for improved education, not only for teenagers, but the general population as well. It is remarkable. In a Michigan study, with 1800 women using the pill, in which in the first, I think, nine months of their use of the pill, 79 different ways of using the pill had been found.

Now, there are not 79 ways of using the pill, I assure you. It has to be taken every day for 21 days. It has to be taken at the same hour of the day, so the variations are all bad variations, which shows clearly that we have failed to education the public. FDA has failed, the schools have failed, and the media has failed.

I think we don't quite know all of these reasons, but I think it needs a lot of new investigation and research because, even taking the number of women we now have, including teenage women, we could reduce the abortion and birth rate considerably. There is something to hope about, but there is more to be done.

REPRESENTATIVE SCHEUER. Mrs. Rosoff, thank you very much for your splendid testified this morning, as well as your years of guidance and wise counsel.

[The prepared statement of Ms. Rosoff, together with attachments, starts on p. 89 of Submissions for the Record:]

REPRESENTATIVE SCHEUER. We will now hear from the Reverend Michael Faulkner, Minister for Youth of the Calvary Baptist Church in New York City. Please proceed.

STATEMENT OF REVEREND MICHAEL J. FAULKNER, MINISTER FOR YOUTH, CALVARY BAPTIST CHURCH IN NEW YORK CITY

REVEREND FAULKNER. Thank you, Mr. Chairman. I am Michael Faulkner. I also serve as the co-chair for the HIV-AIDS Advisory Board for the Board of Education of New York City.

I was raised in a middle-class family here in Washington, D.C. During all my time growing up, I was never told by an adult or authority figure that sex was wrong, or that I should in any way exercise caution, only to use prophylactic protection. My values in this area were shaped at an early age by my peers and exposure to pornography. As a result, I became sexually active at an early age and extremely active in later teen years.

While I am not proud of these things, I do think it is necessary to share them as background for my material so that you will know that my personal journey leads me even more convinced and convicted of the ideals I have espoused today.

I would like to begin by shaping the debate as I see it. I do not see the debate, however unwarranted it is, as being one only over the use or misuse of contraceptive devices. I see the debate, rather, focusing on the essential elements of our moral concern for the dignity and value of each human being.

Contraceptives and contraceptive devices are not evil in and of themselves. I am not here to debate whether young people are engaging in sexual activity. As a minister and educator who works with young people, I can assure you that our young people are having sex and at larger numbers and earlier ages than ever before seen in our Nation's history.

The debate should not be over whether or not young people are having sex, or whether or not we need to give them information about contraceptives, but rather who gives them the information about contraceptives and where and when the information is distributed and in what setting.

The impact of our teen sexuality crisis, we have heard the numbers and talked about the economy and the end result of the bottom line figures, but we really have not focused on what I feel are the most detrimental effects of this country.

I do not feel like the most detrimental effect is the fact that over one million teenage girls will become pregnant this year. I don't think it is that young people are contracting sexually transmitted diseases at epidemic proportion. I do feel like the worst and most devastating fact of this crisis is the fact that we, as adults, have failed to shape and frame this argument properly for young people.

By that, I mean sex in all of its wonder and beauty is meant to be shared in the context of the long-term, mutually-monogomous relationship known as marriage. Unfortunately, young people don't hear that anymore. The value of marriage and the end result for their family is not something we promote in a educational setting. Young people are not hearing that message as they should. They are not being told the truth concerning their sexuality and how their sexuality can best be utilized for maximum enjoyment.

Instead, the debate over this issue and the information we receive mainly focuses on technology. The debate is centered on the technology that it will take to eliminate what some would call the detrimental effects of early teenage sexual activities, eliminate pregnancies, sexually transmitted diseases.

When a person says that they are afraid of getting HIV, we give them a condom. When they become afraid of getting pregnant, we give them a condom. When a person expresses their fear of being jilted by someone they love and care about and they are afraid of the emotional scar it will leave, there is no technological device that we can give them.

There is no magic solution we can hand them. I know from my own personal experience and from working with young people that these are sometimes the most detrimental effects of this crisis, the emotional fallout that young people will have from early sexual involvement. It is devastating. The numbers of suicides indicate that and parallel the rise in teen sexual activity.

There are two reasons I believe we have focused on the high-tech rather than high-touch philosophy. One, we have opted for economics as a control for responsible education, elevating the moral expectation of young people; that is, our overall concern for the quality of life has diminished particularly when dealing with young people of color.

We recognize this crisis in these areas extends beyond socioeconomic or racial barriers, yet we find ourselves coming back to the same stopgap measures that we have used before, over and over again. We keep raising the level of expectations for technology.

The second reason I believe that we find ourselves defining this problem from a technological approach is that we really don't believe in young people anymore. We do not believe that they can control themselves, their sexual urges or desires for an appropriate opportunity to express what is the most wonderful of all human emotions.

Our lack of faith in these young people is demonstrated by the fact that relatively few programs use the "A" word as the cornerstone for education. It is abstinence. That is becoming a profane and outdated idea. One New York official called me Neanderthal for working with abstinence in programs dealing with young people.

This epidemic is fueled by the fire of our technological approaches and also the fact that we lack faith in our young people. And it is also fueled by the fact that we, as adults, refuse to give up our sexual vices and, therefore, lack the moral resolve and commitment to tell young people what is best for them in controlling this problem.

A society without moral guidelines on its sexual relationships is not a society at all, but a group of people poised for anarchy and destruction. Without sexual guidelines in our communities, there are no families; without families, there are no communities; and without communities, there is no structure upon which to hinge the training for the future growth of our Nation.

In order to solve this problem, or at least to begin to properly address it, I feel that we need a vision for the future. We need to be willing to set standards for young people and expect them to achieve those standards. These standards do not have to be set by any particular religious code or dogma, but as what we know as educators and health professionals as the most appropriate behavior for them.

I am sure that my distinguished panel would all agree that sex before marriage or sex for teenagers is an unwise activity. If we agree that it is not a wise activity, then we should be promoting those educational programs that will help them make the healthiest and wisest choices for their lives.

Instead, we have raised the condom to a new level of expectation. What we found out about the condom 30 years ago is still true today. The condom, even with spermicide, is not the most effective means of birth control, for a long list of reasons. Nevertheless, I have heard it said by high-ranking New York City officials that the condom is all we have, it is the only hope that we have for stemming the tide on this runaway problem. Abstinence is not

realistic and, therefore, let's not talk about it, but let's figure out a way to make this technology work better for us.

I am not opposed to the discussion of contraceptives with young people; however, it is imperative that messages of this sensitive nature not be done in a mixed group. People call me old fashioned, but I believe young men and ladies and gentlemen should be separated when talking about intimate sexual matters.

I am not opposed to this information being targeted at senior high school students, because I believe they are at a stage in their lives when they can handle the education and need to hear it. But we would go a long way to helping them build the necessary self-esteem if we separated them while contraceptives and forms are being passed around the room.

Recently, a young lady who participates in my youth program called me. She was devastated. She just sat through a sex class which was unannounced, so she could not opt out. The educator, who was a male, brought into the class a model of the female genitalia with a contraceptive device inserted. This model was passed around the classroom. This young lady and others were embarrassed to have the young men talk about this and handle this in front of them, which led to a lot of discussions.

Finally, let me cite an example that I feel is on the right track and has gone a long way to helping solve these problems. You may be aware of the Emory University study that asked 1,000 16-year-old girls from low-income families in the Atlanta area, what type of sex education they wanted to receive. They had over 20 options.

Eighty-four percent said that they wanted to learn how to say no to sexual pressure. This is the message from the group that is most talked about, the group most abused, the group most at risk. Yet, we continue to pump money into technology that will reduce the risk, rather than giving young people what they need and are asking for.

We need to support these young people before they become pregnant by giving them a feeling of hope and self-esteem and self-actualization and accomplishment. We can do this by setting the standards and giving them the resources to meet those standards. Not simply giving them the technology to reduce what some would call the pitfalls of early sexual involvement.

If a young lady gives birth out of wedlock before graduating high school, what are the statistical chances of her actually going on to college and completing a degree? You have already heard that they are almost nil.

The success of self-help programs that I am talking about are parallel to a program right here in Washington, D.C.—the Kenilworth Community Management Model—where people actually brought back their community and took over a public housing project. Many people said that it wouldn't work. Many people said that the poor didn't want homeownership, or that they didn't want empowerment; they only wanted the Government to take care of them.

This message was, of course, ludicrous and racist, to say the least. Yet, that stands as a shining example of what people can do, any people, if given an opportunity. The young people in our communities, particularly the poor and those of color, are dying for an opportunity to prove to themselves and to others that they can wait, that they can take control of their lives, but they need

us as adults, as leaders, to support them in their decisions and in their initiative to wait and to delay early sexual involvement.

Thank you.

[The prepared statement of Reverend Faulkner starts on p. 107 of Submissions for the Record:]

REPRESENTATIVE SCHEUER. Thank you very much, Reverend Faulkner. You had very fine testimony.

You have heard from the witnesses that the level of sexual activity around the world is fairly constant at a teenage level. There are some regions of the world where it is going through the roof and other regions where it is fairly normal. So there seems to be a common level of sexual activity around the world. And whether we have teenage pregnancy resulting from it seems to reflect how societies differ in helping young people cope with their sexuality.

Do you know of any societies anywhere in the world where there has been an effective program of abstinence counseling that has reduced the level of sexual activity?

REVEREND FAULKNER. Oh, yes. And that is not around the world, that is right here in our country. In the Atlanta area, as a result of the Emory University study, they implemented a program that actually did give young people abstinence-based sex education. And they noticed over a period of two to three years that a drastic reduction in the number of teen pregnancies, and in the number of sexual encounters reported by the young people involved in the program.

There was also another study done in Ohio—I can't give the name because I am not familiar with it, but there are numerous studies as a result of some of the Title XX programs and funding—these studies have produced significant results in the area of the reduction of the, not just reduction of pregnancies or reduction of STDs, but actually the reduction in the number of encounters that young people are having.

You see, we approach this problem from an adult perspective. We think of an adult engaging in sexual activity, and we often focus on our rationale. We fail to really grapple with the rationale that a young person uses when they are engaging or, you know, approached about engaging in sexual activity.

The motivations are totally different from those that we think of as adults. And, therefore, we need to get on their level and begin to deal with them where they are, helping them emotionally, helping them to meet the challenges that they face in order to stem the tide on their early sexual involvement.

REPRESENTATIVE SCHEUER. Well, I see absolutely no reason why there shouldn't be abstinence counseling for those young people for whom that is attractive and acceptable. Certainly nothing is lost from delaying sexual activity, and much may be gained. Certainly it reduces the danger of unwanted pregnancy to the vanishing point. And the transmission of sexually transmitted diseases, the STDs that you talked about, that also goes down to vanishment.

So nobody can but applaud efforts toward counseling young people to delay their sexual activity to a time when it is most appropriate in their lives, when their education is completed, their skills training is completed, where they have achieved a higher level of maturity, and hopefully, marriage, with a

concerned, loving, supportive, involved spouse. Certainly that is very desirable.

But there are some young people who may have considered abstinence, but they have opted for sexual activity. And I take it that you would think that for them we ought to have information and services to help them cope with their sexuality in ways that will not leave them vulnerable to unwanted pregnancy, and to sexually transmitted diseases. Would that be a fair statement?

REVEREND FAULKNER. Let me say it this way. I think that we live in a society in which no matter how good the information, no matter how desirable, quote, unquote, the choices, there are going to be people, no matter what age or socioeconomic strata, who are going to deviate from that and go in a different direction.

I think our approach, though, should be one of not that this is the natural way for you to go, but sure, there are going to be some who are going to disagree and not decide to take advantage of, or to understand, that they can live healthy and normal lives and express affection in nonsexual ways.

I think young people are engaging in sex, and the reasons that they are engaging in sex are different from those that we might have heard, or think that this is just a natural part of human growth or development. It is that, yes, young people's hormones are raging, so to speak, but there are nonsexual ways that we can teach young people to express affection that are very effective.

And those young people—and I am speaking from my own personal experienc—the young people whom I have talked to and whom I have counseled, who have been sexually active and then gotten into an abstinence-based program or an encounter group, have been much happier at the end, because early teen sexual involvement is not the most pleasurable experience in the world for those young people who are engaging in that.

REPRESENTATIVE SCHEUER. All right. I sympathize, and I sympathize with the points of abstinence training. I would simply say that it isn't the lifestyle of choice for all teenagers, and for those for whom abstinence is not the answer and who have sexual drives that they want satisfied, I take it that we ought to provide them with the training and services that will enable them to be sexually active if they so will it, while preserving their health and preserving their life prospects by both avoiding pregnancy and avoiding sexually transmitted diseases.

It seems to me that these two programs ought to go hand-in-hand, and that the two choices—education and abstinence and abstinence and education and safe sex, if you will—ought to be two options in the schools, and that neither option will be satisfactory to everybody and meet everybody's desired lifestyle, and there ought to be options that are freely offered to all young people.

REVEREND FAULKNER. We heard earlier that only 2 percent of all of the monies that are spent for sex education are spent toward abstinence-based programs. You know, if we feel that abstinence is the best and most desirable option for young people, then we really need to put our money where our mouth is, and we really need to begin to fund programs that are going to promote research, and that are going to promote other programs.

You know, as I said before, the real problem in this crisis is adults, because we are approaching this problem from our own vantage point, looking at what we don't want to give up in our lifestyles, and not saying to young people, you know, this is what is best for you, but you know, not forcing it, no.

Nobody is going to try and legislate morality. But I do think we need to tell them that these are the most desirable outcomes for your life; I mean, given the statistical opportunities that you will have, and so on. We really need to put our emphasis behind those programs that will give the best and most desirable outcomes.

REPRESENTATIVE SCHEUER. Fair enough. Jeannie Rosoff.

MS. ROSOFF. I am very familiar with the study that Reverend Faulkner just mentioned, which is at Emory University. As a matter of fact, we published it, so I read my own journals and I am familiar with it. The program, in fact, was quite successful, but it was done with 13- and 14-year-old kids who had not had sex, and among those who hadn't had sex, in fact, the initiation of sexual activity was postponed by 18 months, which I said was really a good and desirable thing.

Among the kids who already have had sex at age 13 and 14, which is unusually low, there was no difference in sexual activity. One of the things which the program found which was interesting, and I think many people do not really believe, that it was in fact possible to give a message of abstinence and have that message work for at least a portion of that population and a message of, "If you are sexually active, use contraception," that the two things were not contradictory or undermining to each other.

I would completely agree, and I think I said this in my remarks, that I think we need to find better ways of communicating these messages, and also finding out at which age they are the most effective. I think it is clear that, to be effective, they have to start basically before sexual activity has started.

REPRESENTATIVE SCHEUER. Yes. In other words, they start far earlier than the senior year in high school. Very much earlier. Yes, Mrs. Johnson.

MS. JOHNSON. I think one of the dilemmas that parents face—and we do encourage and support parents in their roles—is that the parents of so many of our current adolescents, who are in difficulty, are themselves single mothers who are frequently also not married, and it asks an enormous amount of them to find the strength to repudiate, in fact, their own history. And so I think families are a lot of support.

I would also urge Reverend Faulkner to understand that our position on adolescents and their behavior and their needs is not based on an adult perspective. Many of the studies that AGI has conducted are studies of youngsters, their attitude, their behavior, and their perspective. We have a lot of faith in their ability to influence and alter their behavior, and they need to be given that.

But I would want to give you the perspective of what I think of this hearing, that this represents an adult view of adolescent sexual behavior. It does not. It represents a significant investment in determining from youngsters—we know the enormous things that impact, and Dr. Burt talked about how we can alter their behavior with television and movies and music.

It is not just what a teacher says in school that ultimately makes a determination about how a youngster behaves. For example, a study in Chicago showed that a mother spends, on average, maybe 40 minutes with an adolescent child and the father spends five minutes a day, whereas they spend hours with their peers and a significant amount of time watching television. So I think it is important to understand that youngsters don't grow up in a vacuum, and there are many things that impact their behavior.

REPRESENTATIVE SCHEUER. Yes, DR. BURT.

DR. BURT. I think it is also very important to reinforce the point that Jeannie made in passing, which is that programs can give both messages, that abstinence is preferable, or delay is preferable, until you can behave responsibly. However, you want to define that, but that if you are going to be sexually active, then here is the way to not incur grave consequences.

Often, the argument is made that if you say both things, you are basically denying the message of abstinence. In fact, programs are quite capable of giving both and of being effective, usually with the not-yet sexually active with the abstinence message and with the protection part with those who are already sexually active. And I think it is critical to do both of those things.

I personally think that since most people in this country are spending less and less time being married, it is not terribly realistic and not specifically within the moral framework of a lot of people in this country, that the only place and time and way to have sex is to be married.

REPRESENTATIVE SCHEUER. I want to thank this panel for a very enriching and thoughtful discussion of all of these issues. I want to thank each and every one of you for having shared your wisdom and your experience with us.

This is a significant date for me, because I have spent much of my 26 years here involved in these problems. I think this is a very proper and appropriate preview of the Clinton era, in so far as how we, how we perceive of young people's sexuality and the kind of investments we are willing to make in their education and in their counseling, and in the services and facilities that we provide to them. So I am very happy to end my congressional career on this note.

This is the last hearing that I will chair as a Member of Congress. I am very grateful to all of you for having made it a very enriching and a very satisfying one.

Thank you very, very much. The hearing is terminated.

[Whereupon, at 12:05 p.m., the Subcommittee adjourned, subject to the call of the Chair.]

SUBMISSIONS FOR THE RECORD

PREPARED STATEMENT OF M. JOYCELYN ELDERS, M.D.

Chairman Scheuer, members of this honorable committee: Let me thank Representative Scheuer for inviting me to appear before you today to discuss the social costs of teenage pregnancy. This is a subject for which I have been fighting long and hard since Governor Clinton appointed me as director of the Arkansas Department of Health. And, I might just add, Governor Clinton has stood beside me the entire time. Both of us are delighted that this honorable committee has chosen to investigate this issue and we are ready to assist you in your work in any way possible.

Consider these facts:

- Every 21 seconds a 15 to 19 year old woman becomes sexually active for the first time.
- Every 64 seconds an infant is born to a teenage mother.
- Between 1986 and 1990, adolescent childbearing increased 16 percent, from 38.4 to 44.6 births per 1,000 girls aged 15-17.
- For those who give birth during adolescence, one in three will have a subsequent pregnancy within two years.
- Every year more than 1 million adolescents get pregnant. This is nearly one teenage girl out of every ten. This rate is twice that of any other industrialized nation.

What are the nation's social and economic costs of teenage childbearing? In a word, staggering.

- Teenage pregnancy is the number one cause for females to terminate their education prematurely. In addition, those who get pregnant prior to completion of high school are, on the average, 2 years behind grade level at the time of pregnancy, indicating school failure to be a contributing factor to premature motherhood.
- Only 50% of teenage women who give birth before 18 ever complete high school, compared to 96% of those who do not have children before age 20.
- Of those women who become mothers before the age of 20, less than 2% complete college, as compared to 20% of those who wait until age 24 to have their first child.
- 70% of teenage men who become parents complete high school, as compared to 95% of those who do not become parents as teens.
- Men who become fathers in their teens are only 50% as likely to complete college as those who put fatherhood off until their 20's.
- The probability of repeating a grade is 40% higher for adolescents born to early childbearers as compared to 20% for adolescents born to older mothers.
- Women who have their first baby as a teenager have lower status occupations, accumulative less work experience, receive lower hourly wages and earn less annually than women who give birth later in life.

In a recent report released by the Southern Governor' s Association and the Southern Legislative Conference, the public expenditures associated with early childbearing were enormous. In 1991, southern states spent over $5.7 billion to support families started by teenage mothers. This represents a 60% increase since 1987. In 1988, the U.S. spent $19.83 billion on families started by teenage mothers. Consider these other economic facts:

- More than 40% of the never married women younger than 25 who enter the AFDC program when their child is younger than 3 spend 10 years or more on

the program. These young women account for almost one quarter (22%) of new entrants and almost one third (32%) of the total caseload.

- Two thirds of children younger than 6 in families begun by a teen birth are living below the poverty level.
- A family begun by a teenage mother in 1988 will cost the taxpayers $16,450 over 20 years. This is the average for all teenagers, not all of whom receive public assistance. The average for only those who receive assistance is $37,500. The period of 20 years was selected because the public will likely support more than one child to adulthood.
- All the families begun by adolescents having their first baby in 1988 will cost the United States $5.98 billion over the next 20 years.

When I agreed to accept the appointment as director of the Arkansas Department of Health, I chose teen pregnancy as the major health problem in my state which I was going to impact. This has not been an easy job. I have literally worn out my state car driving up and down the highways talking to anyone I could get to listen about the problem of teen pregnancy in our state.

The first time I appeared before a legislative committee at our state capitol, one legislator commented, "Dr. Elders, we didn't have a problem of teen pregnancy in this state until you became our health director.

That just illustrates the importance of educating the public on this issue. But once you get them educated, you must be ready to present a plan and implement that plan. I believe that I have educated my state about our problem. When I travel around the state today and ask people what they think is the biggest health care problem we have, they tell me "teen pregnancy."

Now we are ready for our plan.

The issue of teen pregnancy is much like the chicken and the egg. I am not sure if our poverty rates are high because of the number of unwed mothers or if we have so many unwed mothers because our poverty rates are so high.

I have reviewed with you the statistics which reflect the economic costs of adolescent childbearing. However, little research has been done to indicate the motivations which prompt a young girl to chose to bear a child.

Clearly, for too many, there is no choice. The pregnancy may be the result of sexual abuse, even within their family. Often, the child is too young to even know what is happening to their body as the pregnancy progresses. I could spend all day telling you horror stories about twelve and thirteen year olds who present in labor in the emergency rooms of our hospitals complaining of a stomach ache.

But for some, there is a conscious choice to have a child, someone they can hold and someone who will love them. They chose to become pregnant because of the array of services which we make available to them. These services are important and I would not advocate cutting them out for any reason. But, you must understand that for a poor, young girl living below poverty, in substandard housing, who has repeated one or more grades in school, a pregnancy means an improved quality of life for her. A single mother can move into public housing, collect AFDC, food stamps and receive WIC food vouchers for herself and her child. She may no longer have to go to school if adequate child care is not available. In her eyes, with her grossly limited vision, she becomes an overnight success.

Are we offering these children any hope for success to motivate them to delay parenting? Are we offering them the tools they need to avoid parenting? Are we facing the reality that despite efforts to promote abstinence, 75% of women and 86% of men are sexually active by age 19?

This is why combatting teen pregnancy has been so challenging for me. As director of a health department, I can provide prenatal care for teenagers who get pregnant. But, to keep them from getting pregnant, there are many others areas which must be fixed. It is in some of these areas where you really begin to feel the heat.

I know one of the areas where you feel the heat is Title X, public funding for family planning services. We all know that although funding has risen by $154 million over the past decade, when inflation is taken into account, expenditure have actually fallen by one-third. The publicly supported family planning program saves 3 tax dollars in the following year for every public dollar spent on teen age services. The overall savings for all age groups is $2.00 saved for every dollar spent. Applying this ratio to the 1983 public investment in family planning of $340 million, about $680 was saved the next year.

I recognize the problems associated with Title X and Congress, but I am hopeful that together with the new administration, we can break out of some of the grid-lock that has plagued reproductive health.

On the state level, I have developed what I call my six prescriptions which, I believe, will secure a future for our children. These are:

1. **Universal, early childhood education** will prepare our children to learn and achieve, removing some of the disadvantages that hold them back. Given the success of Head Start in improving school performance, there is no excuse for not making such resources available to all children and families in need.
2. **Comprehensive health and family life education** should be taught to all children, starting in kindergarten and continuing through high school. Of course, instruction should be appropriate to the child's ability to understand and need to know. But we must not be timid about facing our obligations even to the youngest children. After all, messages they get from television and videos, older siblings, and even parents, don't respect their ages. They need and should be encouraged to take responsibility for as much of their lives as they are capable. They need to know about human nutrition and physiology and the risks of substance abuse -- tobacco use, alcohol consumption, abuse of prescription medications (more than narcotics alone), and experimentation with substances they may be offered by friends or strangers. In the same way they need to be armed with knowledge about human reproductive biology and development. The risks of early and unprotected sexual activity are effectively learned in such a context. We must do all we can to empower our children with useful facts and resources.
3. **Parents need more support** in nurturing, caring for and teaching their children. So many of our social problems are worsened by parents' uninformed attitudes toward health and inappropriate behavior toward their children. Instruction, counsel, and peer discussion ought to be available. For our future parents, today's children, this can start in the comprehensive health and family life education mentioned above. For today's parents, accessible programs must be devised for their busy lives. Many resources can be tapped, including churches, civic organizations, work sites, schools and communities.
4. **Male responsibility needs reinforcement**. Family planning and sex education has traditionally focused on young females. This strategy tacitly absolves young males of sexual responsibility. As with young females, many young males have few opportunities other than procreation to prove themselves. Accordingly, they must also have opportunities for growth and self-expression in other arenas of life.
5. **Comprehensive school-based clinics** are needed to provide medical care, including family planning services, to all teens. They are logical partners of comprehensive health and family life education. Providing primary and preventive care in schools assures nearly universally access for youth. School-based clinics make good sense. I know Senator Kennedy recognizes that fact because he introduced legislation during the last session of Congress to provide school-based clinic funding. I have been fighting for funding in Arkansas and we now have some 26 school health programs which offer comprehensive primary health care, often to students who otherwise would be underserved. During a meeting last year of the National Governor's Association Committee

on Health Care Access, Governor Clinton, who chaired this committee, made the statement that he and I had been facing the heat so long on school-based clinics that when we started he had dark hair and I was an albino! The heat can get pretty hot. The issue of funding for condoms in school-based clinics held up my entire department's appropriation bill until the last minutes of the 1991 legislative session. It was the last bill to pass.

6. **Opportunities for higher education** should be guaranteed. All children with a B average or above who exhibit good citizenship and whose family income is less than $20,000 should be guaranteed free tuition and books at state-supported colleges. Our society needs educated, critical minds, and our children need opportunities to develop fully.

Again, I appreciate the opportunity to be heard today and discuss with you this issue from the perspective of a state health director.

America is the world's wealthiest nation. But today, our poorest Americans are the 12 million children who live in poverty. Many of these children were born to teen mothers. They are members of what I call the 5-H--

the hungry
the homeless
the helpless
the hugless, and
the hopeless.

The children, who are our only hope for the future, are hanging by a very slender thread to any hope for their future. Until we address the problems in our society which have resulted in children being poorly housed or homeless, poorly fed, poorly educated and lacking adequate health care, we will continue to hand out Band-Aids when what the patient needs is major surgery.

I am sure you feel like I do so often, overwhelmed by the magnitude of the problem. But, just keep in mind, enough committed fleas can make even the biggest dog uncomfortable and transform even the biggest nation.

I have often compared attacking the problem of teenage pregnancy to dancing with a bear. I have been dancing with that bear for over five years. I am delighted that you are willing to join me in this dance at the federal level. I am also pleased to tell you that the next President of the United States has a demonstrated commitment to dancing with that bear also.

The children of our nation are crying for our help. It is time to become committed to this cause, not just concerned.

I would like to close with my favorite saying which I stole from someone so long ago that I've have forgotten who I borrowed it from:

A society grows great when old men plant trees under whose shade they know they'll never sit.

Thank you.

PREPARED STATEMENT OF THE HONORABLE DAVID WALTERS

Good morning, Mr. Chairman. I am David Walters, Governor of Oklahoma. I am pleased to be here today as the lead governor to the Southern Regional Project on Infant Mortality, which recently authored a report on the public expenditures and investments associated with adolescent childbearing. Within the last few years, the rate of babies born to teenage mothers has been increasing steadily in a majority of states across the South and the nation. Not surprisingly, the public costs associated with supporting these families started by adolescents are on the rise as well.

In 1991, southern states collectively spent over $5.7 billion of federal and state funds to support families begun by adolescents. Included in that figure are the three largest public programs for families-in-need: **$2 billion for Medicaid; $1.5 billion for Food Stamps; and $2.2 billion for Aid to Families with Dependent Children (AFDC).**

By my estimation, the $5.7 billion figure is conservative. We haven't even begun to talk about the remedial education, job training, and day care needs of the adolescent mother.

With the recent increase in babies born to adolescents, the federally-mandated Medicaid expansions for pregnant women and infants, and the growing number of families requiring public assistance, the price tag for adolescent childbearing is skyrocketing. In four years, the region's expenditures jumped 60%, from $3.5 billion to $5.7 billion. Some southern states' expenditures actually doubled. In Oklahoma, 1991 out lays totaled $219 million, up 62% from $135 million in 1987.

The burden of too-early parenthood is not just a personal one. With an incomplete education and inadequate work force skills, teen moms are less likely to be self-sufficient than their non-parenting peers, and consequently, more likely to rely on public financial and medical assistance. The costs extend well beyond the young family and into our public pocket book.

I do not mean to suggest that these public programs are inappropriate or should be abolished. It is not in our best interests to abandon our most vulnerable populations. I do believe, however, that we need to take a good hard look at our spending priorities.

Mr. Chairman, the familiar adage, "an ounce of prevention is worth a pound of cure," is particularly relevant to this morning's discussion. You have heard evidence that we are paying for the pound of cure, but we have only begun to make wise investments in the ounce of prevention. In the same year that the South expended $5.7 billion to support the consequences of adolescent pregnancy, investments to prevent too-early childbearing amounted to $110 million. Compared to $5.7 billion, that is pocket change. In fact, for every one dollar we spend in the South to support the long-term costs of families started by adolescents, only two cents is expended to prevent the initial pregnancy.

As a businessman, I believe in shrewd investments that reduce long-term outlays. For my money, that would mean programs that help school-aged youth delay parenting until they have completed high school, are self-sufficient, and are emotionally and financially capable of raising a family. Eight out of ten adolescent moms did not plan early parenthood. We face a serious, costly social problem that is not only undesirable to the general public, but to the young people it directly affects as well. I would suggest we have a mandate to prevent our youth from facing the life-altering course of unintended pregnancy.

The question was posed to me, "What recommendations do I have for investments that could reduce the incidence of teen pregnancy?" I am glad to proffer my own philosophy which is grounded in research, common sense, and long hours with my health advisors who do their best to educate me. There is no singular solution, they contend. To be successful, our interventions must be a multifaceted response to the multitude of reasons why pregnancies occur among adolescents.

- To combat ignorance, counter misinformation, and dispel myths, communities should provide accurate information about human sexuality and reproductive health. I strongly believe that parents have the primary responsibility for shaping values and attitudes about sexuality, but they clearly are in need of help. Classroom-based health and sexuality education programs do increase knowledge.
- By building interpersonal skills to manage their sexuality responsibly, we empower our young people to resist peer pressure, to make smart, healthful decisions. The most powerful evidence of effective programs we have comes from classroom-based curricula that pulls students from behind their desks and gives them the opportunity to rehearse and practice skills needed to avoid sexual pressures.
- Provide health care and family planning resources for sexually-active teens. It is not uncommon for public health nurses to discover through in-take that adolescents are sexually active, not using a birth control method, and not planning a pregnancy. Too often, adolescents' medical and preventive health care needs are neglected. In Oklahoma, we are making them a priority by establishing special clinic hours, employing professionals who work well with teens, and promoting services to make sure they know about what is available.
- Finally, and this is our greatest challenge, we must link students to the future and give them the sense that they have other options besides early parenthood. So many of our young parents are not motivated enough to avoid the potential consequences of unprotected intercourse. Students who have lost interest in school and have low expectations for success most often fall prey to the early parenthood trap. We need to raise their expectations and regain their interest in learning.

I am proud to say that many of our southern states have taken great strides to make adolescent pregnancy prevention a priority. Their efforts serve as exemplars for the country.

West Virginia and Tennessee, for example, employ adolescent pregnancy specialists statewide to assist communities in their prevention efforts.

I mentioned Oklahoma's attempts to bring adolescents into the public health doors. Georgia has committed a fair portion of its MCH block grant to school-based services in hopes of enhancing their students' health status. Florida's comprehensive and well-funded school health program is a national model; communities across that state are given funding to ensure a basic level of services to all students.

We in Oklahoma, as well as in Georgia, Kentucky, and North Carolina, have established state grant programs that provide communities greater flexibility in responding to local needs by providing funds for innovative projects.

Despite all these efforts, we cannot attempt to match the need. Mr. Chairman, we need the help of Congress to make this a national priority. Your leadership in creating a federal family planning initiative those many years ago has generated a public health response to fighting unintended pregnancy -- not just among teens, but among all women. It is one of our greatest prevention resources. But as you know, those Title X funds continue to buy us less and less when we are required to achieve more and more. Given the limited resources and the myriad of socio-health problems facing our communities, including substance abuse, low birthweight, infant mortality and HIV infection, the public health community is forced to make hard choices about spending priorities. We have stretched our public health dollar as far as possible. And unfortunately, adolescents are paying the consequences. There simply are no federal resources to address the health information and service needs of our children and adolescents.

I am hopeful that this new administration and new Congress will make young people a national priority. Empowering them with accurate information, accessible health resources, and a sense of the future is our greatest hope for curbing the number of pregnancies to our nation's adolescents, the number of families started by young

people not even out of high school, and the exorbitant public costs associated with supporting those families.

Thank you for this opportunity. I would be glad to entertain your questions.

EXPENDITURES AND INVESTMENTS

Adolescent Pregnancy in the South

Southern Regional Project on Infant Mortality
Southern Center on Adolescent Pregnancy Prevention
1992

EXPENDITURES AND INVESTMENTS

Adolescent Pregnancy in the South

Note from the Author

What is the public's bill each year for supporting families that are started by adolescents? It is an often-asked question of advocates who surmise that attaching a price tag to adolescent childbearing might pique the interest of state leaders who set policy and appropriate funds to public agencies. By exposing the exorbitant public spending on adolescent childbearing, advocates hope to prompt fiscally-responsible policy-makers to put prevention before costly remediations. Public expenditures are a compelling argument for greater attention to prevention, but they only tell half the story. Of the billions of dollars being expended each year for adolescent pregnancy, what investments of public funds are being made to prevent pregnancies among adolescents in the first place?

The Southern Center on Adolescent Pregnancy Prevention [the Center] conducted a regional analysis of state policies, programs, and funding related to adolescent pregnancy for the purpose of assessing the state's role in stimulating prevention initiatives. Recognizing that responsibility for adolescent pregnancy prevention crosses agency boundaries, the Center requested information and funding estimates for state-sponsored primary prevention initiatives from state education, health, and human service administrators. Several criteria were used to determine what state efforts to include. The policy, program, or funding should be: directed to initiatives that seek to prevent first pregnancies; directly related to reproductive health and responsible sexuality management; and designated by the state for this purpose. [In some instances, federal funds by-pass state agencies and are used by localities for at-risk prevention programs, but are not designated specifically for adolescent pregnancy prevention.]

This is not a rigorous, scientific study, but rather an analysis of states' commitment to adolescent pregnancy prevention as gauged by state policies and appropriations. Its purpose is to draw attention to the spending differential between programs that serve adolescent parents and those that prevent them from becoming parents. Most importantly, the exemplary programs featured here provide guidance for southern states desiring to combat the poor sexual management of its youth. What *Expenditures and Investments* does not capture is the myriad of programs and initiatives sponsored by non-public entities, including religious institutions, civic groups, hospitals, and community-based youth organizations; their contributions are both invaluable and immeasurable.

The Center staff is indebted to the countless agency representatives who completed surveys and responded to telephone information requests. Special thanks to Kelly Thompson and Meg LaPorte of the Southern Regional Project on Infant Mortality for their assistance in collecting data.

John J. Schlitt
September, 1992

SPECIAL INITIATIVES		
Community Grants	State	48,000
	Federal	690,000
LOUISIANA	**TOTAL**	**$3,284,000**
COMPREHENSIVE SCHOOL HEALTH		
School Health Services State Department of Health and Hospitals dedicates federal funds to school health services personnel and administration.	Title V MCH Block	70,000
PUBLIC HEALTH SERVICES		
Family Planning	State/Federal	3,073,000
Family Planning Case Management Federal funds are dedicated to one community-based family planning case management program to prevent early first pregnancies.	Title V MCH Block	141,000
MARYLAND	**TOTAL**	**$5,682,000**
COMPREHENSIVE SCHOOL HEALTH		
Teacher Training Annual state wellness conference for education personnel; teacher training workshops for teaching the state's health curriculum framework.	CDC/DOE grants	100,000
School Health Services State and federal funds support school nurses in 15 counties.	State DFSC	80,000 540,000
Federal and state funds are dedicated to one school-based clinic.	Title V MCH Block State	1,000 113,000
PUBLIC HEALTH SERVICES		
Family Planning	State/Federal	2,705,000
High-Risk Adolescent Family Planning Grants Program	State	2,000,000
SPECIAL INITIATIVES		
Campaign for Our Children	State	320,000
Community Incentive Grant	State	250,000
State Department of Education Miscellaneous Grants Department funds 4 teen health conferences annually and 7 school-based adolescent pregnancy prevention initiatives for high-risk students.	State	193,000

MISSISSIPPI	TOTAL	$2,303,000
COMPREHENSIVE SCHOOL HEALTH		
Teacher Training State-sponsored "Train the Trainers" workshops.	CDC/DFSC	40,000
School Health Services State Department of Health dedicates federal block grant funds to school nurse programs for high-risk areas.	Title V MCH Block SSBG	85,000 203,000
PUBLIC HEALTH SERVICES		
Family Planning	State/Federal	1,745,000
Adolescent Discovery Clinic Federal funds are dedicated to a community-based adolescent health project.	Title V MCH Block	230,000

MISSOURI	TOTAL	$2,129,000
PUBLIC HEALTH SERVICES		
Family Planning	Federal	2,069,000
SPECIAL INITIATIVES		
Teen Health Consultants Federal funds passed through the state health department are earmarked by metropolitan health officials for a peer-to-peer health education program.	Title V MCH Block	60,000

* Missouri's Title X funds are administered through a non-governmental agency.

NORTH CAROLINA	TOTAL	$5,148,000
PUBLIC HEALTH SERVICES		
Family Planning	State/Federal	3,706,000
SPECIAL INITIATIVES		
Community Grants	State SSBG	997,000 445,000

OKLAHOMA	TOTAL	3,536,000
PUBLIC HEALTH SERVICES		
Family Planning	State/Federal	2,948,000
Comprehensive Adolescent Clinics	State Title V MCH Block	100,000 180,685
SPECIAL INITIATIVES		
Community Grants	State	250,000
"Transitions" State Department of Health sponsors workshops across the state on	Title X	41,000

adolescent sexuality for parents, teachers, counselors.		
Male Involvement Program Funds state family planning staff position to stimulate male involvement activities in schools and public health agencies.	Title X	16,000
Adolescent Health Conferences Coordinated by state public health staff and local leaders, one-day health conferences link over 8,700 students with health information and community resources.	Title V MCH Block/ Community funds	unavailable
SOUTH CAROLINA	**TOTAL**	**$4,903,000**
COMPREHENSIVE SCHOOL HEALTH		
Teacher Training	State	101,000
	CDC	18,500
PUBLIC HEALTH SERVICES		
Family Planning	State/Federal	2,287,000
Teen Health Scene	State	36,000
Community-based comprehensive teen and family planning clinic.	Medicaid	360,000
SPECIAL INITIATIVES		
Teen Companion Program	Medicaid	2,100,000
TENNESSEE	**TOTAL**	**$4,619,000**
PUBLIC HEALTH SERVICES		
Family Planning	State/Federal	4,022,000
Teen Clinic State dedicates federal funds to a community-based comprehensive adolescent health clinic.	Title V MCH Block	245,000
SPECIAL INITIATIVES		
Adolescent Pregnancy Prevention Initiative	State	320,000
Teen Theatre The PG-13 Players provide health related information peer-to-peer through theatre.	Title X	20,000
Male Involvement Funds support staff for a community-based family planning male involvement education program.	Title X	12,000

TEXAS	TOTAL	$15,092,000
COMPREHENSIVE SCHOOL HEALTH		
Health Education Specialist	State	700,000
School Based Clinic Coordination	State	60,000
PUBLIC HEALTH SERVICES		
Family Planning	State/Federal	11,430,000
Adolescent Primary Care Clinics	State/Title V	1,965,000
Teen Family Planning Clinic	Title X	739,000
SPECIAL INITIATIVES		
Teen Theatre	Title X	120,000
Male Involvement	State	51,000
Hispanic Male Teen Health Education Initiative	State	27,000

VIRGINIA	TOTAL	$7,020,000
COMPREHENSIVE SCHOOL HEALTH		
Teacher Training Nine HIV/AIDS and health education teacher training facilities across the state; reached nearly 2,000 teachers in 1991-92 school year.	CDC	160,000
PUBLIC HEALTH SERVICES		
Family Planning	State/Federal	6,705,000
SPECIAL INITIATIVES		
Male Involvement Support male staff in "teen only" family planning program.	Title X	5,000
Community Coalition Initiative	Title V MCH Block	150,000

WEST VIRGINIA	TOTAL	$5,425,000
COMPREHENSIVE SCHOOL HEALTH		
Teacher Training Statewide training to integrate the eight components of a school health program.	DFSC/CDC/State	200,000
School Health Services Personnel	State/Local	3,778,000
PUBLIC HEALTH SERVICES		
Family Planning	State/Federal	1,152,000
SPECIAL INITIATIVES		
Community Organization	Title V MCH Block	320,000
Community Grants	State	5,000

The Southern Center on Adolescent Pregnancy Prevention is a clearinghouse and technical assistance function of the Southern Regional Project on Infant Mortality and is sponsored by the Southern Governors' Association and the Southern Legislative Conference. The Center is funded by a generous grant from the Carnegie Corporation of New York. The views in this report do not constitute positions of the Southern Governors' Association, the Southern Legislative Conference, or the Carnegie Corporation of New York.

The Project's region encompasses Alabama, Arkansas, Delaware, the District of Columbia, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, Missouri, North Carolina, Oklahoma, Puerto Rico, South Carolina, Tennessee, Texas, Virginia, the Virgin Islands, and West Virginia. The District of Columbia and the territories were not included in this study because data were not readily available.

Southern Center on Adolescent Pregnancy Prevention

John J. Schlitt
Coordinator

444 N. Capitol St., N.W.
Suite 200
Washington, D.C. 20001
202/624-5897

$10.00

For every $1.00 spent on public programs for families begun as adolescents, the South spends an estimated 2¢ on primary prevention of adolescent pregnancy.

There are two types of public costs associated with adolescent pregnancy: funds dedicated to the primary prevention of pregnancies among adolescents and funds directed to programs for pregnant and parenting adolescents. For the purpose of this report, these costs shall be referred to as investments and expenditures, respectively. Distinctly different from each other, investments are directed to prevent the activity resulting in pregnancy [early and unprotected sexual intercourse]; expenditures deal with the consequences of pregnancy. Expenditures might be considered the public cost of failing to make prevention investments.

This report examines the different costs associated with adolescent pregnancy and its prevention in southern states. Its purpose is to draw attention to the exorbitant public expenditures related to adolescent childbearing in contrast to minimal investments of state and federal resources for adolescent pregnancy prevention. The argument is not that assistance for pregnant and parenting adolescents is inappropriate, but that greater attention to primary prevention efforts might yield fewer unintended pregnancies, and as a consequence, fewer publicly supported families. This report also speaks to those who contend that tax dollars have no place being invested in adolescent sexuality issues. The South's bill to support families begun by adolescents reveals that tax dollars are already being committed; for every $1.00 spent on public programs for families begun by adolescents, the South spends an estimated 2¢ on primary prevention of adolescent pregnancy.

PUBLIC EXPENDITURES

The analysis of consequences associated with adolescent childbearing, typically framed around the personal costs to the adolescent and her child, has been broadened within recent years to include economic impact. As measured by public expenditures related to families begun by adolescents, the cost data provide compelling evidence which suggest that the public, too, pays a high price for adolescent pregnancy and childbearing. Advocates have found the financial impact to be a particularly persuasive tool for prompting leaders who set public agency policies, balance budgets, and curb government spending to give greater attention to primary prevention programs that reduce too-early childbearing.

In fiscal year 1991, adolescent childbearing cost southern states more than an estimated $5.7 billion in federal and state funds [see table for state-specific estimates]. This figure includes outlays for the three largest public programs which serve families-in-need: Aid to Families with Dependent Children [$2.2 billion], Medicaid [$2.0 billion], and food stamps [$1.5 billion]. These single year cost estimates are based on national data which suggest that 53% of families receiving public assistance were begun when the mother was a teenager.

PUBLIC EXPENDITURES RELATED TO ADOLESCENT CHILDBEARING FY 1991

	AFDC	Food Stamps	Medicaid	Total
Alabama	$ 45,426,000	48,360,000	23,556,000	117,342,000
Arkansas	$ 31,156,000	23,892,000	42,839,000	97,887,000
Delaware	$ 21,643,000	18,677,000	28,585,000	68,905,000
Florida	$301,075,000	198,863,000	295,951,000	795,889,000
Georgia	$196,381,000	137,045,000	202,578,000	536,004,000
Kentucky	$118,791,000	19,597,000	128,504,000	266,892,000
Louisiana	$112,055,000	122,187,000	100,773,000	335,015,000
Maryland	$229,234,000	79,931,000	140,131,000	449,296,000
Mississippi	$ 51,696,000	65,482,000	102,876,000	220,054,000
Missouri	$127,942,000	73,201,000	126,729,000	327,872,000
N. Carolina	$181,718,000	79,100,000	197,010,000	457,828,000
Oklahoma	$100,452,000	53,945,000	64,697,000	219,094,000
S. Carolina	$ 68,103,000	60,004,000	45,151,000	173,258,000
Tennessee	$158,520,000	123,850,000	143,487,000	425,857,000
Texas	$278,927,000	251,131,000	224,876,000	754,934,000
Virginia	$123,424,000	69,326,000	91,956,000	284,706,000
West Virginia	$63,861,000	70,599,000	67,720,000	202,180,000
Regional Total	2,210,404,000	1,495,190,000	2,027,419,000	5,733,013,000

Public costs have risen dramatically since 1987, when estimates were last compiled for the region. Between 1987 and 1991, total costs increased 60%, up from $3.6 billion.

The $5.7 billion figure is conservative because it does not take into account other public costs associated with adolescent parenting, including remedial education, job training, and day care for the mother and her infant. Other potential long-term costs that might be incurred by needy families begun by adolescents include housing subsidies, WIC, subsidized school meals, special education, and foster care.[1]

Spending Trends

Public costs have risen dramatically since 1987, when estimates were last compiled for the region. Between 1987 and 1991, total costs increased 60%, up from $3.6 billion. Southern states experiencing the largest increases were Florida (110%), Tennessee (108%), North Carolina (96%), Delaware (92%), and West Virginia (90%). Alabama was the only state whose expenditures remained unchanged. Although there are minor differences from state to state, the increase can be attributed generally to a combination of several factors: childbearing among adolescents aged 15-17 has been increasing steadily since 1986; the number of families eligible for public support has increased across the region; and payment levels for AFDC, Medicaid, and food stamps, too, have increased over the last four years.

PUBLIC INVESTMENTS

States' investments in primary prevention of adolescent pregnancy are reflected in the policies, programs, and funding that facilitate local prevention efforts. For the purpose of this report, the Center looked at a broad range of state-sponsored initiatives that have potential for preventing adolescent pregnancy, including health and human sexuality education, health services, family planning, and life options programs. Surveys reveal that state legislative and agency activity is concentrated in three areas: comprehensive school health, public health services for adolescents, and special initiatives targeted at reducing adolescent pregnancy.

COMPREHENSIVE SCHOOL HEALTH EDUCATION AND SERVICES

Comprehensive school health has long been regarded as an essential component of the adolescent pregnancy prevention paradigm.[2] To successfully delay early parenthood, young people need information, skills, and resources to manage their sexuality responsibly. School health programs have had promising impact on increasing students' knowledge of human sexuality and reproduction, building skills for responsible sexual decision-making, supporting parents as sexuality educators, and providing linkages with health personnel and services. Comprehensive school health programs can establish a foundation of knowledge that stresses personal responsibility for well-

1 Center for Population Options, 1992. *Teenage pregnancy and too-early childbearing: Public costs, personal consequences*, 6th edition, Washington D.C.

2 Schlitt, J. (1991). *Bringing Health to School*, Southern Regional Project on Infant Mortality.

	HEALTH EDUCATION POLICY	DIRECTIVES FOR PREGNANCY PREVENTION	HEALTH/FAMILY LIFE TEACHER TRAINING	SCHOOL HEALTH SERVICES POLICY
AL	Mandate: grades K-8 and one high school unit.	None	None	None
AR	Mandate: grades K-8 and one-half unit in high school.	None	Curricula training for 5-6 districts a year.	State law mandates the services of a licensed nurse per school district; suggested nurse-student ratio is 1:1,000.
DE	Mandate: grades K-12	required; see bullet	46 teacher trainings in 1991- 92 for 2800 school personnel.	State law mandates one nurse per 40 teacher units; see bullet.
FL	Mandate: grades K-12.	Mandated human sexuality education grades K-12.	Variety of training events across the state serving 1,000 teachers annually.	See bullet
GA	Mandate: 30 hours for grades K-8 and 1 high school unit.	Human sexuality education is included as required competency.	see bullet	None
KY	Local option.	None	None	State defines essential health services to be provided; no mandate for school nurses.
LA	Two units of Health and Physical Education are required for graduation.	None	Health topics teacher training by request.	None
MD	Mandate: grades K-8.	required; see bullet	Wellness conference for school personnel; teacher training for health curriculum	State health and education agencies adopted standards for school health; no state funding was attached.
MS	Local option; state-adopted comprehensive health education curriculum is available.	None	Train the trainer workshops for state health education curriculum	Authorized, but not funded by state.
MO	Local option.	None	None	None
NC	Mandate: grades K-9.	None	None	Authorized, but not funded by state
OK	Mandate: Beginning school year '93, grades 1-12.	learner outcomes for Family Life are provided to schools, but not mandated.	HIV/AIDS and health topics workshops serving 466 personnel in 1991-92.	Written description of health services required.
SC	Mandate: grades K-8.	required; see bullet	See bullet	None
TN	Mandate: grades K-12.	required; see bullet	Family life education teacher training by request; 700 teachers served in 1991-92.	Authorized, but not funded by state.
TX	Mandate: grades K-12.	None	See bullet	Essential health services mandated; no state funding for implementation.
VA	Mandate: grades K-10.	required; see bullet	See bullet	None
WV	Mandate: grades K-12.	required; see bullet	Statewide teacher training to integrate 8 components of school health program.	Mandated student-nurse ratio; health personnel state funded; see bullet.

ness, and aid students in understanding choices and behaviors that impact their physical, mental, social, and emotional health.

The Center examined state school health policies as they relate to the prevention of adolescent pregnancy. Is there a legal basis for school-based health education? Does the state code support the inclusion of human sexuality and pregnancy prevention topics? What state-sponsored training opportunities are available for health and human sexuality instructors?

Comprehensive Health Education Policy

The primary mechanism by which states support comprehensive health education is through legislation or agency policy. Thirteen of the 17 southern states provide a legal basis (see table); Kentucky, Mississippi, Missouri, and Oklahoma[1] encourage, but do not mandate, local school districts to provide health education.

1 As of 1993, Oklahoma school districts will be required to provide health education in all grades.

Human Sexuality/ Adolescent Pregnancy Prevention

Many states that establish learner outcomes for comprehensive health education include topics which address human reproduction and the prevention of adolescent pregnancy (i.e. human sexuality, family life education, etc.). Of the 13 states mandating health education, 8 identify human sexuality and/or the prevention of adolescent pregnancy as a required component (see table). Some states provide broad parameters for addressing human sexuality, giving communities flexibility in meeting the state objective:

- Florida law mandates human sexuality education in grades K-12; local school districts have the option of including as a part of, or separate from, health education.
- Maryland's State Board of Education requires that health instruction help young people make responsible decisions about sexual behavior, family planning, and preventing pregnancy.
- South Carolina requires a minimum of 750 minutes of classroom time dedicated to reproductive health and pregnancy prevention for grades 9-12.
- Tennessee code requires family life education for all counties with an adolescent pregnancy rate exceeding 19.5 (per thousand females aged 15-17). "The locally devised and implemented program ...shall emphasize abstinence from sexual relations outside of marriage, the right and responsibility of a person to refuse to engage in such relations, basic moral values, as well as the obligations and consequences which arise from intimacy."

Other states prescribe very specific objectives which must be met in the classroom:

- Delaware's State Board of Education set health education objectives which include analyzing the

benefits of postponing sexual involvement, the effects of teenage pregnancy, and the various methods of pregnancy prevention.

- The Virginia State Board of Education's family life education learning objectives include understanding the benefits of postponing sexual involvement, the consequences of teenage sexual activity, the responsibility of family planning, and the effectiveness of contraception.
- West Virginia's state health education include analyzing the implications of adolescent pregnancy; evaluating methods of fertility control; and recognizing the responsibility of parenthood and the significance of family planning.

Health and Human Sexuality Education Training

Tangible support for health education is apparent when states sponsor health and human sexuality education training. State funds for training school personnel to provide health instruction have been limited. In recent years federal Drug Free Schools and Communities and HIV/AIDS prevention grant programs have provided fiscal support for health education, including state administrative staff, professional development, and health materials. While the categorical funds relate to very specific health topics, many states have used the funds to support a comprehensive health framework for addressing all health risk behaviors, including too-early sexual activity. The inclusion of human sexuality and pregnancy prevention in state-sponsored training activities depends greatly on the education agency's philosophy regarding comprehensive health programs. The following states have demonstrated a significant commitment toward supporting health and human sexuality educators:

- In 1991, Georgia's Governor Miller earmarked $500,000 of state revenue to fund salaries for family life education trainers in each of the 16 regional education service agencies thereby assisting schools in implementing the state's family life education mandate.
- South Carolina's State Department of Education funds two full-time health educators to travel across the state in a mobile health education van and provide teacher training.
- The Texas School Health Project, state-funded at $700,000 via the Texas Cancer Council, provides staff development for school personnel interested in infusing health topics into existing curricula.

School Health Services Policy

Among the school health components, health services has probably received the least amount of attention from state government. Six southern states report having no code regulating school health services; seven states authorize the

provision of essential services but do not provide funding for implementation [see table]. While school nurses, the dominant provider of school health services, are supported primarily by local funds, some states designate federal block grant funds for health personnel. Three states have made a significant financial commitment to school health services and personnel:

- Delaware and West Virginia mandate school nurse programs, including a specific nurse ratio (per students in West Virginia; per number of teachers in Delaware). The nearly 160 school health personnel in each state are considered state employees; their salaries are funded through state funds.
- Florida's school health code establishes the foundation for district programs and includes state funding [$5.7 million] for basic health services; an additional appropriation [$9 million] is allocated for expanded school-based services for high-risk populations.

PUBLIC HEALTH SERVICES

Adolescent public health services are a vital part of the prevention paradigm because they link young people to health personnel—counselors, educators, and service providers—and medical care. Public health agencies have enormous capacity for supporting responsible adolescent sexuality management, for encouraging the postponement of sexual involvement, and for providing family planning resources to adolescents. The Center examined public health initiatives designed to improve adolescents' access to health education, counseling, and services.

While the estimates vary from source to source, more than half of all adolescents are thought to be sexually active by 18 years of age.[1] For each of these adolescents the risk of an unintended pregnancy is significant; for the 25% of sexually active adolescents who use no contraception, the risks are great. Many of the state prevention initiatives focus on providing family planning counseling and contraceptive services to sexually active adolescents. In fact, family planning represents the region's largest investment of state and federal funds toward adolescent pregnancy prevention. With adolescents representing nearly 30% of the South's family planning clients, state and federal family planning counseling and contraceptive resources for this population alone total over $67,000,000 [see table].

Not all adolescents at risk of an unintended pregnancy seek family planning. Many state public health agencies across the region have identified this high-risk population as an agency priority and have made concerted efforts to improve the delivery of and increase access to health care and family planning services for adolescents. Efforts to provide service outreach, establish nontraditional delivery sites, publicize programs, implement aggressive follow-up, and hire staff sensitive to adolescents have been greatly enhanced

1 Moore, K., Snyder, N., & Daly, M. (1992) *Facts At A Glance*. Child Trends: Washington, D.C.

STATE AND FEDERAL RESOURCES FOR FAMILY PLANNING FY 1990

	Adolescents as a % of family planning caseload[1]	Family Planning Investments for Adolescents[2]		
		State	**Federal[3]**	**Total**
AL	31%	$1,104,000	$1,815,000	$2,919,000
AR	28%	681,000	652,000	1,333,000
DE	28%	73,000	202,000	275,000
FL	29%	4,097,000	5,080,000	9,177,000
GA	31%	1,431,000	7,365,000	8,796,000
KY	33%	1,378,000	1,987,000	3,365,000
LA	27%	250,000	2,823,000	3,073,000
MD	26%	1,292,000	1,413,000	2,705,000
MS	28%	66,000	1,679,000	1,745,000
MO	21% (Public Health)	0	1,359,000	
	30% (Title X agency)		710,000	2,069,000
NC	33%	571,000	3,135,000	3,706,000
OK	28%	1,530,000	1,418,000	2,948,000
SC	31%	923,000	1,364,000	2,287,000
TN	26%	195,000	3,827,000	4,022,000
TX	24%	1,865,000	9,565,000	11,430,000
VA	33%	4,241,000	2,464,000	6,705,000
WV	34%	298,000	863,000	1,161,000
South	29%	$19,995,000	$47,721,000	$67,716,000

1 Estimated by state health agency administration

2 Gold and Daley (1992). Public Funding of Contraceptive, Sterilization and Abortion Services, Fiscal Year 1990, *Family Planning Perspectives, 23(5)*, p. 204-211; and reports of adolescents as a percentage of family planning clients served.

3 Federal funds comprise Title X, Medicaid, Title V MCH Block Grant, and Title XX Social Services Block Grant.

by states' commitment of federal and state dollars toward adolescent primary care services.

- With $500,000 in combined state and federal funds, Arkansas' State Department of Health has forged a partnership with local education agencies to create 20 school-based health centers across the state.
- The Georgia Department of Human Resources commits nearly $1 million of its federal Maternal and Child Health Block Grant annually to school-based health centers in 14 counties across the state.
- The Kentucky State Department of Health dedicates nearly $.5 million of its Maternal and Child Health Block Grant toward 12 school-based adolescent primary care facilities.
- Following a state survey that revealed adolescents face a variety of barriers in accessing family planning, Maryland appropriated $2 million of state revenue for a family planning demonstration grant program in seven communities with large proportions of high-risk youth.
- Oklahoma allots $280,000 of state and federal funds to public health clinics around the state to enhance health delivery to adolescents.

SPECIAL INITIATIVES

There is an increasing belief among prevention advocates, social researchers, and program providers that adolescent pregnancy prevention must be broader than human sexuality education and family planning. Adolescents who lack the motivation to delay early parenthood, they contend, will require a greater commitment from society than an hour of reproductive health instruction or expanded after-school hours for family planning services. The following initiatives reflect a variety of strategies that states are implementing to help communities reduce adolescent pregnancy and childbearing:

Primary Prevention Initiatives

As evidenced by the growing expenditures related to families begun by adolescents, the lion's share of public resources and programs are dedicated to serving the consequences of young people's sexual activity. Reaching young people before they become sexually active, while seemingly logical, is the exception, not the norm, to how public institutions treat adolescent sexuality issues (see Schlitt, J. (1992). *Primary Prevention of Adolescent Pregnancy Among High-Risk Youth*, Southern Regional Project on Infant Mortality). Two states have created innovative programs that break from the traditional delivery of services. These programs are innovative in that they represent statewide efforts to delay the initiation of sexual activity among high-risk youth.

- South Carolina's Departments of Social Services and Health Care Financing teamed up to establish an after-

school prevention program for Medicaid-eligible youth. Called the Teen Companion Program, the statewide initiative links peer and adult companions with young people to help them delay early sexual activity and parenthood through education and mentoring.

- A combination media campaign and family life education program, Maryland's Campaign for Our Children advises children across the state that "You can go farther when you don't go all the way." The message promoting sexual abstinence is delivered through a variety of media, including billboards, prime time television and radio ads, and posters. Classroom lesson plans give teachers an opportunity to discuss and explore the campaign's themes with students.

Community Organization

The participation of the community in distinguishing adolescent pregnancy and childbearing as undesirable and in developing prevention solutions is indisputably necessary to creating effective programs. Four southern states provide funds to facilitate community organization around identifying local strategies and resources for preventing adolescent pregnancy.

- Virginia and Maryland provide seed money, or incentive grants, to community-based organizations to stimulate the collaboration, coordination, and strengthening of linkages between public and private youth-serving agencies. Funds are used to form and maintain coalitions, as well as undertake special activities, including needs assessments, resource guides, etc.
- West Virginia and Tennessee have taken a unique approach to organizing communities and resources: state health agencies employ full-time staff dedicated solely to coordinating community adolescent pregnancy prevention activities.

Adolescent Pregnancy Prevention Community Grants

Unlike most categorical grant programs which address one aspect of adolescent pregnancy prevention, state grant programs provide communities greater flexibility in developing comprehensive responses to local needs. State grant programs augment local prevention efforts by providing resources and/or staff that were heretofore cost-prohibitive. The grant process also prompts collaboration among community agencies to determine how the funding could best serve its youth. Programs fulfill a wide range of community needs, including teacher training workshops, male responsibility programs, health instruction materials, and adolescent health conferences.

- Georgia provides an annual $1.1 million state appropriation to local health departments for community-based initiatives;
- Kentucky combines state revenue and a variety of federal

block grant dollars to sponsor a $738,000 special prevention initiatives fund for communities;

- North Carolina's $1.4 million grant program, comprised of state funds and Social Service Block Grant money, is directed to local adolescent pregnancy prevention projects on a competitive basis;
- Oklahoma provides $250,000 of state funds to local community agencies to implement adolescent pregnancy prevention initiatives, which must include the establishment of a community task force and educational components for youth and public awareness.

COMPUTING REGION'S FINANCIAL INVESTMENT

For the purpose of contrasting expenditure and investment figures, states' financial commitment to adolescent pregnancy prevention was measured. In approximating the states' investment of federal and state dollars, the Center requested state agencies to affix a dollar amount and source to the programs featured throughout this report. The criterion for being included was that the funding must be dedicated to primary prevention and directed to the community [i.e. non-administrative]. While every effort was made to include all state adolescent pregnancy prevention activities, some program information and funding may have been missed. It cannot be emphasized enough that these are estimates and should be used accordingly. It is the Center's intent to create a sense of states' spending patterns related to adolescent pregnancy prevention: What resources are dedicated to prevention? What is the funding source? Are some states making greater investments in prevention than others? How do the figures compare with expenditures associated with adolescent childbearing?

In total, the investment of state and federal funds in adolescent pregnancy prevention reached $110 million for fiscal year 1992 [see table; appendix A delineates spending breakdown state by state]. Family planning services make up the largest portion [61%], with the remaining spread across various school and public health initiatives. The distribution between federal block grants and state revenue is evenly matched, suggesting that states are looking beyond categorical grant programs to fund innovative projects. The maternal and child health block grant [Title V of the Social Security Act] is the predominant federal funding source for prevention programs not under the family planning roof. Use of the social services block grant and Title X family planning funds for special initiatives is sporadic.

To make the figures meaningful across states, investments per capita were computed using census data for 10-19 year olds in each state. For example: North Carolina's investments totaled $5,148,000; divided by

an estimated 918,000 adolescents aged 10-19, North Carolina's per capita investment is $5.60. The South's per capita investment is $8.50. Delaware's figure, $65, appears to be an anomaly among the regional range of $3-20; the high number reflects the state's nearly $5 million commitment to school health personnel. Divided by the estimated 90,000 adolescents, the financial investment is much higher than its neighboring states in the South. Low per capita figures are representative of states which make minimal investments beyond family planning; high per capita figures reflect a greater commitment to providing prevention resources to communities.

ADOLESCENT PREGNANCY IN THE SOUTH
PUBLIC EXPENDITURES AND INVESTMENTS/ INVESTMENT PER CAPITA

	Expenditures[1]	Investments[2]	Investments Per Capita[3]
Alabama	$117,342,000	$ 3,349,000	$ 5.50
Arkansas	$97,887,000	$ 2,033,000	$ 5.70
Delaware	$ 68,905,000	$ 5,728,000	$65.00
Florida	$795,889,000	$23,805,000	$15.40
Georgia	$536,004,000	$11,685,000	$12.10
Kentucky	$266,892,000	$ 4,573,000	$ 8.20
Louisiana	$335,015,000	$ 3,284,000	$ 4.85
Maryland	$449,296,000	$ 5,682,000	$ 9.30
Mississippi	$220,054,000	$ 2,303,000	$ 5.30
Missouri	$327,872,000	$ 2,129,000	$ 2.90
N. Carolina	$457,828,000	$ 5,148,000	$ 5.60
Oklahoma	$219,094,000	$ 3,536,000	$ 7.50
S. Carolina	$173,258,000	$ 4,903,000	$ 9.30
Tennessee	$425,857,000	$ 4,619,000	$ 6.60
Texas	$754,934,000	$15,092,000	$ 5.70
Virginia	$284,706,000	$ 7,020,000	$ 8.40
West Virginia	$202,180,000	$ 5,425,000	$19.90
Regional Total	**$5,733,013,000**	**$110,314,000**	**$ 8.50**

1 Medicaid, AFDC, and Food Stamp expenditures for families begun by adolescents; based on FY 1991 data as reported by state human service and Medicaid agencies.

2 Primary prevention program costs (i.e. school health, public health, special initiatives, etc.); based on FY 1992 program information collected from state departments of health, education, and human services.

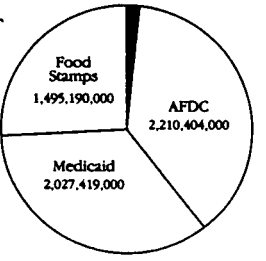
3 Based on 1991 state census estimates for males and females aged 10-19; Population Estimates Branch, Bureau of the Census.

ANALYSIS

In contrast to the $5.7 billion expended to serve families begun by adolescents, the $110 million investment of state and federal dollars toward programs designed to prevent pregnancies among adolescents seems minuscule. The region's largest investment in preventing unintended pregnancies among adolescents, family planning, represents only 1% of the region's total public expenditures related to adolescent childbearing. For every $1.00 spent on adolescent pregnancy programs, only 2¢ is directed to primary prevention. This inequity reflects a societal conflict: we agree the problem exists but we cannot agree on how to resolve it. As a consequence, support for public adolescent pregnancy prevention programs is minimal.

While few would argue that the most effective solutions to preventing adolescent pregnancy and childbearing are locally derived and supported, it is the public institutions, more often than not, that take responsibility for community prevention initiatives. And it is the state that provides funding, regulatory policies, and programmatic directives for those institutions. Accordingly, it is the state that can establish adolescent pregnancy prevention as a priority among local youth-serving institutions, most especially, schools, health departments, and social service agencies. The relationship between state government and local initiatives cannot be dismissed. The challenge remains for state government to carry out its complicated role of prescribing solutions, all the while providing the flexibility and support to help localities determine their particular needs.

PUBLIC SPENDING RELATED TO ADOLESCENT PREGNANCY FY 1991



Investments =
- Family Planning
- Public Health
- School Health
- Special Initiatives

$110,314,000

Expenditures =
- AFDC
- Medicaid
- Food stamps

$5,733,013,000

APPENDIX
STATE INVESTMENTS IN ADOLESCENT PREGNANCY PREVENTION

CDC =	Centers for Disease Control HIV/AIDS prevention grant
DFSC =	U.S. Department of Education Drug Free Schools and Communities
DOE =	U.S. Department of Education
SSBG =	Title XX Social Services Block Grant
Title X =	Federal family planning program
Federal =	Refers to any combination of federal funds, typically, Title V MCH Block Grant, Title XX Social Services Block Grant, Medicaid, and Title X Family Planning.
State =	Refers to state appropriations

ALABAMA	**TOTAL**	**$3,349,000**
PUBLIC HEALTH SERVICES		
Family Planning	State/Federal	2,919,000
Adolescent Primary Care Hospital-based Children & Youth Project; serves large metropolitan area and provides professional development to adolescent health providers across the state.	Title V MCH Block	430,000
ARKANSAS	**TOTAL**	**$2,033,000**
COMPREHENSIVE SCHOOL HEALTH		
School Health Services Combination state and federal funds support 20 school health centers across the state.	Title V MCH Block State	430,000 450,000
PUBLIC HEALTH SERVICES		
Family Planning	State/Federal	1,333,000
SPECIAL INITIATIVE		
Statewide Media Campaign	State/Federal	200,000
DELAWARE	**TOTAL**	**$5,728,000**
COMPREHENSIVE SCHOOL HEALTH		
Teacher Training State held 46 health education teacher trainings in 1991-92 school year for 2800 teachers and nurses; Annual wellness conference attracts additional 120 school personnel.	CDC/DFSC	30,000

School Health Services		
State law mandates one nurse per 40 teacher units; nurses are funded through state and federal appropriations.	State Federal	4,900,000 47,000
Four school-based clinics are supported with federal and state funds.	State Title V MCH Block	341,000 120,000
PUBLIC HEALTH SERVICES		
Family Planning	State/Federal	275,000
SPECIAL INITIATIVES		
Evaluation of the state's school-based health initiative.	Title V MCH Block	15,000
FLORIDA	**TOTAL**	**$23,805,000**
COMPREHENSIVE SCHOOL HEALTH		
School Health Services		
• Basic School Health Program	State	5,679,000
• Supplemental, high-risk school-health grants fund 49 projects statewide.	State	9,009,000
PUBLIC HEALTH SERVICES		
Family Planning	State/Federal	9,177,000
GEORGIA	**TOTAL**	**$11,685,000**
COMPREHENSIVE SCHOOL HEALTH		
Teacher Training	State	500,000
School-Based Primary Care State Human Resources Department dedicates federal funds to middle and high school-based clinics in seven health districts.	Title V MCH Block	980,000
PUBLIC HEALTH SERVICES		
Family Planning	State/Federal	8,796,000
Teen Clinics State-sponsored grants to district health offices to enhance family planning services for adolescents.	State	290,483
SPECIAL INITIATIVES		
Community Grants	State	1,119,000
KENTUCKY	**TOTAL**	**$4,473,000**
COMPREHENSIVE SCHOOL HEALTH		
School-Based Adolescent Primary Health Services	Title V MCH Block	470,000
PUBLIC HEALTH SERVICES		
Family Planning	State/Federal	3,365,000

PREPARED STATEMENT OF JANE JOHNSON

Good morning. I am Jane Johnson, Vice President of Affiliate Development and Education for the Planned Parenthood Federation of America (PPFA) I have spent my life trying to improve the lives of women, children and families. I am trained as a social worker. Prior to my 23-year association with Planned Parenthood, I was a counselor. I managed social service departments at teaching hospitals in Michigan, Alabama, Oklahoma, Wisconsin and New York City. I worked in child welfare in Georgia.

I am appearing today on behalf of more than 30,000 volunteers and staff who operate the 169 Planned Parenthood affiliates throughout the country, the one mill ionplus individuals who contribute to our organization, and above all, the more than 1.6 million adolescent women and men who are served by our affiliates each year. I want to thank you, Chairman Scheuer, for the opportunity to speak about the issue of adolescent pregnancy and the risks it poses to the health and well-being of young Americans.

Before I go any further with my statement, I want to thank you, Mr. Chairman, for the dedication you have given over the years to the issues of family planning. Your presence as a true advocate will be very much missed on Capitol Hill.

For 75 years, Planned Parenthood has been concerned with the social and health repercussions of early and unintended childbearing. In 1989, we rededicated our commitment to reducing teenage pregnancy by launching a new initiative - First Things First. The goal of First Things First is an ambitious one: to reduce by half, by the year 2000, the number of adolescents who become pregnant and give birth annually.

It borders on scandal that in the United States, a million teenage girls become pregnant each year, and 500,000 give birth. Little can more profoundly undermine the well-being of a society than the premature, unprepared formation of families by youngsters who often are themselves struggling to get through their adolescence.

Think about it. 500,000 teen mothers a year, five million in ten years. Let's put that number in perspective. There are approximately half a million persons each in Seattle, El Paso, Denver, Cleveland and, New Orleans. Imagine for a moment that during a one year period, half of these cities' productivity was cut in half, half of their bus drivers, doctors, nurses, teachers, dry cleaners, taxis, restaurants, stopped functioning or came to a halt.

Stop functioning and coming to a halt, is what happens to half, 50%, of the adolescent girls in the United States when they become pregnant and deliver a child. Half of them stop functioning in their "occupations they stop going to school. But unlike the cities in our imagining, these youngsters are without job skills, dependent, and bizarrely expected to assume the most difficult occupation on the planet, parenting.

Not only is there a high risk of disfunction and disintegration in these young families, there is the corollary loss of two, and often more, productive citizens. It is estimated that nearly 20 billion dollars are spent annually to support families begun by adolescents.

The personal costs of too-early childbearing are often devastating - - perpetuating poverty, hopelessness, and the abandonment of school and productive work. And the cost to society is far-reaching. The vast resources spent by government for the most part are not directed to preventing too-early childbearing, but in attempting to repair its consequences.

First Things First is designed to help adolescents avoid the pitfalls of early sexual involvement, because sexual involvement interrupts and even ends personal development in adolescents. Joining PPFA in promoting First Things First are a number of well-known and respected individuals and organizations.

First Things First offers guidance and materials to participating community organizations. Our strategies include:

- Recognizing the family's role as primary sexuality educators by providing assistance to parents and caretakers in communicating with children about sexuality.
- Highlighting effective programs that involve, educate, and provide services to adolescent men, whose role in sexual decision-making often has been neglected.

A centerpiece of First Things First is its reliance on adolescents to help design and implement the programs and efforts that can prevent the early unintended pregnancy and childbearing that plagues them. Ironically, while some apparently find that it does not ask too much for adolescents to perform adequately as parents, their demonstrated potential for helping to resolve their own dilemmas is effectively ignored.

We call on the government and the private sector to follow our example and assure that all programs designed to stem the tide of adolescent pregnancy and childbearing include an adolescent perspective. Professional expertise is critical, but without the unique perspective brought by adolescents themselves, it's doubtful that any program can succeed. Not only is their understanding fresh and unique, but the acknowledgment of their fundamental resourcefulness achieves the empowerment so many of them have been denied.

We professionals wring our collective hands as we note that teens are initiating intercourse at earlier ages, and that one-third of them use no birth control during first intercourse. I am persuaded by the adolescents who advise us that, with support and information, adolescents are capable not only of altering their own behavior but also of impacting the behavior of their peers, and that of their younger siblings.

We also promote the involvement of caring adults to supplement the nurture and guidance available from mature families. Since we cannot mandate parental affection, guidance and wisdom, it is counterproductive to the goal of reducing adolescent pregnancy and childbearing to mandate parental involvement in adolescent reproductive decisionmaking.

A key component of First Things First is the recognition that to reduce adolescent childbearing, intervention must begin in early childhood. Unless children are nurtured and affirmed in their early years, the chances are greatly reduced that later interventions will be of much use.

Traditional programs for involving and serving adolescents must be expanded, and innovative programs begun. First Things First will do this, but it also will work with communities to assure small children love, security and proper care.

Americans must face the reality of adolescent sexual activity. Fifty percent of unmarried women and 60 percent of unmarried men aged 15-19 have had sexual intercourse. Teenagers are having sex for the first time at younger ages - - in 1979, 56 percent of urban, unmarried females aged 17 had experienced intercourse; in 1988, 72 percent. Most of the increase in female sexual activity in the 1980s was among white teenagers and those in higher income families - - narrowing previous racial, ethnic and economic differences. Six in 10 sexually active women aged 15-19 report having had two or more sexual partners.

These are the hard truths. For over a decade, our only national effort addressing teen pregnancy has focused on promoting abstinence. I urge Congress to replace the Adolescent Family Life program with a more comprehensive approach. The task facing us is a tough one, but it is of fundamental importance to the welfare of our children and the future of our nation. It merits the energy and resources it will require.

First Things First acknowledges the right of every child to accomplish first things first - by securing an education, attaining physical and emotional maturity, and developing life goals - Before assuming the responsibilities of parenthood. Each year, the reality of too-early parenthood denies almost a million U.S. teens access to first things first, and changes their lives forever.

PREPARED STATEMENT OF MARTHA R. BURT*

The Joint Economic Committee of the U.S. Congress has asked me to discuss the impact of teenage childbearing on expenditures incurred by federal and other government programs. There are many reasons to care about teenagers having babies. First, most teenagers are not mature enough themselves to provide effective parenting to infants and young children. Second, many teenagers do not take care of their own health, so the health of the babies they carry is compromised. Third, many of the adolescents who give birth are very poor, and their poverty affects the immediate well-being and future chances of their children. Fourth, the responsibilities of caring for infants and small children compete with school work and jeopardize the young mothers' economic prospects for the future, which may depend on high school completion. Many teens who have babies were already experiencing difficulties with and alienation from school before getting pregnant. Their pregnancy may be a result of their disaffection from school, but pregnancy and parenting also assures that young mothers will have more difficulty completing their education and gaining work experience.

These are the human costs of teenage childbearing. But there are also public costs, which can be measured in the dollars spent through public programs to support the families of mothers who had their first birth while still teenagers. When the full monetary costs to society of too-early childbearing are recognized, they add another compelling reason to identify and implement approaches that can prevent teens from having babies.

* Any opinions expressed herein are solely those of the author and should not be attributed to the Urban Institute or its officers or funders.

Types Of Cost Estimates

The cost figures I will share with you today are based on a method I developed in 1986 for calculating public sector costs of families begun by a first birth to a teenager at either a national or a local level.[1] After reviewing all available methods and their applications, the pragmatic approach I chose was adapted from the much more complex analyzes undertaken by researchers at the Urban Institute and elsewhere,[2]. I developed the estimates for 1985; estimates for subsequent years were calculated by the Center for Population Options.[3]

The size of cost estimates for teenage childbearing depend very much on what is included in the calculations, and on which approach one takes. Three approaches are presented here: single year costs, single birth costs, and whole annual cohort costs. Exhibit 1 illustrates the differences in these three approaches.

- **Single Year Costs** -- this approach can be considered a "slice in time." It estimates the total public outlay in a given year for all families begun by a teen birth who receive assistance through relevant government programs. The mothers in these families may be of any age during the year in question; that is, a 30 year old mother whose oldest child is 13, a 22 year old mother whose oldest child is 6, and a 17 year old mother would all be counted, since each had her first baby as a teenager.

  What Costs Are Included -- In this method, the cost of supporting these families through the three biggest relevant public programs are estimated:

  - ► Aid to Families with Dependent Children (AFDC);
  - ► Medicaid;
  - ► Food Stamps.

- **Single Birth Costs** -- this approach can be considered a "corridor (or tunnel) in time" for one family. It calculates the cost over 20 years of supporting a family begun by a birth to a teenager through the use of various government programs. It asks what the childbearing career of a woman who has her first baby as a teenager in a particular year will cost the public by the time her first baby reaches adulthood. The cost calculations are done separately for a first birth to a teenager aged 14 or younger, a teenager aged 15-17, and a teenager aged 18-19.

  What Costs Are Included: The method takes into consideration the probability that any family begun by a teen birth will receive AFDC and related program benefits in each of the 20 years of the projection. It also discounts the projected costs to arrive at a figure in "today's dollars." It includes estimates of costs for:

  - ► AFDC;
  - ► Medicaid;
  - ► Food Stamps;
  - ► Publicly subsidized housing;
  - ► Social services;

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[1] M.R. Burt, "Estimating Public Costs of Teenage Childbearing." Family Planning perspectives, 18(5), 1986, 221-226; M.R. Burt and D. Haffner, Teenage Childbearing: How Much Does It Cost? A manual for estimating local costs. Washington, DC: Center for Population Options, 1986; M.R. Burt and F. Levy, "Estimates of Public Costs for Teenage Childbearing: A Review of Recent Studies and Estimates of 1985 Public Costs." Chapter 10 in S.L Hofferth and C.D. Hayes (eds.), Risking the Future: Adolescent Sexuality, Pregnancy, and Childbearing, Volume II. Washington, DC: National Academy Press, 1987.

[2] R.F. Wertheimer and K. Moore, Teenage Childbearing: Public Sector Costs. Washington, DC: Urban Institute, 1982; SRI International, "An Analysis of Government Expenditures Consequent on Teenage Childbirth. Menlo Park, CA: 1979.

[3] See Center for Population Options, "Teenage Pregnancy and Too-Early Childbearing: Public Costs, Personal Consequences," 6th edition. Washington, DC: Center for Population Options, 1992.

► Program administrative costs.

- **Whole Annual Cohort Costs** -- this approach estimates the 20-year costs of the entire cohort of families begun by a first birth to a teenager in a given year. Thus it multiplies the Single Birth Cost of 20 years of support for a mother 14 or younger by all the first births to girls of that age during a given year, does the same for teens aged 15-17 and 18-19. It then adds the results together to obtain the cost of the entire annual cohort.

  For example, all the first births to teenagers in 1985 (approximately 371,000) are one cohort, and begin one "corridor in time" that will end only in 2004. The 1986 cohort will begin another "corridor," this one ending in 2005. Thus many cohorts or "corridors" exist at the same time, with cohort members being more or less advanced toward the end of their 20 year projection, depending on when they started.

Costs Not Covered

Several types of public outlay are not covered by any of the projections, because no adequate data exist on which to base an expectation of use among families begun by a first birth to a teen. I mention them here because there is some evidence that children in families begun by a teen birth may have a higher likelihood than other children of needing the programs through which these costs would accrue. The types of services for which this may be true in some as-yet-unknown degree are: treatment for sexually-transmitted diseases; child protective services and foster care or other out-of-home placement; compensatory education or special education; special needs/mental health services; and emergency services related to homelessness or potential homelessness such as emergency food, shelter, or health care.

Estimating Potential Savings To Be Gained From Delaying Births To Teens

Single Year Cost

In addition to these three types of cost estimates, it is also possible to estimate the amount the government would save if every teenager who had a baby had postponed that birth until she was at least 20 years old. The major savings come from the fact that women 20 and older who did not have children before reaching the age of 20 are less likely to rely on AFDC and other government programs than are women who had their first child as a teenager. The assumption underlying the calculation of net savings is that any teenager who manages to postpone a birth to the age of 20 or later will experience the same rates of welfare dependency (and hence government expense) as observed in other women who wait until they are 20 or older to have children.

Having a baby as a teenager increases a woman's chances of needing and receiving welfare (AFDC) beyond what a woman who waited to have children would experience. But waiting until 20 or later to have children does not reduce the chance of needing welfare to zero. Given the impoverished backgrounds and often poor educational attainment of women who have babies as teenagers, they run a considerable risk of eventual welfare dependency even if they postpone childbearing. Thus delaying a birth until a woman is beyond her teen years is likely to reduce, but not entirely eliminate, the risk that a woman will at some time need to rely on welfare. The net savings to the government of delaying these first births depends on the difference between these two probabilities. In research conducted at the Urban Institute, this difference was projected to result in a savings of 40 percent in public costs.[4] That projection of 40 percent savings is used in all the calculations reported here.

Estimated Costs And Potential Savings

Exhibit 2 shows the single year cost of supporting families begun by a first birth to a teenager through the three biggest public programs for the six years 1985 through 1990. These figures are in the current dollars of their year; they are not adjusted for inflation.

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[4] Wertheimer and Moore, Public Sector Costs.

In 1985, the cost for that year along of supporting families begun by a first birth to a teen through AFDC, Medicaid, and Food Stamps was $16.7 billion. The cost increased gradually over the next four years, due to automatic inflation adjustments in Food Stamps and changes in Medicaid outlays. AFDC caseloads fluctuated up and down during these years by less than 1 percent. The big jump of 16 percent between 1989 and 1990 was due to two things: a 5 percent increase in the AFDC caseload, so that more households are included in the calculations; and a significant rise in Medicaid costs for this population.

If one totals the cost to these three programs for the six-year period 1985-1990, public outlays related to teenage childbearing totaled $120.4 billion. There are, of course, other public outlays for this population that are not included in these figures, which focus only on the three biggest programs.

Exhibit 2 also shows what savings we might expect if teenage pregnancy and childbearing were not a factor in AFDC and related costs. These savings are 40 percent of each year's outlays, for a total potential savings of $48.2 billion over the 1985-1990 period.

Single Birth Cost

Exhibit 3 displays the average public cost over 20 years for a single family begun by a teen birth. In 1985 that cost was $13,900; by 1990 it was up to $18,100.

These costs may seem very low to many readers, who envision every teenage other immediately going on welfare and staying there for 20 years. In fact, however, only about one-third of teen mothers receive welfare in any single year while they are still teenagers, and the probability of receiving welfare goes down from there for every year after the mother reaches 20 years of age. However, we can calculate the cost if the public image of immediate and prolonged welfare dependency were actually to occur. In 1985, these figures turn out to be $46,500 for a family begun by a birth to a teen 14 or younger with a 10-year welfare spell, $44,200 for a teen 15-17 at first birth with a 7.5 year spell, and $31,000 for an 18-19 year old with a 5 year spell. I want to stress, however, that these patterns of prolonged welfare dependency are not the norm for all families begun by a teen birth.

Exhibit 3 also shows potential savings for postponing all births until the mother is 20 or older. At 40 percent of projected costs, these savings would be $5,600 per family in 1985, up to $7,200 per family in 1990.

Annual Whole Cohort Cost

Exhibit 4 shows what happens when you add up the cost of every birth to a teenager in a given year to get the cost for the entire annual cohort of teen births, projected over a 20-year period. The first cohort examined, 1985, was projected to cost $5.2 billion in public outlays over a 20-year period. By 1990, the annual whole cohort cost was up to $7.2 billion for families begun in that year by a first birth to a teen. Some part of the increase was due to automatic adjustments to benefit levels, and some part was due to a slight rise in births to teens beginning in 1989.

As with the other projections, 40 percent of each cohort's cost could have been saved had these births been delayed until age 20 or later. Over the six-year period covered by Exhibit 4, these savings would have amounted to $14.3 billion.

Conclusions

The public cost of teenage childbearing is enormous; so too are the human costs in reduced opportunity, reduced earnings, and health, mental health, and educational outcomes for the children born to teenage parents. The question is always--"What should be done to reduce all of these costs?"

We could reduce the outlay of public funds for families begun by a teen birth by changing eligibility rules for public programs, restricting length of time on welfare, and similar measures. Some states have already taken steps in this direction. But taken by themselves, such measures are merely punitive--and further, they would certainly

increase the human costs for children born to teenagers. The real solutions lie elsewhere, in changing the opportunities available to poor teenagers.

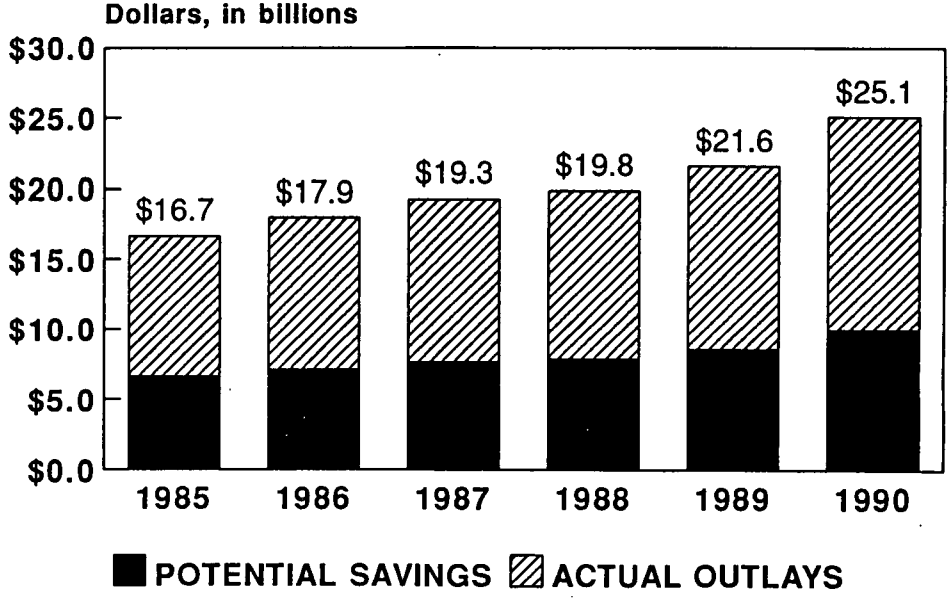
The opportunities I refer to are of two types: 1) accessible and affordable family planning services, including clear and unprejudiced discussion of sexual behavior and choices at an age young enough to make a difference; and 2) life options holding more attraction and promise than early childbearing.

Teens must know the facts about sexual activity and contraception, experience support from both adults and peers for making responsible decisions, and have access to reliable contraceptive care so they can behave responsibly if they choose to be sexually active. Expanding health care options, investing more in and doing more outreach through family planning programs, and greatly improving the content and timing of sexuality education curricula through schools and other mechanisms are all essential.

But no amount of knowledge or access to family planning will make a difference if teenagers do not have a motive for controlling their fertility and the support to act on that motive. Expanding life options for the youth most likely to have babies in their teens will require a major societal investment--in health care, in child-supportive programs, in education, and in job training. It will also require a societal investment in job development, to assure jobs able to pay enough to maintain a family without recourse to public assistance. At the same time, teens and younger children will need support to take advantage of expanded opportunities. The experience of the last decade of intervention efforts suggests that exhortation without opportunity will do little, but changing the real and perceived opportunity structures can have considerable impact.

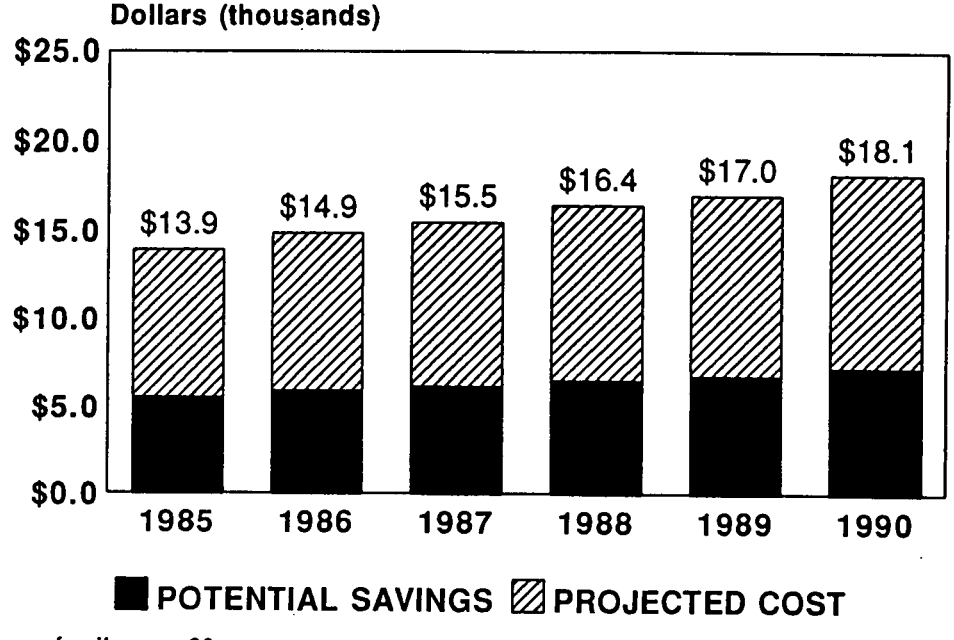
EXHIBIT 1: DIFFERENT COST ESTIMATES

EXHIBIT 2: SINGLE YEAR COST
AFDC, MEDICAID, FOOD STAMPS



Cost of families begun by teen births, in current dollars

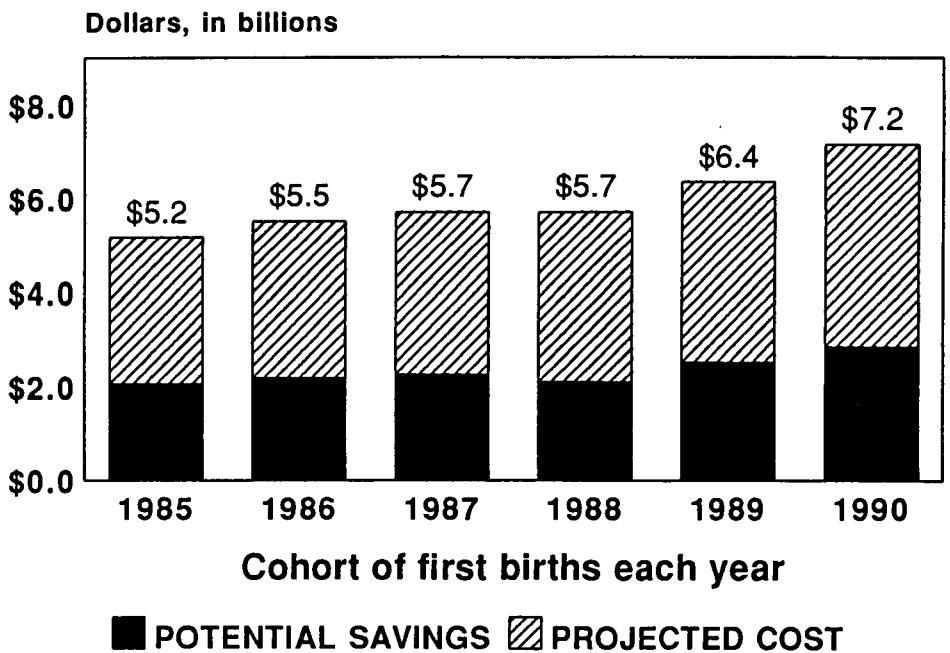
EXHIBIT 3: SINGLE BIRTH COST
20-YEAR PROJECTION FOR ONE FAMILY



Cost of one family over 20 years
in dollars discounted to current year

EXHIBIT 4: ANNUAL WHOLE COHORT COST

20-YEAR PROJECTION FOR EACH COHORT



Cost of families begun by teen births, in current dollars

ATTACHMENT TO MS. BURT'S PREPARED STATEMENT

TEENAGE PREGNANCY AND TOO-EARLY CHILDBEARING: PUBLIC COSTS, PERSONAL CONSEQUENCES

Summary Report

In 1989 every minute another teenager became a mother. Nearly one-fourth of these young women was giving birth for the second, third or more time. Every 46 minutes an adolescent 14 years old or younger had a child.

Altogether, 517,989 babies were born to teenagers in 1989, up from 488,941 the year before. This represents an 8 percent increase in the teen birth rate, defined as the number of births per 1,000 individuals, making it the highest since 1974: 58.1 for teens 15-19 and 1.4 for teens under 15. Birth rates among teens 15-17 have risen 19 percent since 1986. Even before these increases, adolescent pregnancy rates in America were the highest among developed countries, despite similar proportions of teens who are sexually experienced.

There is broad consensus that preventing teenage pregnancy and childbearing is an important national goal. Healthy People 2000, the Bush Administration's health agenda for the nation, calls for the reduction of pregnancies among adolescents under 18 by nearly one-third by the turn of the century. Nevertheless, it has been enormously difficult to galvanize the political will to move forward with real solutions.

America's teens are paying the price. For teen parents and their children, too-early childbearing can result in lost economic and educational opportunity, in short- and long- term health consequences, and in emotional and social stress. However, disadvantaged young people often remain invisible to policy-makers who must negotiate competing claims for diminishing public resources.

The Center for Population Options (CPO) has conducted a study for each of the last six years to translate the human realities of too-early childbearing into a form that commands the attention of the nation's leaders. This study estimates the economic impact of teen parenting: what it costs America's taxpayers to support families begun when the mother was a teenager.

In addition to federal costs, state and local governments also bear the burden of supporting families begun by too-early childbearing. CPO has estimated costs to seven states – Florida, Kansas, New Mexico, Ohio, Oregon, Vermont and Wyoming -- and two cities – Baltimore and San Francisco. States have initiated a variety of measures to help teens avoid pregnancy and too-early childbearing, and some of these are described briefly in the report. However, much more can be done.

CPO believes that "quick fixes" focused on short-term cost reductions are likely only to defer payment by society for a brief while, and exact payment, with interest, at a later time. Rather, investment in America's young people and in programs to help them avoid pregnancy and parenthood before they are ready will reap enormous benefits for them, their families and for all Americans.

ESTIMATED FEDERAL COSTS OF TEENAGE CHILDBEARING FOR FISCAL YEAR 1990

The costs of teenage childbearing are conceptualized in three ways: Single Year Costs, the amount the U.S. spends in a single year on behalf of all families in which the first birth occurred while the mother was a teenager; Single Birth Costs, the average amount taxpayers will spend as a result of a single teen birth over the next 20 years; and Single Cohort Cost, the amount taxpayers will spend over the next 20 years on all teen births in a given year.

the Center for Population Options

1025 Vermont Avenue, N.W. Suite 210 Washington, D.C. 20005 USA
202/347-5700 FAX 202/347-2263

Estimates of Single Year Costs are based on a percentage of Aid to Families with Dependent Children (AFDC), Medicaid and Food Stamp payments that are made in a given year to families that began with a teen birth. The figure, which includes direct payments as well as administrative costs, is actually a conservative estimate. It does not include other public costs commonly associated with family support such as job training, housing subsidies, the Women, Infants and Children (WIC) supplemental food program, subsidized school meals, special education, foster care or day care.

IN 1990, THE U.S. SINGLE YEAR COST WAS OVER $25 BILLION, up an alarming 16 percent, or $3.5 billion, from 1989 (Table I). CPO estimates that if every birth to a teen mother had been delayed until the mother was in her 20s, the U.S. would have saved 40 percent of the calculated expenditures, or $10.02 billion.

EACH FAMILY BEGUN BY A TEENAGE MOTHER IN 1990 WILL COST THE TAXPAYER AN AVERAGE OF $18,133 BY THE TIME THAT CHILD REACHES AGE 20 (Single Birth Costs, Table II). If the birth were delayed until the mother was in her 20s, the average potential saving would be $7,253. Since only one-third of families begun with a teen birth actually receive public assistance, the average amount to each family receiving public assistance after a teen birth would be around three times the Single Birth Costs, or $54,399 over 20 years.

Finally, **THE ESTIMATED COST OF ALL FAMILIES BEGUN WITH A TEEN BIRTH OVER THE FOLLOWING 20 YEARS IS 7.15 BILLION** (Single Cohort Cost, Table III.) This figure is calculated by multiplying the Single Birth Costs by the number of first births to teens, 394,119 in 1989, the latest year for which data is available. By delaying those births, CPO estimates the federal government could save as much as $2.86 billion.

1985 - 1990 Single Year Costs

TABLE I

Six Year Trend in Single Year Costs Attributable to Teenage Childbearing

(in billions)

SINGLE YEAR COST:	1985	1986	1987	1988	1989	1990
Aid to Families with Dependent Children (AFDC)	$8.32	$9.49	$9.87	$10.07	$10.43	$11.23
Food Stamps	$3.42	$2.82	$2.97	$3.23	$3.44	$3.98
Medicaid	$4.91	$5.62	$6.43	$6.53	$7.68	$9.84
	$16.65	$17.93	$19.27	$19.83	$21.55	$25.05

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1985 - 1990 Single Birth Cost

TABLE II

Six Year Trend in Projected 20-Year Public Costs to Support *Each* Family Begun by a Teen Birth
(average cost)

Age	1985	1986	1987	1988	1989	1990
<15	$17,724	$18,913	$19,691	$20,723	$21,491	$23,094
15-17	$17,689	$18,897	$19,638	$20,679	$21,446	$23,050
18-19	$11,214	$11,984	$12,416	$13,101	$13,579	$14,581
All Teens	$13,902	$14,852	$15,450	$16,410	$16,975	$18,133

1985 - 1990 Single Cohort Costs

TABLE III

Six Year Trend in Projected 20-Year Costs to Support *All* Families Begun by a Teen
(in billions)

Age	1985	1986	1987	1988	1989	1990
<15	$0.17	$0.18	$0.19	$0.21	$0.22	$0.25
15-17	$2.55	$2.73	$2.85	$3.08	$3.24	$3.56
18-19	$2.44	$2.60	$2.66	$2.69	$2.89	$3.34
All Teens	$5.16	$5.51	$5.70	$5.98	$6.35	$7.15

TEEN PREGNANCY PREVENTION: IMPERATIVES FOR THE 1990s

Since 1986, the U.S. has been losing ground in the effort to prevent teenage pregnancy and childbearing. Policy initiatives have been caught up in societal ambivalence about adolescent sexual behavior, in anxieties about parental roles and in philosophical, theological and political conflicts over abortion.

EVERY YEAR OVER ONE MILLION TEENAGED WOMEN – ONE IN TEN – BECOME PREGNANT. Eighty-two percent of these pregnancies are unintended, and three out of five occur to teenagers not using any form of contraception. By the age of 20, an estimated 43 percent of all adolescent girls will have become pregnant at least once. Clearly, the strategies of the last decade that have resulted in reduced access to services and alternatively rely on "just-say-no" messages have failed.

MORE TEENS ARE SEXUALLY ACTIVE. By the time they reach the age of 20, three-fourths of American females and 86 percent of American males are sexually active. Nearly one-third (31.9 percent) of ninth-grade girls and nearly half (48.7 percent) of ninth-grade boys report having had sexual intercourse. In 1988 over half of all females 15-19 reported having had sexual intercourse, up from 28.6 percent in 1970. Despite this increase, between 1970 and 1986 teen pregnancy and birth rates continued to fall due to improved access to and use of contraceptives and the legalization of abortion. The trend has now reversed.

BOTH FAMILY PLANNING AND ABORTION SERVICES ARE BECOMING MORE DIFFICULT FOR TEENS TO OBTAIN at a time when they need them more. Already 37 states have enacted laws limiting minors' access to confidential abortion, although not all are currently enforced. If Roe v. Wade is overturned by the Supreme Court, explicitly or in effect, teens in some states will lose access to abortion services altogether and more teens will become mothers. Should abortion be illegal and should all teens now choosing abortion be forced to give birth, then U.S. taxpayers could expect to pay billions more in Medicaid, AFDC and Food Stamp costs. With abortion less available to teens, prevention becomes even more urgent.

PREVENTING TEEN PREGNANCY IS EXTREMELY COST-EFFECTIVE. A study by the Alan Guttmacher Institute found that for every dollar of federal funds spent to provide contraceptives to women of all ages, $4.40 is saved that would otherwise be needed for medical care, welfare and nutrition programs just in the two years following a birth. Yet after adjustments for inflation, the federal FY 1990 spending for contraceptives has actually decreased by over one third since 1980. While most states have dramatically increased their own spending for contraceptive services to compensate for federal cutbacks, total federal and state spending has not kept pace with inflation.

TOO-EARLY CHILDBEARING REPRESENTS A SIGNIFICANT HEALTH RISK FOR THE TEEN MOTHER. During pregnancy, teenagers are at a much higher risk than older women of suffering from serious medical complications, including anemia, pregnancy-induced hypertension, toxemia, cervical trauma and premature delivery. This results in higher medical costs associated with pregnancy, and has an impact on the present and future health of the individual teen. The maternal mortality rate for mothers under age 15 is 60 percent greater than for women in their 20s. Teenagers' tendency to delay or forego prenatal care contributes to the increased health risk of pregnancy. Only 54 percent of teens who gave birth in 1989 received prenatal care in the first trimester (compared to 85 percent for women 30-34), and 14 percent received late or no prenatal care.

TOO-EARLY CHILDBEARING REPRESENTS A SIGNIFICANT HEALTH RISK TO THE CHILD. One of the most heart-rending costs of teen pregnancy is paid by the infants themselves. The infant mortality rate in this country is strongly related to the number of infants born at low birth weights. In 1989, over 10 percent of babies born to teens under 18 were of low (2,500 grams or less) or very low (1,500 grams or less) birth weight. Even normal birth weight infants of teen mothers have a higher rate of rehospitalization than infants of older mothers. Lengthy hospital stays, painful procedures and greater risk of chronic illness and disability exact high personal medical costs and increase the burdens on an inadequate health care system.

The Center for Population Options, 1992

TEEN MOTHERS ARE LESS LIKELY TO GRADUATE FROM HIGH SCHOOL. Teen mothers are less likely than their childless peers to have the education and skills needed to become economically independent. Eighty percent of teen mothers drop out and only 56 percent ever graduate from high school. A woman who begins parenting in her teens makes half the lifetime earnings of a woman who waits until she is 20 to have her first child. In 1985 and 1986, 81 percent of young mothers living alone had incomes below the federal poverty level, and poverty rates even of married teen mothers were twice the national average.

TEEN MOTHERS ARE UNLIKELY TO RECEIVE CHILD SUPPORT. Two-thirds of parenting teens 15-19, and almost all teens 14 or younger, are unmarried, increasing the likelihood that they will need public assistance. Any form of child support from the father is extremely rare. Furthermore, in many cases of teen births the father is not identified. Where the age of the father is known, almost one-third of fathers are teenagers themselves. Even if the father is older he is likely to be unskilled and/or unemployed.

EVEN MARRIED TEENS FACE HIGHER RATES OF POVERTY. In the short run, marriage appears to reduce the poverty associated with teen childbearing, since fewer married teens receive public assistance. This is misleading, however, because prior to FY 1991 two-parent families were ineligible for benefits in many states. Even when teenaged girls marry, their husbands are almost three times less likely to have completed high school, and have higher unemployment rates than their male peers. One survey showed that 40 percent of the husbands of young mothers were not high school graduates, and are unlikely to be highly skilled or have high-paying jobs. Furthermore, many of these early marriages are short-lived. Married teen mothers face higher divorce rates than women who wait until they are older to have children.

TEEN MOTHERS NEED HELP DEVELOPING PARENTING SKILLS. Over 90 percent of teens who choose to carry a pregnancy to term also choose to raise the child themselves. Teens who parent are suddenly faced with the awesome responsibility of shaping the lives and characters of their children, at a time when they themselves are in the midst of overwhelming and confusing physical and emotional developmental tasks. Too often teen parents have little or no social support system. Not only is their own development interrupted by parenthood, but that of their children is all too often negatively affected as well.

Guiding the growth and development of the next generation and passing on the collective wisdom of the culture is one of the most important tasks of any society. We owe a productive and healthy future to all our children. Education and services can help teens avoid becoming parents until they are ready. Many programs are being implemented in states to prevent too-early childbearing and assist parenting teens – both young women and young men – to achieve brighter futures for themselves and their children. But these and other efforts must overcome lack of funds, political agendas and years of counterproductive policies. The urgent need to reduce the heavy burden on taxpayers from too-early childbearing must move policy-makers to adopt policies that are effective in reducing teen births and reject those that do not work.

TEENAGE CHILDBEARING: SEVEN STATES AND TWO CITIES

Teenage pregnancy exacts a toll at the state and local levels as well as at the national level. Estimated costs of teen childbearing for Florida, Kansas, New Mexico, Ohio, Oregon, Vermont, Wyoming, Baltimore and San Francisco were calculated to highlight the extent of these costs. The numbers thrust into sharp relief the budgetary toll exacted by too-early childbearing in those individual states and cities.

The costs and potential savings reported for these states and cities vary widely and are not meant to be compared with each other. Some of these jurisdictions have a much greater number of AFDC participants than others. In addition, teenage birthrates vary among the states and cities. Lastly, AFDC, Medicaid and food stamp payments vary from state to state; therefore, a locality providing payments at a higher percent of poverty level than another locality will have higher costs associated with teen childbearing, but will also provide more completely for those families in need.

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The number calculated for each jurisdiction is an estimate of the Single Year Cost – the equivalent of the $25.05 billion that the Federal government spends each year to support families begun when the mother was a teenager. The total figures for each state and city reported here represent those locales' allocations of federal funds – part of the $25.05 billion described earlier – as well as other monies originating from state and local revenue. Most city governments do not directly fund Medicaid services. A local contribution to the non-federal portion of Medicaid, when required by the state plan, is more often provided by counties than by cities. The two cities included in this report, however, are examples of city-county consolidations that do provide services.

Teenage Childbearing: Seven States & Two Cities

TABLE IV

Single Year Public Cost for All Families Started

by a Teen Birth in Selected States and Cities

Estimate for 1990

(in millions)

	Outlay Attributable to Teenage Childbearing			
	Aid to Families with Dependent Children (AFDC)	Food Stamps	Medicaid	TOTAL
Florida	$301.08	$198.87	$295.95	$795.90
Kansas	$ 64.00	$ 25.48	$ 24.29	$113.77
New Mexico	$ 37.23	$ 19.53	$ 31.22	$ 87.98
Ohio	$427.10	$271.93	$302.45	$1,001.46
Oregon	$ 91.73	$ 29.38	$ 31.83	$152.94
Vermont	$ 26.59	$ 8.36	$ 6.88	$ 41.83
Wyoming	$ 11.50	$ 8.06	$ 7.39	$ 26.95
Baltimore	$123.68	$ 46.14	$ 76.09	$245.91
San Francisco	$ 46.28	$ 10.29	$ 6.79	$ 63.36

STATE AND LOCAL PREVENTION INITIATIVES

A survey of adolescent pregnancy prevention programs in Florida, Kansas, New Mexico, Ohio, Oregon, Vermont, Wyoming, Baltimore and San Francisco reveals common themes and some innovative programmatic twists. Experts understand that **early intervention** is a key to forestalling too-early pregnancy; many of these states and cities address middle-school-aged children. In Florida, for example, Project First Class focuses on boys in an urban area, providing mentors and a program emphasizing human sexuality information and decision-making skills. Baltimore's Teen Impact Program Series (TIPS) is a six week, six session educational program implemented in three middle schools, covering a range of topics related to preventing teenage pregnancy.

Increased access to contraceptive services is cited in most of the states and cities as a critical component of any concerted effort to lower teenage pregnancy rates. In Vermont, Planned Parenthood of Northern New England specifically reaches out to teens. Oregon's legislature has provided funds to expand the capacity of local family planning clinics and to provide outreach activities for adolescents. Wyoming's Reproductive Health Council coordinated statewide family planning services so that all counties are now served.

Too often teenage pregnancy prevention efforts exclude potential fathers, focusing solely on young women. **Male involvement** programs place the focus on young men, helping them to understand the consequences of their actions. In New Mexico, a statewide Male Involvement Coordinator provides technical assistance to state-funded pregnancy prevention programs, beefing up male involvement in those projects. Florida's Leadership for Young Men Program is an eight week program located in a rural high school that empowers young men to plan for a future with opportunities and helps them develop the motivation to delay sexual activity.

Prevention of repeat pregnancies among teens is another essential piece of any prevention strategy. Young men and women who have already become fathers and mothers need the information, skills and services that will help them delay unwanted subsequent births. Fully half of New Mexico's prevention projects are designed for already-pregnant and parenting teens. In Vermont, a community-based program, Teen Pregnancy Initiative, works to prevent second and third births to teenagers. Wyoming's Governor's Pregnancy Task Force is focusing on establishing case management and mentoring projects aimed at reducing repeat pregnancies among adolescents.

Peer counseling – teens teaching teens -- is noted as one of the most effective ways to reach adolescents with any prevention messages. Ohio has discovered that some of its most successful efforts to reduce teen pregnancy have utilized a peer-to-peer discussion approach to teenage sexuality, pregnancy and parenting. San Francisco's innovative Teen Peer Counselors Program involves parenting teens, both male and female, as peer counselors and trainers who visit both middle and high schools covering the topics of birth control methods, sexually transmitted diseases and the consequences of teen parenting.

All teens need **access to health care services**. School-based or school-linked clinics in many states and cities provides high school students with on-site health care services, including contraceptive counseling and referral. A unique mall-based teen comprehensive teen health clinic in Baltimore attracts all youth, both those enrolled in school and those not.

Parents are the primary sexuality educators of their children and so programs that improve **parent-child communication** are very useful. Two pilot projects in Kansas focus on young people between the ages of 10 and 17 and their parents; the emphasis is on improving parent-child communication skills, building self-esteem and promoting abstinence. Baltimore hosts free Parents and Children Talking events, funded by the state, that help parents polish their sex education and communication skills.

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Lastly, **media campaigns to increase public awareness** of the severity of the problem of teenage pregnancy are popular. Ohio ran a statewide campaign targeted at children between the ages of 10 and 14 with the message "Your decisions about sex change your life – forever." Public service announcements on radio and television, billboards and other printed material promoted a toll-free hotline number and a brochure. The public awareness campaign in Kansas featured posters, billboards, rap songs on the radio, ads in high school newspapers, public service announcements in movie theaters and a teen parent speakers panel. Baltimore's abstinence-based media program, Campaign for Our Children, blitzed the city with messages targeted to middle-school children and parents.

Most of the states and cities included in this report have a governor's or mayor's task force on adolescent pregnancy, indicating consensus in the top levels of government that teenage parenthood is reaching crisis proportions in many communities. The range of recommended strategies emerging from these bodies provide a blueprint for reducing the incidence of teenage childbearing in the U.S.

For a copy of the full report, including a complete listing of sources of data and citations, send $8 to the Center for Population Options, 1025 Vermont Ave., NW, Suite 210, Washington, D.C. 20005.

PREPARED STATEMENT OF JEANNIE ROSOFF

I am Jeannie Rosoff, President of The Alan Guttmacher Institute (AGI), an independent, nonprofit corporation for research, policy analysis and public education on issues relating to reproductive health. I want to thank you, Chairman Scheuer, and the Subcommittee on Education and Health of the Joint Economic Committee, for the opportunity to make this statement regarding the scope of the adolescent pregnancy problem in the United States and the compelling need for national attention to the issue of adolescent pregnancy prevention.

Adolescence has never been an easy time of life. The adolescent years are a turbulent time when young people with developing personal skills increasingly take on the seemingly confusing tasks and responsibilities of adulthood. But the general task of making the transition into adulthood may be the only common aspect to all the young people we label "adolescent." Despite the fact that we tend to think of all adolescents as the same, adolescents are a very diverse group -- the variances in age, living arrangements, education and economic status are but a portion of the list of differences that are present in the very diverse group that we like to label with the oneterm "adolescent." Young people develop at different rates -- both developmentally and legally. Developmentally, a 14 year-old is often very different from a 17 year-old. And in most states the law treats a 14 year-old and a 17 year-old differently when it comes to her ability to make reproductive health decisions for herself. Because of the diversity within the adolescent population -- no matter what the question -- there will never be just one answer that will embrace the concerns of them all. And the question of how best to handle the issue of adolescent sexuality and pregnancy prevention is no exception.

For the majority of Americans today, the teen years are a transition time into sexual activity. This is a reality that many American adults find hard to face. Some recent data suggest that adolescent sexual activity may be starting to plateau, but at a high level: 50 percent of unmarried women and 60 percent of unmarried men aged 15-19 have had sexual intercourse. In addition, over the past 20 years (the only period for which we have national data on sexual activity of adolescent women) the trend has been toward earlier initiation of sex, but later marriage. As a result, young women, and young men also, spend a longer time than their elders did being sexually active before marriage. This period is especially risky in terms of both STDs and unintended pregnancy, and presents special challenges to our society in meetmg needs for education and services.

Today's youth are facing consequences from their sexual activity that are very adult in nature, but to try to prevent and deal with these consequences they must maneuver their way through a health care and education system that is often unresponsive to their needs. Too often, the focus on their age has been used to deny adolescents needed services, rather than a reason to develop ageappropriate and culturally- appropriate, adolescent-specific programs to address their needs. They need more from us in order to thrive. It is the responsibility of parents and of our society as a whole to prepare teens for these transitions and to help them through them as successfully as possible. We do this much more readily when it comes to education and employment; we fulfill these responsibilities much less often -- and much less well -- when it comes to preparmg youth with the knowledge, values and means to deal responsibly with their sexual activity.

The consequences of unprotected sexual activity -- pregnancies and either the abortions or largely out-ofwedlock births that result -- have been with us since time immemorial. What is most shocking is not that these problems are still with us, but the extent to which they exist in our society. Each year, more than one million teenage females -- one in 10 women aged 15-19 and one in five who are sexually active -- become pregnant. By age 18, one in four teenagers will become pregnant at least once. Eight in 10 teenage pregnancies are unintended. Nearly one in five teenagers who experience a premarital pregnancy become pregnant again within a year.

In addition, while this hearing may focus on the problem of adolescent pregnancy, it is important not to overlook the unfortunate fact that the risks from unprotected sexual intercourse also include sexually transmitted diseases, including HIVIAIDS. Nearly 3 million teens -- one in six teens -- contract an STh annually. Adolescents represent at least 20 percent of all STD cases. Certain types of STDs, such as chlamydia and human papilloma virus, can lead to infertility and cervical cancer, respectively. While the numbers are lower than for other STDs, the statistics for adolescents and HIVIAIDS are certainly alarming. of the estimated 1 million Americans with HIV, over 75,000 are believed to be between the ages of 13 and 24. Persons in their twenties make up the largest portion of HIV infected persons, and with the latency period of approximately 10 years it is reasonable to assume that a large share of persons with AIDS contracted the virus while adolescents.

Despite the statistics, it is important to say that what really distinguishes today's generation of sexually active youth is the extent to which they are trying to be responsible about their sexuality. Between 1982 and 1988, the proportion of teenage women who reported they or their partner used a contraceptive method at first intercourse rose 52 percent to 65 percent and the proportion using condoms increased from 23 percent to 47 percent. Among those women currently sexually active and trying to avoid unintended pregnancy, 79 percent are using a contraceptive method. But while these developments are promising, the unfortunate fact remains that one sexually active teenage woman in five uses no method -- and as many as nine in ten sexually active teenage women will become pregnant within a year if they continue to have sex without contraceptives.

Moreover, even when sexually active adolescent women do use contraception, they still face some degree of uncertainty. Most teens who are sexually active and who use contraceptives rely either on the pill or on condoms. These and all other reversible methods, except fbr the recently available contraceptive implants (Norplant) and the injectable (Depo-Provera) which was just approved by the Food and Drug Administration and should become available early next year, require ongoing attention from the user. Among women of all ages, but especially among younger women, the effectiveness rates with these methods are much lower that what could be achieved if they were used consistently and correctiy. In addition, the methods that are the most effective for pregnancy prevention -- like Norplant and DepoProvera, or even the pill -- do not offer protection from STDs and HIV, while the only methods that offer any protection from STDs and HIV -- like the condom -- are the methods that have the highest user failure rates among all users, especially adolescents. These are very serious problems, indeed.

The issue of contraceptive user failure brings us to the issue of contraceptive use and sexuality education. Adolescents need better contraceptive education, for it is the nonuse and ineffective use of contraceptives -- problems born, in part, out of insufficient information and education -- that make sexually active adolescents vulnerable to a number of health problems. With contraceptive education, user failure rates can be improved. But the current state of affairs is one where this kind of education may not be readily available to teens in need. In spite of increased emphasis on sexuality education by parents, schools and other organizations, over half of young women aged 15-19 say that there is too little accurate information on sex and reproduction available today. The content and intensity of sexuality education programs vary widely, but in most schools, the total time devoted to instruction is 39 hours between grades 7 and 12, with just 5 hours spent on birth control and 6 on STDs.

Family planning clinics have served as a major source of information and education to teens about contraceptive use. Teens are much more likely than older women to rely on family planning clinics for their contraceptive care. Among those surveyed in the 1988 National Survey of Family Growth, for example, 62 percent of the women aged 15-19 who had made a family planning visit in the past year had gone to a clinic, compared with only 42 percent of women aged 20-24. The prtmary reason young women give for using a clinic rather than a private doctor is that doctors are too

expensive. The second is that they are concerned about keeping their medical visit confidential.

Mr. Scheuer, you were instrumental in bringing the national network of family planning clinics into being. They have been a crucial source of care for women of all ages, most especially low income women and young women who are unable to use private physicians. Poor women and teens are more likely to use contraceptives today than in the past. The pregnancy rate among sexually active teens has fallen over the past two decades. (The pregnancy rate among all teens has increased because more teens are sexually active and at risk of pregnancy.) However, the initial goals of those who started the program have not been met. As a result, teens and especially low-income teens, are overrepresented among women having STDs, unintended pregnancies, abortions and poor birth outcomes.

A foundation has been laid, but much more needs to be done. In large part due to political fighting about issues tangential to the family planning program, the program has limped along. It needs rejuvenating -- not only in terms of increased funds -- but more over in terms of attention to questions of what services it should offer, especially those that would help more teens postpone sexual intercourse, use contraceptives whenever they have sex and support to help them continue to use their chosen methods effectively. In the coming months, our country will consider changes in how health care is financed, and how it is delivered. In the process, it is important that the value of contraceptive use in preventing accidental pregnancies -- and abortions and unintended births that result from them -- be recognized and that contraceptive services be included along with other preventive health measures -- especially for the teens that have been so dependent upon them. The special needs of adolescents must be paid attention to in the coming deliberations. Indeed, we must not allow adolescent pregnancy and parenting to become one of the intractable "facts of life" for American youth, because we as adults are unable to implement an effective federal program that deals realistically with adolescent sexual activity and pregnancy prevention.

Thank you.

ATTACHMENT TO MS. ROSOFF'S PREPARED STATEMENT

March 1990

ISSUES in BRIEF

The Alan Guttmacher Institute

An Independent, Nonprofit Corporation for Research, Policy Analysis and Public Education

2010 Massachusetts Avenue, NW
Washington, DC 20036
Telephone 202 296-4012
Fax 202 223-5756

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The Cost-Benefit of Publicly Funded Family Planning Services

There are many ways to assess the value of the educational and preventive health services offered by publicly subsidized family planning providers. One evaluative tool that may be particularly useful at a time of concern about high federal budget deficits is a "cost-benefit analysis" – that is, a study which attempts to calculate what if any savings eventually accrue back to the taxpayer from expenditures for contraceptive services that help women avoid unintended pregnancies.

Evaluating the impact of publicly subsidized family planning services is important since, according to the most recent data available, almost one in every four women in the United States who uses a contraceptive method each year (exclusive of contraceptive sterilization) obtains it from a publicly subsidized source. Over 90 percent of these women – about 4.1 million – rely on family planning clinics; an additional 400,000 go to private physicians who are reimbursed by Medicaid.

Because neither contraceptives nor the people who use them are perfect, these 4.5 million women experience approximately 430,000 unintended pregnancies a year. New calculations by The Alan Guttmacher Institute (AGI)* show that, in the absence of government support for family planning services, an average of 1.2 million additional unintended pregnancies could be expected to occur each year among these women – at least four in 10 of which would end in abortion. According to these calculations, every public dollar spent to provide contraceptive services saves an average of $4.40 in funds that otherwise would have to be spent to provide medical care, welfare and other social services to women who by law would be eligible for such services if they became pregnant.

Background

For almost 20 years, family planning services have been subsidized for people who otherwise might not be able to obtain them through several federal programs, including Title X of the Public Health Service Act, Medicaid and the Maternal and Child Health and Social Services Block Grants. Most states now also make some appropriations for family planning services.

While providing contraceptive methods to help women avoid unintended pregnancies is the primary purpose of family planning programs, these programs also offer a range of related reproductive health care services. These include contraceptive information and counseling; gynecological examinations, including basic lab tests and screening for high blood pressure as well as screening for breast and cervical cancer (Pap smears); pregnancy testing and testing for sexually transmitted diseases; the provision of contraceptive methods, including instruction in natural family planning; and basic infertility services.

Measuring the amount of money saved by public expenditures on family planning services is difficult, since the savings to be calculated come from events – pregnancies – that do not occur because they are averted by contraceptive use. Over the years, there have been several such attempts to evaluate family planning programs. Almost without exception, these studies have concluded that large numbers of unintended pregnancies (and, therefore, births and abortions) are averted by subsidized family planning efforts, and that, as a result, for every dollar appropriated for contraceptive services, considerably more is saved in medical care and welfare costs.

These studies are by now quite old, and each was limited by lack of key data at the time, including data on such important variables as sexual activity, extent of overall contraceptive use and publicly subsidized contraceptive care obtained from private physicians. The new AGI calculations are based on more recent estimates of many of the variables used in the earlier research as well as on actual measures of variables that had been either inadequately measured or left out completely from the earlier analyses.

*J.D. Forrest and S. Singh, "Public-Sector Savings Resulting from Expenditures for Contraceptive Services," *Family Planning Perspectives*, 22:6, 1990.

FACTS in BRIEF

The Alan Guttmacher Institute

An Independent, Nonprofit Corporation for Research, Policy Analysis and Public Education

111 Fifth Avenue
New York, New York 10003
Telephone: 212 254-5656
Fax: 212 254-9891

2010 Massachusetts Avenue, NW
Washington, DC 20036
Telephone: 202 296-4012
Fax: 202 223-5756

Teenage Sexual and Reproductive Behavior in the United States

SEXUAL ACTIVITY

- 97% of women and 99% of men aged 15–19 are unmarried.
- 50% of unmarried women and 60% of unmarried men aged 15–19 have had sexual intercourse.
- Levels of sexual activity increase with each year of age: 27% of unmarried 15-year-old women and 33% of unmarried 15-year-old men have had intercourse at least once; at age 19, 75% of women and 86% of men have had intercourse.
- Teenagers are having sex for the first time at younger ages: In 1982, 19% of unmarried women aged 15 had had intercourse; in 1988, 27%. In 1979, 56% of unmarried men aged 17 living in metropolitan areas had had intercourse; in 1988, 72%.
- Sexual activity levels vary considerably by race and ethnicity—among unmarried 15–19-year-old men, 81% of blacks, 60% of Hispanics and 57% of whites have had intercourse. Proportions among women aged 15–19 are 59%, 45% and 48.
- Most of the increase in female sexual activity in the 1980s was among white teenagers and those in higher income families, narrowing the previous racial, ethnic and income differences.
- 6 in 10 sexually active women aged 15–19 report having had 2 or more sexual partners.

SEX EDUCATION

- Nearly all junior and senior high school teachers report that their schools offer sex education, but most think it is often provided too late and that too little time is spent on the subject.
- On average, secondary schools offer only 6 1/2 hours a year on sex education—fewer than 2 of those hours focus on contraception and the prevention of sexually transmitted diseases.
- Most states and large school districts in the United States support sex education in their public schools, yet 1/3 of the states and 1/5 of the larger school districts do not require or encourage their schools to teach pregnancy prevention.
- Measuring the relationship between sex education programs and teenage pregnancy is limited by many factors, including lack of data on teenagers' sexual activity at the state or local level.
- Studies have found no conclusive evidence that sex education causes teenagers to become sexually active earlier or later.
- In-depth studies of a few specific sex education programs have shown that some approaches contribute to greater delay in teenagers becoming sexually active, at least in the short term.
- Sex education programs have been shown to effectively provide information about reproduction and contraception and thus increase teenagers' knowledge about these subjects.

CONTRACEPTIVE USE

- More teenage women surveyed in 1988 used a contraceptive method the first time they had intercourse than in 1982 (65% vs. 48%), yet 1/3 used no protection the first time they had sex.
- Contraceptive use at first intercourse has increased almost entirely because of a doubling in condom use during the 1980s (from 23% to 47%).
- 79% of sexually active teenage women use a contraceptive method—up from 71% in 1982. They are more likely, however, than any other age group to be nonusers: 1 in 5 use no method.
- 57% of sexually active unmarried men aged 15–19 used a condom the last time they had intercourse, and among those aged 17–19 in metropolitan areas, condom use more than doubled between 1979 and 1988—from 21% to 58%.
- 66% of black, 54% of white and 53% of Hispanic men aged 15–19 used a condom the last time they had sex.
- In general, young women are more likely than older women to become pregnant while using any contraceptive—11% of teenage pill users experience a contraceptive failure during the first year of use, compared with 6% among women aged 15–44.

TEENAGE PREGNANCY

- U.S. teenagers have one of the highest pregnancy rates in the western world—twice as high as in England and Wales, France and Canada; 3 times as high as in Sweden; and 7 times as high as in the Netherlands.
- Each year more than one million teenagers (1,014,620 in 1987)—1 in 10 women aged 15–19 and 1 in 5 who are sexually active—become pregnant.
- 50% of teenage pregnancies conceived in 1987 resulted in a birth, 36% in an abortion and an estimated 14% in miscarriage.
- In 1987, the teenage pregnancy rate (pregnancies per 1,000 women age 15–19) was 109, and 72 among those aged 15–17.
- Minority teenagers have twice the pregnancy rate of white teenagers—in 1987, the rates were 189 and 90, respectively.
- By age 18, 1 in 4 (24%) teenagers will become pregnant at least once—and more than 4 in 10 (44%) will do so by age 20.

- 21% of white teenagers and 40% of minority teenagers will become pregnant at least once by age 18, and 41% of whites and 63% of nonwhites by age 20.
- Nearly 1 in 5 teenagers who experience a premarital pregnancy become pregnant again within a year. Within 2 years, more than 31% have a repeat pregnancy.
- 8 in 10 teenage pregnancies are unintended—9 in 10 among unmarried teenagers and about half among married teenagers.
- States with the highest teenage pregnancy rates in 1985 were CA (151), AK (144), GA (132), TX (131), AZ (128); states with the lowest rates were ND (60), MN (62), IA (67), SD (70), WI (73).
- The number of teenage pregnancies and the teenage pregnancy rate rose gradually during the 1970s but leveled off in the 1980s. In 1972, the pregnancy rate was 95—in 1980, 111 and in 1987, 109.

CHILDBEARING

- The U.S. teenage childbearing rate is halfway between Canada's and Latin America's. By age 20, 1 in 9 women in Canada, 2 in 10 in the United States, 3 in 10 in Brazil and 5 in 10 in Guatemala, have had their first child.
- About 1/2 of all teenage pregnancies end in births. In 1988, teenage births totaled 488,941 (10,558 to those under age 15) and 66% were to those unmarried—54% of the births to whites and 91% of the births to blacks.
- 7 in 10 births to teenagers result from unplanned pregnancies.
- The teenage birthrate (births per 1,000 women aged 15–19) in 1988 was 53.6—among whites, 43.7, and among minorities, 95.3.
- The birthrate for teenagers aged 15–17 increased 10% between 1986 and 1988; the 1988 rate was the highest since 1977. The increase occurred entirely among nonwhites and Hispanics.
- Of women having their first birth in 1988, 23% were teenagers. Among whites, 2 in 10 first births were to teenagers and among blacks, 4 in 10 were to teenagers.
- Nearly 1/4 of all babies born to teenagers are not first births.
- Less than 10% of teenagers who give birth place their babies for adoption.
- On average, 33% of women under age 20 who give birth receive inadequate prenatal care, either because they start care late in their pregnancy or because they have too few medical visits.

CONSEQUENCES OF EARLY CHILDBEARING

- The younger the mother, the greater the likelihood that she and her baby will experience health complications, as a result of later prenatal care, poor nutrition, and other lifestyle factors.
- Teenage mothers are at greater risk of socioeconomic disadvantage throughout their lives than those who delay childbearing until their 20s. They are generally less educated and have more children and higher levels of nonmarital, unintended births.
- More teenage mothers are now graduating from high school than ever before, yet only 1/2 of the women who have their first child at age 17 or younger will have graduated by age 30.
- Teenagers who become mothers are disproportionately poor and dependent on public assistance for their economic support.
- Public funds pay for the delivery costs of at least 1/2 of the births to teenagers.
- The government spent over $21 billion in 1989 for social, health and welfare services to families begun by teenage mothers. Babies born to teenagers in 1989 will cost U.S. taxpayers $6 billion over the next 20 years.
- Children of teenage mothers are at greater risk of lower intellectual and academic achievement, behavior problems, and problems of self-control than are children of older mothers, primarily because of the effects of single parenthood, lower maternal education and larger family size.
- Although it is not inevitable, the daughters of teenage mothers are more likely to become teenage parents themselves.

ABORTION

- 4 in 10 teenage pregnancies (excluding miscarriages) end in abortion.
- While the teenage abortion rate (number of abortions per 1,000 women aged 15–19) among minorities (73) is considerably higher than the rate among whites (36), the likelihood that they will end a pregnancy in abortion (abortion ratio) is about the same as for whites.
- 26% of all abortions in the United States each year are to women under age 20—in 1987 the total number of abortions in this age group was 406,790.
- Every year, about 4% of women aged 15–19 have an abortion.
- The three reasons most often given by teenagers for choosing to have an abortion are: concern about how having a baby would change their lives, feeling that they are not mature enough to have a child, and financial problems.
- 18 states currently have mandatory parental consent or notice laws in effect for a minor to obtain an abortion: AL, AR, CT, IN, LA, MA, ME, MI, MN, MO, ND, OH, RI, SC, UT, WV, WI, WY.

SOURCES OF DATA

Most of the data in this factsheet are from research conducted by The Alan Guttmacher Institute and/or published in *Family Planning Perspectives*. Additional sources include: The Centers for Disease Control, The Center for Population Options, the National Center for Health Statistics, and the National Academy of Sciences' report, *Risking the Future*.

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Abortion and Women's Health: A Turning Point for America?, 1990, 74 pp., $12.00.

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

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

Risk and Responsibility: Teaching Sex Education in America's Schools Today, 1989, 24 pp., $5.00.

Teenage Pregnancy in Industrialized Countries, 1986, 310 pp., $30.00 clothbound, $12.95 paperbound (Yale University Press).

Teenage Pregnancy in the United States: The Scope of the Problem and State Responses, 1989, 72 pp., $15.00.

Today's Adolescents, Tomorrow's Parents: A Portrait of the Americas, 1990, 97 pp., $20.00, available in English and in Spanish.

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

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Calculations

The new AGI study had four major steps:

- using data from the National Survey of Family Growth to determine the number and characteristics of women who obtain contraceptives from publicly supported programs, either family planning clinics or private physicians reimbursed through Medicaid;
- using newly available data on failure rates of the various contraceptive methods in actual use to estimate the number of unintended births, abortions and miscarriages these women would experience under conditions of continued access to publicly funded services and under three scenarios of probable behavior if such services were unavailable;**
- calculating the public-sector costs of providing family planning services on the one hand and, on the other hand, of providing medical care for pregnancy and childbirth (and abortions in those few states that fund abortion services) and, for a two-year period after childbirth, pediatric care (Medicaid) and social services (AFDC, food stamps and WIC) to women and infants who, under the terms of current law, would be eligible for such services; and
- computing the savings in public spending resulting from expenditures on contraceptive services.

Major Findings

These calculations yield the following major findings:

- The 4.5 million users of reversible contraceptives in the United States who rely on publicly funded providers experience approximately 433,000 unintended pregnancies a year.
- Under the three scenarios of probable behavior, an average of 1.2 million additional unintended pregnancies would occur in the absence of publicly funded services, including 509,000 additional unintended births and 516,000 additional abortions.
- Federal and state governments spend a total of approximately $400 million for contraceptive services annually. If these services were not available, the additional short-term expenditures that would be required by law would average $1.8 billion – an average savings of $4.40 for every one dollar spent.

Implications for Public Policy

The new AGI analysis focuses on a narrow but crucial area of family planning program impact – prevention of unintended pregnancies by contraceptive use and the resulting taxpayer savings in health and welfare expenditures. However, it is important to note that women making visits for contraceptive care to publicly funded providers – which are often their only source of health care – may receive, in addition to free or low-cost contraceptive supplies, a variety of related and important health and educational services, as well as counseling and referral to other health providers for specialized care when needed.

The following major conclusions may be drawn from the new study:

- Public subsidy remains critically important to the provision of family planning services in the United States. Almost one in every four women who uses a contraceptive method each year (and one in three who uses either of the most effective methods, the pill or the IUD) obtains it from a publicly subsidized provider.
- Family planning clinics remain the key source of care for women seeking subsidized contraceptive services. Of the 4.5 million women receiving subsidized services each year, over 90 percent rely on family planning clinics; less than 10 percent go to private doctors who are reimbursed by Medicaid.
- Because women receiving publicly subsidized contraceptive services are disproportionately young, unmarried, poor and nonwhite, they have higher rates of contraceptive failure than do American women generally. However, since these women tend to use the most highly effective methods of contraception, their overall pregnancy rates are similar to those of all other women using reversible methods.
- Publicly funded family planning services allow substantial numbers of women to prevent unintended pregnancies, births and abortions. The amounts spent to provide these services are small relative to the large savings that result.

Finally, despite the substantial social and economic benefits that accrue from subsidized family planning services currently being offered, more needs to be done. The gap between the low contraceptive failure rates that can be achieved theoretically and the actual levels obtained with normal use is well documented. In addition, although only a small number of women at risk of unintended pregnancy use no method of contraception – about eight percent – these women account for over half of all unintended pregnancies and half of all abortions.

Since 1980, total government funds for family planning services, measured in constant dollars, have actually declined. Expanding and improving the provision of contraceptive services and related education and counseling would help more couples practice contraception more effectively and would further reduce the number and rates of unintended pregnancies and abortions experienced in the United States today.

**Since it is impossible to predict exactly what every woman might do if publicly funded contraceptive services were no longer available to her, a range of possibilities was considered. At one end of the behavioral spectrum, Pattern I (which would result in an additional approximately 800,000 unintended pregnancies each year) assumed that women using publicly funded providers would behave in their absence similarly to women at risk of unintended pregnancy and of the same income level who did not use subsidized services. Pattern II (resulting in an additional 1.1 million unintended pregnancies) was based on information about what contraceptive methods women switch to if they stop taking the birth control pill and do not use another prescription method or have a contraceptive sterilization (especially important because of the large number of clinic clients who are pill users). Pattern III (resulting in an additional 1.7 million unintended pregnancies) was based on information about what contraceptive methods women used before they came to a family planning clinic. A fourth scenario (which would result in an additional 3.1 million unintended pregnancies) assumed that none of the women affected would continue to use contraceptives but all would continue to be sexually active. While admittedly unrealistic, this scenario illustrates the total contribution of subsidized contraceptive services to the prevention of unintended pregnancy nationally.

Teenage Pregnancy in Developed Countries: Determinants and Policy Implications

By Elise F. Jones, Jacqueline Darroch Forrest, Noreen Goldman, Stanley K. Henshaw, Richard Lincoln, Jeannie I. Rosoff, Charles F. Westoff and Deirdre Wulf

Introduction

This article summarizes the results of a comparative study of adolescent pregnancy and childbearing in developed countries, undertaken by The Alan Guttmacher Institute (AGI). The study's main purpose was to gain some insight into the determinants of teenage reproductive behavior, especially factors that might be subject to policy changes.

A 1983 article by Charles F. Westoff, Gérard Calot and Andrew D. Foster reported that although adolescent fertility rates have been declining in the United States, as they have in virtually all the countries of Western and northern Europe, teenage fertility is still considerably higher in the United States than in the great majority of other developed countries.[1] There is a large differential within the United States between the rates of white and black teenagers. However, even if only whites are considered, the rates in the United States are still much higher than those in most of the other countries. The gap between the United States and the other countries is greater among younger adolescents (for whom the great majority of births are out of wedlock and, presumably, unintended) than it is among older teenagers. Abortion rates are also higher among U.S. teenagers than among adolescents in the dozen or so countries for which there are data.[2]

Two major questions were suggested by these comparisons: Why are teenage fertility and abortion rates so much higher in the United States than in other developed countries? And, since most teenage pregnancies in the United States are unintended,[3] and their consequences often adverse,[4] what can be learned from the experience of countries with lower adolescent pregnancy rates that might be useful for reducing the number of teenage conceptions in the United States?

"[U.S.] teenagers . . . have inherited the worst of all possible worlds. . . . Movies, music, radio and TV tell them that sex is romantic, exciting, titillating. . . . Yet, at the same time, young people get the message that good girls should say no."

The AGI study involved two distinct undertakings: quantitative bivariate and multivariate analyses of the factors associated with adolescent fertility in 37 developed countries, and case studies of teenage pregnancy and its antecedents in five selected countries and the United States.

The 37-Country Analysis

The two dependent variables selected for the 37-country* study were cumulative age-specific birthrates for girls under age 18 and those for women 18–19. The rates are explained in the appendix (page 61). Birthrates rather than pregnancy rates were chosen because abortion data were available for only 13 of the 37 countries. However, it was found that abortion rates and birthrates were highly correlated, so that it seeemed reasonable to assume that birthrates are an acceptable proxy for pregnancy rates. Measures for 42 independent variables selected for the quantitative analysis were obtained from published data and from a country-level survey conducted by the AGI designed to supplement inadequately documented areas of information, such as the prevalence of sex education within each country, the availability of contraceptive services for minors and social attitudes that might have a bearing on adolescent sexual activity. The questionnaire was sent to the public affairs officer of the American embassy in each foreign country included in the study, to the embassy of each of these countries in Washington, D.C., and to the family planning organization or other agency responsible for family planning services in each country.

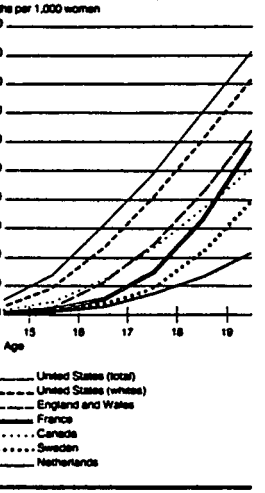
Scatter plots and pairwise relationships between each independent variable and the two dependent variables were examined initially, and on the basis of these results, a multivariate analysis was attempted. Descriptions of the methodology and of the major results of the bivariate analysis are carried in the appendix. The results of the multivariate analysis presented here have to be taken as suggestive rather than conclusive, and they are described only in broad terms.

- The analysis found a positive association between teenage childbearing and the proportion of the labor force employed in agriculture (a variable interpreted as indicating level of socioeconomic development).
- There is a positive relationship between levels of maternity leaves and benefits and the teenage birthrate. (Because the United States does not have a uniform national policy, it was not represented on this variable. In fact, U.S. maternity benefit policies tend to be less liberal than those in most European countries,[5] and, thus, the United States would not have fit this pattern.)
- Analysis of the relationship between fertil-

Elise F. Jones directed the study upon which this article is based while she was a Senior Research Associate at The Alan Guttmacher Institute (AGI). Jacqueline Darroch Forrest is Research Director, Stanley K. Henshaw is Deputy Research Director, Richard Lincoln is Senior Vice President, Jeannie I. Rosoff is President and Deirdre Wulf is Deputy Director of Publications, of the AGI. Noreen Goldman is Research Demographer and Charles F. Westoff is Director, Office of Population Research, Princeton University. The contributions of Lynne Bowser, Karen Fuller, Ellen E. Kisker and Camila Makinson are gratefully acknowledged. The study was supported by the Ford Foundation.

*Australia, Austria, Belgium, Bulgaria, Canada, Chile, Cuba, Czechoslovakia, Denmark, the Federal Republic of Germany, Finland, France, the German Democratic Republic, Great Britain (England and Wales, and, considered separately, Scotland), Greece, Hong Kong, Hungary, Iceland, Israel, Italy, Japan, the Netherlands, New Zealand, Norway, Poland, Portugal, Puerto Rico, Romania, Singapore, Spain, Sweden, Switzerland, Taiwan, the USSR, the United States, and Yugoslavia.

Figure 1. Births per 1,000 women under age 20, by woman's age, case-study countries, 1981



ity and openness about sex (defined on the basis of four items: media presentation of female nudity, the extent of nudity on public beaches, sales of sexually explicit literature and media advertising of condoms) in a given society reveals low birthrates in countries found to exemplify the most liberal views.

- More equitable distribution of income (i.e., a greater proportion of a country's total household income received by the poorest 20 percent of the population) is negatively related to the cumulative birthrate for girls under 18. Of the 19 countries for which this information was available, Canada, the United States and New Zealand have the least equitable distribution of income. Of these three countries, the United States has by far the highest teenage birthrate.
- The birthrate for older teenagers is lower where the minimum age for marriage is higher. (Again, the United States was not represented on this variable because the legal age at marriage varies from state to state, although in most states women can marry on their own consent by age 18.)
- Finally, the rate for older teenagers is also somewhat responsive to government policies to increase fertility.

It is notable that the United States differs from most of the countries with comparably high adolescent fertility on four factors. The position of the United States is anomalous with regard to socioeconomic development, one of the most important factors associated with low teenage fertility. Although it is one of the most highly developed countries examined, the United States has a teenage fertility rate much higher than those observed in countries that are comparably modernized; and the U.S. rates are considerably higher than those found in a number of much less developed countries. The inconsonance applies particularly to fertility among younger teenagers, where the U.S. rate falls between those of Romania and Hungary. The relatively high adolescent birthrate in the United States would also suggest, if the experience of the United States were consistent with that of other countries, that the country has a pronatalist fertility policy, high levels of maternity leaves and benefits and a low minimum age at marriage. In fact, the United States has none of these.

The United States fits the general pattern for high teenage fertility a that it is less open about sexual matters than most countries with low teenage birthrates, and a relatively small proportion of its income is distributed to families on the bottom rungs of the economic ladder.

Had better or more complete information been available, it is likely that at least some of the additional variables found to be associated with adolescent fertility in the bivariate analysis would have retained their importance in the multivariate analysis. Certain of them deserve mention because of their policy significance and because they figure prominently in the individual country case studies that follow, for which more detailed information was available. These include restrictions placed on teenagers' access to contraception, the level of religiosity in the country (both associated with high birthrates) and teaching about contraceptives in the schools (associated with low birthrates). It is noteworthy that government subsidy of abortions is *not* associated with teenage fertility.

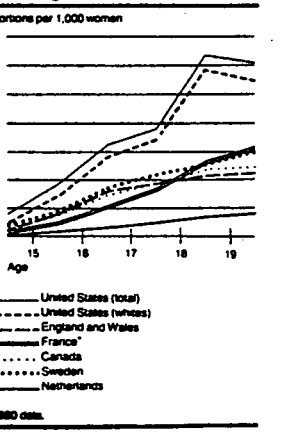
In the 37-country study, the United States does not appear to be more restrictive than low-fertility countries in the provision of contraceptive services to teenagers; however, comparable data could not be obtained on the provision of contraceptives free of charge or at very low cost—a factor that, as we shall see, appears to be very important in terms of accessibility in the country case studies. Teenagers are much less likely to get free or very low-cost contraceptive services in the United States than in the other five countries studied in detail—all of which have much lower adolescent birthrates and abortion rates than the United States. The very high level of religiosity reported for the United States (the highest of any of the 13 countries for which there are data) is probably one factor underlying the low rating of the United States on openness about sex. It is also notable that the United States scores relatively low among the 37 countries on the measures of availability of contraceptive education in the schools.

Country Case Studies

The five countries selected for the case studies in addition to the United States—Canada, England and Wales, France, the Netherlands and Sweden—were chosen on the basis of three considerations: Their rates of adolescent pregnancy are considerably lower than that of the United States, and it was believed that sexual activity among young people is not very different; the countries are similar to the United States in general cultural background and stage of economic development; finally, from the investigators' experience with the first phase of the project, it was apparent that for these countries, some crucial data related to adolescent pregnancy were available.

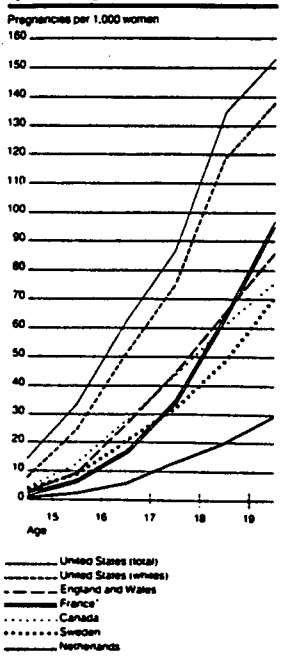
Figures 1, 2 and 3 present, for the United States and each of the five countries, 1981 birthrates, abortion rates and pregnancy rates by single year of age. The exceptional position of the United States is immediately apparent. The U.S. teenage birthrates, as Figure 1 shows, are much higher than those

Figure 2. Abortions per 1,000 women, by woman's age, 1981



*1980 data.

Figure 3. Pregnancy rates per 1,000 women by woman's age, 1981



*1980 data

Note: Pregnancies are defined here as births plus abortions; age is the age at outcome

of each of the five countries at every age, by a considerable margin. The contrast is particularly striking for younger teenagers. In fact, the maximum relative difference in the birthrate between the United States and other countries occurs at ages under 15. With more than five births per 1,000 girls aged 14, the U.S. rate is around four times that of Canada, the only other country with as much as one birth per 1,000 girls of comparable age.

Teenagers from the Netherlands clearly have the lowest birthrate at every age. In 1981, Dutch women aged 19 were about as likely to bear a child as were American women aged 15–16. The birthrates are also very low in Sweden, especially among the youngest teenagers. Canada, England and Wales, and France compose an intermediate group. Birthrates are relatively high for Canadian girls aged 14–16, and rise gradually with age. The French rates are low among women up to age 16, but increase very sharply among older teenagers.

In 1981, as Figure 2 shows, the relative positions of the countries with respect to abortion are surprisingly close to the pattern observed for births. The United States has by far the highest rate, and the Netherlands, very much the lowest, at each age. French teenage abortion rates climb steeply with age,* while the Canadian curve is somewhat flatter. The rate for England and Wales rises relatively little after age 17. The chief difference between the patterns for births and abortions involves Sweden, which has age-specific abortion rates as high as, or higher than, those of any of the other countries except the United States.

The teenage pregnancy rates† necessarily follow the same pattern, as Figure 3 reveals. The U.S. rates are distinctly higher than those of the other five countries; the Dutch rates are clearly lower. The French teenage pregnancy rates appear to be low among teenagers 16 and younger, and after that age, to be high. The reverse is true of Canada.

Thus, the six countries represent a rather varied experience. At one extreme is the United States, which has the highest rates of teenage birth, abortion and pregnancy. At the other stands the Netherlands, with very low levels on all three measures. Canada, France, and England and Wales are quite similar to one another. Sweden is notable for its low adolescent birthrates, although its teenage abortion rates are generally higher than those reported for any country except the United States. It is noteworthy that the United States is the only country where the incidence of teenage pregnancy has been increasing in recent years. The increase reflects a rise in the abortion rate that has not been completely offset by a decline in the birthrate. For both younger and older teenagers, the disparity between the U.S. pregnancy rates and those for other countries increased somewhat between 1976 and 1981.

In the United States, the pregnancy rates among black teenagers are sufficiently higher than those among whites to influence the rates for the total adolescent population, even though in 1980, black teenagers represented only 14 percent of all 15–19-year-olds. Restriction of the international comparisons to pregnancy rates among white U.S. teenagers reduces the difference between the United States and other countries by about one-fifth. However, the pregnancy rate for white U.S. adolescents remains much higher than the rates for the teenage populations in the other countries, as shown in the table in the next column.

Pregnancy rate	15–19	15–17	18–1
U.S. total	96	62	14
U.S. white	83	51	12
England & Wales	45	27	7
France	43	19	7
Canada	44	28	6
Sweden	35	20	5
Netherlands	14	7	2

What is more, some of the other countries studied also have minority populations that appear to have higher-than-average teenage reproductive rates (e.g., Caribbean and Asian women in England), so that it would not be appropriate to compare white U.S. rates with rates for the total adolescent population in those countries.

A common approach was established for the study of the six countries selected for close examination. Detailed information on teenage births and abortions was collected and a systematic effort was made to assemble quantitative data on the proximate determinants of pregnancy—specifically, the proportion of teenagers cohabiting, rates of sexual activity among those not living together and levels of contraceptive practice. In addition, the investigators sought descriptive material on a number of related topics: policies and practices regarding teenage access to contraceptive and abortion services, the delivery of those services, and the formal and informal provision of sex education. Several aspects of teenage life were explored to try to enhance understanding of certain social and economic considerations that might influence the desire to bear children and contraceptive practice. These include the proportions of young people in school, employment and unemployment patterns, the move away from the family home, and government assistance programs for young people and, particularly, for young unmarried mothers.

Teams of two investigators each visited Canada, England, France, the Netherlands and Sweden for one week and conducted interviews with government officials, statisticians, demographers and other researchers and family planning, abortion and adolescent health service providers. These interviews provided the opportunity to discuss attitudes and other less tangible factors that might not otherwise have been possible to document and helped the investigators to identify other sources of data.

The five countries that were visited and the United States have much in common. All

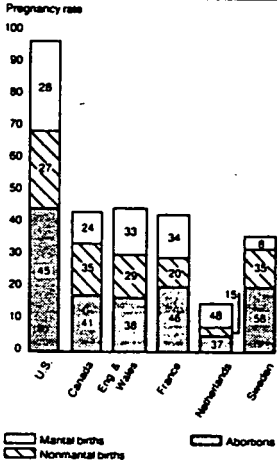
*The relatively low rates among younger teenagers may be due to underreporting at these ages in France.

†Calculated as the sum of births and abortions experienced by women of a given age divided by the midyear estimate of the female population of that age.

are highly developed nations, sharing the benefits and problems of industrialized modern societies. All belong essentially to the cultural tradition of northwestern Europe. All have reached an advanced stage in the process of demographic transition. Life expectancy is over 70 years for men and women of all the countries. Finally, all have fertility levels below that required for replacement. Yet, as Figure 3 demonstrates, teenage pregnancy rates in the six countries are quite diverse. However, the consistency of the six countries' positions in Figures 1 and 2 points to an immediate and important conclusion: The reason that adolescent birthrates are lower in the five other countries than they are in the United States is not more frequent resort to abortion in those countries. Where the birthrate is lower, the abortion rate also tends to be lower. Thus, the explanation of intercountry differences can focus on the determinants of pregnancy as the antecedent of both births and abortions.

• *The desire for pregnancy.* Are the differences in adolescent birthrates due to the fact that in some countries, higher proportions of young women choose to become pregnant? The number of marital births per 1,000 teenagers is higher in the United States than in any other of the countries studied, and the proportion of teenagers who are married is at least twice as high in the United States as in the other countries (not shown). Data on teenagers' pregnancy intentions are available only for the United States. In 1980, 78 percent of marital teenage pregnancies and only nine percent of nonmarital teenage pregnancies were intended. On the assumption that all pregnancies ending in abortions are unintended, and that a large majority of nonmarital births are the result of unintended pregnancies (except in Sweden, where nonmarital childbearing has traditionally been free of social stigma), the distribution of pregnancy outcomes illustrated in Figure 4 sheds some light on the contribution of unintended pregnancy to the differences among the six countries. The combined fraction of all pregnancies accounted for by abortions and nonmarital births is approximately three-quarters in the United States and Canada, close to two-thirds in England and Wales and France, and only about one-half in the Netherlands. Thus, in England and Wales, France and the Netherlands, unintended pregnancy appears to constitute a smaller part of adolescent pregnancy than it does in the United States. Even more striking is the fact that the abortion rate alone in the United States is about as high as, or higher than, the overall teenage pregnancy rate in any of the other countries.

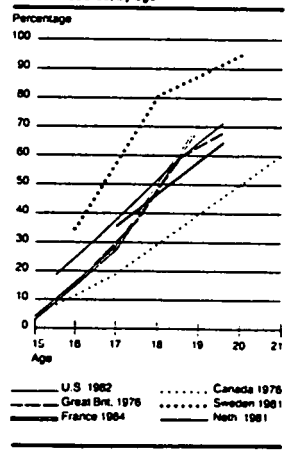
Figure 4. Percentage distribution of pregnancies, and pregnancy rates, by outcome,* for women aged 15–19, 1980/1981



*The rates can be estimated by measuring the height of the bars against the vertical axis. The numbers inside the bars represent the percentage distributions

• *Exposure to the risk of pregnancy.* Figure 5 illustrates some recent findings on levels of sexual activity (defined here as the proportion who have ever had intercourse) among teenagers in the six countries. The data should be interpreted cautiously, however, as there are numerous problems of comparability and quality. (Two potentially important aspects of sexual activity among adolescents—the number of sexual partners and frequency of intercourse—could not be examined because data on them were not available for most countries.) The most striking observation from the figure is that the differences in sexual activity among teenagers in the six countries do not appear to be nearly as great as the differences in pregnancy rates. Sexual activity is initiated considerably earlier in Sweden than elsewhere. By age 18, around one-third of all Swedish girls have had intercourse, and by age 18, four-fifths have done so. In Canada, by comparison, women may have had their first sexual experience later than the average for all six countries. At ages 16–17, only one out of five girls are sexually active. Smaller proportions of women are reported as having initiated sexual intercourse before the age of 18 in both Great Britain (England, Wales and Scotland) and France than in the United States. However, a rapid catch-up seems to take place, and in France the proportion of young women who have had intercourse by the time they are 19 appears to be higher than that found in the United States. The median age at first intercourse is very similar for the United States, France, Great Britain and the Netherlands—something under age 18—and is about a year younger in Sweden, and may be about a year higher in Canada.

Figure 5. Percentage of women ever having had intercourse, by age



These data indicate that the variation in adolescent pregnancy rates shown in Figure 3 cannot, by and large, be explained by differences in levels of sexual experience. The examples of the Netherlands and Sweden make it clear that the postponement of first intercourse is not a prerequisite for the avoidance of early pregnancy. It does seem possible that reduced sexual exposure among younger Canadian teenagers is partly responsible for keeping their pregnancy rates relatively low. The difference in pregnancy rates between the Netherlands and Sweden may also be partly attributable to the older age at sexual initiation in the Netherlands.

• *Contraceptive use.* The data on contraceptive practice, represented schematically in Figure 6, were, likewise, derived from surveys that differed widely in their design and approach to the issue.[b] Nevertheless, it is possible to make some estimates of proportions using any contraceptive method, and proportions using the pill, at various ages.

Contraceptive use among French teenagers is probably underestimated because condom use was not included in the published results of the survey. It is likely, therefore, that the United States has the lowest level of contraceptive practice among teenagers of all six countries.

In particular, pill use appears to be less widespread among U.S. teenagers than among those in the other countries. This difference suggests that American adolescents use less effective contraceptives to avoid accidental pregnancy, even if they are using a birth control method.

• *Access to contraceptive and abortion services.* Contraceptive services appear to be most accessible to teenagers in England and Wales, the Netherlands and Sweden. In England and Wales and the Netherlands, those seeking care may choose to go either to a general practitioner (limited to their own family doctor in the Netherlands) or to one of a reasonably dense network of clinics. The Dutch clinic system is less extensive than the British one, but it is directed largely toward meeting the special needs of youth, whereas in England and Wales, there are relatively few clinics specially designed for young people. In Sweden, there are two parallel clinic systems, one consisting of the primary health care centers that serve every community, and the other consisting of a less complete network providing contraceptive care and related services to the school-age population.

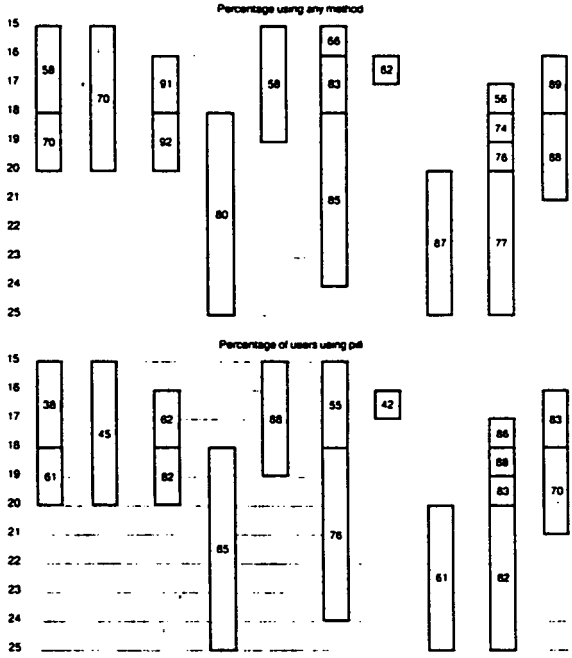
Canada, France and the United States also have clinic systems, but these appear to be less accessible than those found in the other countries. (In France, however, the clinic system has expanded considerably since 1981.) The Canadian clinic system is uneven, with fairly complete coverage for adolescents in Ontario and Quebec, and scattered services elsewhere. The U.S. clinic network is reasonably accessible in a strictly geographic sense. Moreover, all family planning clinics receiving federal funds are required to serve adolescents. A basic drawback of the U.S. clinic system, however, is that it was developed as a service for the poor, and is often avoided by teenagers who consider clinics places where only welfare clients go.[7]

Condoms are widely available in England and Wales, the Netherlands and Sweden. They not only are available from family planning clinics and pharmacies, but also are sold in supermarkets and other shops and in vending machines. In France and in many parts of Canada and the United States, condoms are less freely available.

Confidentiality was found to be an important issue in every country. Even where attitudes about sex are very open, as in the Netherlands and Sweden, the research teams were told that young people wish to keep their personal sex lives private. The need for confidential services is probably best met in Sweden, where doctors are specifically forbidden to inform parents about an adolescent's request for contraceptive services. Dutch doctors also are required to keep the visit confidential if the teenager requests it; and the services in Dutch clinics are entirely confidential. French official policy stipulates that clinic services for women under age 18 be absolutely confidential. Although the prescription of contraceptives to girls younger than 16 without a requirement that the parents be informed is now being legally contested in Britain, the practice was

Figure 6. Percentage of sexually experienced women using any contraceptive method and, among users, percentage using the pill, by age and marital status of woman and occasion of contraceptive use

Age	United States		Great Brit.	France*		Canada	Sweden		Netherlands	
	1976	1979	1976	1979	1980	1976	1978†	1981	1979/1980	1981
	NM‡	NM‡	NM‡	T‡	T‡	T‡	T‡	T‡	T‡	NM‡
	Used at last coitus	Used at last coitus	Use currently	Use regularly	Use regularly	Use currently	Used at last coitus	Used in last 4 wks	Used in last 6 mos	Used at last coitus



*Students only; condom use excluded. †Students in one city. ‡T = all women; NM = never-married women.

Notes: The data should be interpreted cautiously because of problems in their comparability and quality. As an example of how to read this figure, the data for Canada indicate that among all sexually active women, 66 percent of 15-year-olds, 83 percent of 16–17-year-olds and 85 percent of 18–23-year-olds were using some method in 1976.

followed through the period covered by this study, and the British government is seeking to preserve confidentiality for young teenagers. In Canada and the United States, many individual doctors insist on parental consent before they will provide contraceptives to minors. However, most family planning clinics in Canada and the United States provide services to young women without any such restriction.

Like all medical care, contraceptive services, including supplies, are provided free of charge to young people in England and Wales and Sweden. Free services and supplies are available from clinics to French women under age 18; and for older teenagers, most of these expenses are reimbursable under social security. Contraceptive services provided by Dutch family doctors are covered under the national health insurance scheme, but the clinics charge a small fee. Until very recently, no charge was made to have a prescription filled at a pharmacy. In Canada, doctors' services are likewise covered by national medical insurance, and clinic services are free; but all patients except those on welfare have to pay for supplies obtained from pharmacies. The potential expense of obtaining contraceptive services in the United States varies considerably. Indigent teenagers from eligible families are able to get free care through Medicaid, and others do not have to pay anything because of individual clinic policy; otherwise, clinic fees are likely to be modest. On the other hand, consulting a private doctor usually entails appreciable expense, as does purchase of supplies at pharmacies.

An additional observation concerns the central role of the pill everywhere outside the United States. In each country, the research teams were told that the medical profession accepts the pill as a highly appropriate, usually *the most* appropriate, method for adolescents. Moreover, a pelvic examination is not necessarily required before the pill can be prescribed in some of these countries. The emphasis on pill use emerged more clearly from the interviews than from the incomplete statistics on contraceptive use summarized in Figure 6. By contrast, in the United States, there seems to be a good deal of ambivalence about pill use, both on the part of the medical profession and among potential young users. In the United States, medical protocol requires that a pelvic examination be performed before the pill can be prescribed, a procedure some young people find daunting.[3] Whether justified or not, this requirement undoubtedly influences method selection among young women.

Postcoital contraceptive pills have been available at many family planning clinics in the United Kingdom for a number of years. Postcoital IUD insertion and oral contraceptives are available in the clinics run by both the Dutch and the French family planning associations. However, it is unlikely that these methods are sufficiently widely utilized to influence the birthrate appreciably. In Sweden, the morning-after pill is not yet permitted for general use. The federal Food and Drug Administration has not approved postcoital use of pills in the United States, and no plan exists to market them, but they are available in some college health clinics and rape treatment centers.

Geographically, abortion services are most easily accessible in the Netherlands and Sweden. Although services are theoretically in place throughout England and Wales and France, wide differences in the abortion rates by area are believed to be attributable to variation in the availability of abortion facilities. In all three countries, as in Canada and the United States, services are likely to be found in cities. In Canada, England and Wales, and France, abortions typically involve at least an overnight hospital stay.

In Sweden, there is no charge for abortion; Canadian women usually pay only a small portion of the cost; and abortions obtained under the national health service in Britain are also free. However, because of bureaucratic delays in the national health service, almost half of British women choose to pay for an abortion in the private sector. In the Netherlands, the cost of an abortion is borne by the patient but is not high. The same was true in France up until 1982, when the service became free. Most U.S. women must pay for the abortion procedure themselves. For a second-trimester abortion, in particular, the cost may be substantial.

• *Sex education.* Sweden has the distinction of being the first country in the world to have established an official sex education curriculum in its schools. The curriculum, which is compulsory and extends to all grade levels, gives special attention to contraception and the discussion of human and sexual relationships. Perhaps most important, there is a close, carefully established link in Sweden between the schools and contraceptive clinic services for adolescents. None of the other countries comes close to the Swedish model. Sweden established this link in 1975, following liberalization of the abortion law, because of concern that liberalized abortion access might otherwise result in a sharp rise in teenage abortion rates. In fact, adolescent abortion rates have declined dramatically since 1975, whereas the rates for adults have not changed much. (In the other countries studied, teenage abortion rates have not fallen during this period.) The Swedish authorities credit the combination of sex education with the adolescent clinic program for the decline.

In Canada, England and Wales, and the United States, school sex education is a community option, and it is essentially up to the local authorities, school principals or individual teachers to determine how much is taught and at what age. In England and Wales, however, there is a national policy favoring the inclusion of topics related to sex and family life in the curriculum, whereas there is no such national policy in Canada and the United States. French policy now mandates broad coverage of sexuality for all adolescents, although in practice, interpretation of this provision similarly devolves on local decision-makers.

The Netherlands is a case apart. Coverage of sex in the school curriculum is limited on the whole to the facts of reproduction in natural science classes. The Dutch government, nevertheless, encourages the teaching of contraception indirectly by subsidizing mobile educational teams that operate under the auspices of the private family planning association. At the same time, in recent years there has been an explosion of materials on contraception and other sex-related topics in the media, much of which is of a responsible and informative nature. Youth surveys show that knowledge of how to avoid pregnancy appears to be virtually universal.

In Sweden, sex education is completely accepted by the vast majority of parents, most of whom themselves had sex education while they were in school. Objections are confined to the immigrant community, for some of whom sex education represents a direct challenge to their own traditions. British law requires schools offering sex education to notify the parents. In the United States, many of the school districts that provide sex education give parents the option of excusing their children from such courses.

The Wider Context

Consideration was given to a number of other social, economic and political factors that appear to be related to the phenomenon of adolescent pregnancy. The investigators who visited the four European countries were struck by the fact that in those countries, the government, as the main provider of preventive and basic health services, perceives its responsibility in the area of adolescent pregnancy to be the provision of contraceptive services to sexually active teenagers. This commitment to action and the enunciation of an unambiguous social policy appear to be associated with a positive public climate surrounding the issue. Teenage childbearing is viewed, in general, to be undesirable, and broad agreement exists that teenagers re-

quire help in avoiding pregnancies and births.

Another aspect of government involvement in and commitment to contraceptive services for teenagers has to do with the rationale for such programs. In France, the Netherlands and Sweden, the decision to develop such services was strongly linked to the desire to minimize abortions among young people. In France and the Netherlands, for example, conservative medical groups had shown some reluctance to endorse the provision of contraceptives to young, unmarried women. Apparently, the alternative of rising abortion rates among teenagers helped to persuade them that such services were justified. In Sweden, the connection was made explicit by the government, and the 1973 law that liberalized abortion also laid the groundwork for the development of contraceptive services for young people, with the specific understanding that prevention of the need for abortion could best be achieved by putting safe, effective, confidential services within the reach of all teenagers. In the United States, in contrast, some powerful public figures reflect the view that the availability of contraceptive services acts as an incitement to premarital sexual activity and claim, therefore, that such services actually cause an increase in abortions.

The use of contraceptive services is obviously made simpler in the European countries, as in Canada, by the fact that medical services of all kinds are easily accessible through national health programs, and teenagers, in particular, grow up accustomed to using public health facilities or to visiting their local general practitioner as a matter of course. This combination of ease of accessibility and familiarity with the health care system probably serves to remove many of the social, psychological and financial barriers to contraceptive services experienced by young people in the United States.

There seems to be more tolerance of teenage sexual activity in the European countries visited than there is in most of the United States and in parts of Canada. Such acceptance of adolescent sexuality is unremarkable in a country like Sweden, with its long history of support for sexual freedom, and the absence there of taboos against premarital sex. However, such acceptance represents a considerable break with traditional standards in the Netherlands, France and, in Canada, Quebec. One reason for the more successful experience of the European countries may be that public attention was generally not directly focused on the morality of early sexual activity but, rather, was directed at a search for solutions to prevent increased teenage pregnancy and childbearing.

In the United States, sex tends to be treated as a special topic, and there is much ambivalence: Sex is romantic but also sinful and dirty; it is flaunted but also something to be hidden. This is less true in several European countries, where matter-of-fact attitudes seem to be more prevalent. Again, Sweden is the outstanding example, but the contrast with the United States was evident in most of the countries visited. Survey results tend to bear out this impression, although the questions asked are not directly comparable from country to country. For instance, in 1981, 76 percent of Dutch adults agreed with the statement that "sex is natural—even outside marriage," whereas in 1978, only 39 percent of Americans thought premarital sex was "not wrong at all."[9] These observations tend to confirm the findings of the 37-country study, which found that openness about sex may be an especially important factor in lowering adolescent fertility.

While the association between sexual conservatism and religiosity is not automatic, in the case of the United States the relationship appears to be relatively close. The proportion of the population who attend religious services and feel that God is important in their lives is higher in the United States than in the other case-study countries.[10] Although England and Wales and Sweden have an established church, both countries are more secular in outlook than the United States. Moreover, in the Netherlands, France and Quebec Province, increasing secularization is believed to be an important aspect of recent broad social changes. Fundamentalist groups in America are prominent and highly vocal. Such groups often hold extremely conservative views on sexual behavior, of a sort rarely encountered in most of Western Europe. Both the nature and the intensity of religious feeling in the United States serve to inject an emotional quality into public debate dealing with adolescent sexual behavior that seems to be generally lacking in the other countries. It is notable that religiosity was found to correlate highly with adolescent fertility in the 37-country study, although the number of country observations was small.

Although all six countries included in the survey are parliamentary democracies, the nature of each country's political institutions differs, and there is considerable variation in the way in which public issues are developed and public policies formulated. The U.S. political system appears to foster divisiveness and confrontation at many levels of society, while these elements seem less salient a part of political life in the other countries. In addition, the United States is distinguished by the widespread use of private funds to mount political campaigns and create myriad pressure groups. While the American confrontational style may have its political uses, it makes the resolution of certain emotionally charged issues hard to achieve. Positions tend to become polarized, and the possibilities for creative compromise are narrowed. The most interesting country to contrast with the United States, in terms of political style, is probably the Netherlands. It has strong and diverse religious and political groups, but a complex range of formal and informal conventions exists to defuse and resolve ideological conflicts before these emerge into the open. As a result, through accommodation and negotiation, the Dutch administrations of all political tendencies have, in the past 15 years or so, been able to make birth control services available to teenagers without exacerbating divisions in the society.

Directly related to this issue is the fact that with the exception of Canada, the United States is a much larger country than any of the others, in terms of both its geographic and its population size. In smaller, more compact countries, where lines of communication are more direct, it is easier than in the United States to engage in a national debate that includes all the appropriate parties to the discussion. For example, in the early 1960s, debate within the Dutch medical community over the advisability of prescribing the pill to teenagers quickly resulted in a broad consensus. A similar process would be much harder to implement in the United States. As a result, informing concerned professionals about the terms of a debate may be as hard as keeping the general population up to date on any issue.

Another closely related facet of national life is the extent to which political and administrative power is concentrated in the national government. France is often cited as the epitome of a centralized state, and even the existence of two "nations" within England and Wales is a simple arrangement compared with the federal systems of Canada and the United States. Both countries have two-tiered government structures, with some powers delegated to the central government and some reserved to the provinces or states. This structure has two main consequences: First, major differences can develop within the country in policy-making. Second, the task of giving shape to social change, in terms of public policies and programs, becomes enormously complicated because of the many bureaucracies that must be dealt with and the sometimes indeterminate boundaries of their separate jurisdictions.

Many observers from different backgrounds have suggested that early teenage childbearing in the United States is a response to social anomie and to a sense of

hopelessness about the future on the part of large numbers of young people growing up in poverty. In the course of the country visits, the investigators collected information on teenage education and employment patterns, in order to explore further the possible association between career and life opportunities for young people and their attitudes toward reproductive planning. The finding was that educational opportunities in the United States appear to be as great as, or greater than, those in other countries, except, possibly, Sweden. In Sweden, about 85 percent of young people aged 18–19 are pursuing academic or vocational schooling. In Canada and France, most young people leave school at around 18, as they do in the United States, although a higher proportion of U.S. students go on to college. However, in the Netherlands, only about half of girls are still in school at age 18, while in England and Wales, the majority of young people end their full-time schooling at age 16.

The employment situation is difficult to compare or assess, since definitions of labor-force participation and unemployment differ from country to country. The most that can be concluded is that unemployment among the young is considered a very serious problem everywhere, and young people themselves are universally uneasy on this score. The chances of getting and keeping a satisfying or well-paying job do not appear to be worse in the United States than in other countries. To a greater extent than in the United States, however, all the other countries offer assistance to ease the problem, in the form of youth training, unemployment benefits and other kinds of support.

It is often suggested that in the United States, the availability of public assistance for unmarried mothers creates a financial incentive for poor women, especially the young, to bear children outside of marriage. Yet, all the countries studied provide extensive benefits to poor mothers that usually include medical care, food supplements, housing and family allowances. In most cases, the overall level of support appears to be more generous than that provided under the Aid to Families with Dependent Children program in the United States. Benefits in the other countries tend to be available regardless of women's marital or reproductive status, although in England and Wales and in France, at least, special supplementary benefit programs for poor single mothers also exist. In those countries, however, the existence of considerable financial support for out-of-wedlock childbearing does not appear to stimulate adolescent birthrates or explain the differences between their rates and the U.S. rates.

The final difference between the United States and the other countries that may be relevant to teenage pregnancy concerns the overall extent and nature of poverty. Poverty to the degree that exists in the United States is essentially unknown in Europe. Regardless of which way the political winds are blowing, Western European governments are committed to the philosophy of the welfare state. The Dutch and the Swedes have been especially successful in achieving reasonably egalitarian societies, but even in England and Wales and France, the contrast between those who are better off and those who are less well off is not so great as it is in the United States. In every country, when respondents were pressed to describe the kind of young woman who would be most likely to bear a child, the answer was the same: adolescents who have been deprived, emotionally as well as economically, and who unrealistically seek gratification and fulfillment in a child of their own. Such explanations are also given in the United States, but they tend to apply to a much larger proportion of people growing up in a culture of poverty. No data are available that would have made it possible to examine adolescent pregnancy in terms of teenagers' family income. However, as noted earlier, the 37-country study found that more equitable distribution of household income is associated with lower teenage fertility—at least among the younger teenagers.

Policy Implications

The 37-country study and the individual country studies provide convincing evidence that many widely held beliefs about teenage pregnancy cannot explain the large differences in adolescent pregnancy rates found between the United States and other developed countries: Teenagers in these other countries apparently are *not* too immature to use contraceptives consistently and effectively; the level and availability of welfare services does *not* seem correlated with higher adolescent fertility; teenage pregnancy rates are *lower* in countries where there is *greater* availability of contraceptive services and of sex education; levels of adolescent sexual activity in the United States are not very different from those in countries with much *lower* teenage pregnancy rates; although the teenage pregnancy rate of American blacks is much higher than that of whites, this difference does not explain the gap between the pregnancy rates in the United States and the other countries; teenage unemployment appears to be at least as serious a problem in all the countries studied as it is in the United States; and American teenagers have more, or at least as much, schooling as those in most of the countries studied.

The other case-study countries have more extensive public health and welfare benefit systems, and they do not have so extensive and economically deprived an underclass as does the United States.

Clearly, then, it *is* possible to achieve lower teenage pregnancy rates even in the presence of high rates of sexual activity, and a number of countries have done so. Although no single factor has been found to be responsible for the differences in adolescent pregnancy rates between the United States and the other five countries, is there anything to be learned from these countries' experience that can be applied to improve the situation in the United States?

A number of factors that have been discussed here, of course, are not easily transferable, or are not exportable at all, to the United States: Each of the other five case-study countries is considerably smaller, and all but Canada are more compact than the United States—making rapid dissemination of innovations easier; their populations are less heterogeneous ethnically (though not so homogenous as is commonly assumed—most have substantial minority nonwhite populations, usually with higher-than-average fertility); religion, and the influence of conservative religious bodies, is less pervasive in the other countries than it is in the United States; their governments tend to be more centralized; the provision of wide-ranging social and welfare benefits is firmly established, whether the country is led by parties labeled conservative or liberal; income distribution is less unequal than it is in the United States; and constituencies that oppose contraception, sex education and legal abortion are not so powerful or well funded as they are in the United States.

Some factors associated with low pregnancy rates that *are*, at least theoretically, transferable receive varying levels of emphasis in each country. For example, school sex education appears to be a much more important factor in Sweden than it is in the other countries; a high level of exposure to contraceptive information and sex-related topics through the media is prominent in the Netherlands; condoms are more widely available in England, the Netherlands and Sweden. Access to the pill by teenagers is probably easiest in the Netherlands.

On the other hand, although initiation of sexual activity may begin slightly earlier in the United States than in the other countries (except for Sweden), none of the others have developed official programs designed to discourage teenagers from having sexual relations—a program intervention that is now advocated and subsidized by the U.S. government. The other countries have tended to

leave such matters to parents and churches or to teenagers' informed judgments.

By and large, of all the countries studied, Sweden has been the most active in developing programs and policies to reduce teenage pregnancy. These efforts include universal education in sexuality and contraception; development of special clinics—closely associated with the schools—where young people receive contraceptive services and counseling; free, widely available and confidential contraceptive and abortion services; widespread advertising of contraceptives in all media; frank treatment of sex; and availability of condoms from a variety of sources. It is notable that Sweden has *lower* teenage pregnancy rates than have all of the countries examined, except for the Netherlands, although teenagers begin intercourse at earlier ages in Sweden. It is also noteworthy that Sweden is the only one of the countries observed to have shown a rapid decline in teenage abortion rates in recent years, even after its abortion law was liberalized.

The study findings point to several approaches observed in countries other than Sweden that also might help reduce teenage pregnancy rates in the United States. These include upgrading the family planning clinic system to provide free or low-cost contraceptive services to *all* teenagers who want them, and publicizing the fact that these services are not limited to the poor; establishment of special adolescent clinics, including clinics associated with schools, to provide confidential contraceptive services as part of general health care; encouraging local school districts to provide comprehensive sex education programs, where possible, closely integrated with family planning clinic services; relaxation of restrictions on distribution and advertising of nonprescription contraceptives, especially the condom; dissemination of more realistic information about the health benefits, as well as the health risks, of the pill; and approval of the use of postcoital methods.

In sum, increasing the legitimacy and availability of contraception and sex education (in its broadest sense) is likely to result in declining teenage pregnancy rates. That has been the experience of many countries of Western Europe, and there is no reason to think that such an approach would not also be successful in the United States.

Admittedly, application of any of the program and policy measures that appear to have been effective in other countries is more difficult in the United States nationally, where government authority is far more diffused. But their application may, in fact, be as easy or easier in some states and communities. Efforts need to be directed not just to the federal executive branch of government, but to Congress, the courts, state legislatures, local authorities and school superintendents and principals—as well as to families and such private-sector and charitable enterprises as insurance companies, broadcast and publishing executives, church groups and youth-serving agencies.

Among the most striking of the observations common to the four European countries included in the six-country study is the degree to which the governments of those countries, whatever their political persuasion, have demonstrated the clear-cut will to reduce levels of teenage pregnancy. Pregnancy, rather than adolescent sexual activity itself, is identified as the major problem. Through a number of routes, with varying emphasis on types of effort, the governments of those countries have made a concerted, public effort to help sexually active young people to avoid unintended pregnancy and childbearing. In the United States, in contrast, there has been no well-defined expression of political will. Political and religious leaders, particularly, appear divided over what their primary mission should be: the eradication or discouragement of sexual activity among young unmarried people, or the reduction of teenage pregnancy through promotion of contraceptive use.

American teenagers seem to have inherited the worst of all possible worlds regarding their exposure to messages about sex: Movies, music, radio and TV tell them that sex is romantic, exciting, titillating; premarital sex and cohabitation are visible ways of life among the adults they see and hear about; their own parents or their parents' friends are likely to be divorced or separated but involved in sexual relationships. Yet, at the same time, young people get the message good girls should say no. Almost nothing that they see or hear about sex informs them about contraception or the importance of avoiding pregnancy. For example, they are more likely to hear about abortions than about contraception on the daily TV soap opera. Such messages lead to an ambivalence about sex that stifles communication and exposes young people to increased risk of pregnancy, out-of-wedlock births and abortions.

Appendix

Two criteria were applied in defining "developed" countries for the statistical analysis in the 37-country study: a total fertility rate of less than 3.5 children per woman, and a per capita income level of over $2,000 a year. A population size boundary of at least one million was also imposed. Three of the 40 countries that qualified for inclusion—Argentina, Trinidad and Tobago, and Uruguay—were dropped from the analysis because they had no recent data on teenage fertility. Cuba was included despite the fact that no per capita income data were available. Where possible, England and Wales were treated as a separate country from Scotland. It should be stressed that the final group of 37 countries constitute a universe rather than a sample, so that statistical inferences based on sampling theory cannot be made from the findings.

Initially, eight dependent variables* involving teenage birthrates and pregnancy rates were selected for consideration, allowing for the varying coverage and precision of the data. Since the correlation coefficients† among these eight variables suggested that the relationship between birthrates and pregnancy rates was quite close—and pregnancy rates were available for fewer than two-fifths of the countries—cumulative birthrates for girls under 18 and for women 18–19 were finally chosen as dependent variables. These were formed by summing the single-year age-specific birthrates across each of the two age spans.

Almost 100 independent variables were initially considered for inclusion in the 37-country study. However, high-quality data for sufficient numbers of countries were not always available, making it necessary to reduce the final number to 42.

A few caveats about the quality of the data used in the bivariate analysis are also in order. It is not possible to tell whether a low correlation indicates the absence of a relationship or is due to shortcomings in the data. In many instances, the measures available are only rough approximations of the concept they were intended to represent, and even though a number of other potential variables were excluded because the data were not comparable from country to country, more subtle forms of noncomparability no doubt remain. In addition, the variables derived from the AGI country survey must be regarded as subject to a considerable margin of error, since they represent informed observation rather than quantitative fact.

It was decided to exclude from the multivariate analysis variables for which 18 or fewer country observations were available and those having a correlation coefficient of less than 0.3 with both dependent variables.

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*These were the birthrate for women aged 15–19, cumulative birthrates for women under 20, for women less than 18, and for women 18–19; the pregnancy rate for women aged 15–19 and cumulative pregnancy rates for women 15–19, for women under 20, for women less than 18 and for women 18–19.

†The calculation was made only for the countries for which data on adolescent abortion rates were available: Canada, Czechoslovakia, Denmark, England and Wales, Finland, France, Hungary, the Netherlands, New Zealand, Norway, Scotland, Sweden and the United States.

Appendix Table 1. Zero-order correlations between the independent variables and the cumulative birthrates for women under age 18 and women aged 18–19

Variable	Cumulative birthrate: Women < 18	Cumulative birthrate: Women 18–19	N
Marriage			
Proportion of females married at ages 15–19	0.83	0.84	37
Minimum age for marriage without parental consent	−0.33	−0.39	24
Childbearing			
Five-year total fertility rate for ages ≥20	0.06	0.13	37
Policy to raise fertility	0.25	0.38	35
Liberal policy on maternity leaves and benefits	0.45	0.58	28
Proportion of gov't expenditure on income maintenance and family allowances	−0.19	0.09	17
Paternal financial support (O)	0.07	0.21	31
Contraception			
Proportion of all currently married using the pill	−0.18	−0.17	20
Proportion of all currently married using condoms	−0.83	−0.58	13
Policy to provide contraceptives for young, unmarried women (O)	−0.46	−0.44	36
Favorable policy on teaching contraception (O)	−0.21	−0.08	37
Proportion of female students taught about contraception (O)	−0.31	−0.17	36
Age at which contraception is taught (O)	0.12	0.17	28
Abortion			
Abortions per women 15–44*	0.67	0.77	24
Parental consent for abortion not required (O)	0.01	−0.04	33
Public funding of abortions (O)	0.05	0.26	29
Sex			
Open about sex (O)	−0.50	−0.51	37
Minimum age for consensual intercourse† (O)	0.30	0.24	34
Proportion of female students in coeducational schools (O)	−0.00	0.04	36
Health			
Population per physician	0.12	0.05	34
Maternal mortality	0.43	0.51	35
Per capita gov't expenditure on health care	−0.13	−0.11	19
Education			
Proportion of secondary-school-age females attending school	−0.13	−0.27	31
Proportion of females 15–19 attending school	−0.20	−0.12	14
Per capita gov't expenditure on education	−0.44	−0.38	18
Social integration			
Total marital divorce rate	−0.26	−0.27	19
Mortality rate from liver cirrhosis	0.34	0.35	34
Incidence of suicide at ages 15–24	−0.17	−0.15	30
Proportion foreign-born	−0.35	−0.28	19
General social conditions			
Log of population density	−0.18	−0.13	35
Proportion in cities with populations ≥500,000	−0.12	−0.32	34
Proportion of labor force in agriculture	0.60	0.66	34
Religiosity	0.66	0.67	13
Employment			
Labor-force participation rate for females 15–19	0.28	0.11	15
Labor-force participation rate for males 15–19	0.11	0.02	15
Proportion of labor force female	0.22	0.39	33
Labor-force participation rate for females 25–44	0.35	0.42	18
Overall unemployment rate†	0.15	0.16	27
General economic conditions			
Gross national product per capita	−0.51	−0.61	33
Average annual growth in gross domestic product	−0.16	−0.11	28
Proportion of total household income distributed to top 10% of population	0.08	0.09	14
Proportion of total household income distributed to bottom 20% of population	−0.41	−0.14	19

*Excluding Japan †Excluding Puerto Rico Note: O=comes from the AQI country questionnaire.

Appendix Table 1 shows the correlations between the two dependent and 42 independent variables. The latter are grouped under headings intended to indicate in a general way the nature of their possible link to adolescent fertility. The variables associated with low adolescent birthrates (ranked according to degree of correlation) are GNP per capita; openness about sex; a government policy to provide contraceptives to young, unmarried women; a high proportion of household income distributed to the bottom 20 percent of the population; a high proportion of the population foreign-born (the last two for younger teenagers only); a high minimum age at marriage without parental consent; a high percentage of women taught about contraception in the schools (for younger teenagers only); and a high percentage of the population living in large cities (for older teenagers only).

Associated with high teenage birthrates are a high percentage of the labor force engaged in agriculture, a generous policy of maternity leaves and benefits, high levels of maternal mortality; a government policy to raise fertility; a high proportion of the labor force composed of women (the last two for older teens only); a high rate of mortality from liver cirrhosis—a proxy for alcoholism; and a high minimum age for consensual intercourse (for younger teenagers only).

Two variables with high correlation coefficients and for which 19 or more country observations were available were not used for the multivariate analysis because of their special status as intermediate variables closely correlated with birthrates. These were the proportion of females married at ages 15–19 and the abortion rate for women aged 15–44.

High correlation coefficients were obtained for the variables proportion of married women whose partner used condoms (negative) and the level of religiosity in the country (positive), but too few countries had this information to meet the requirement for inclusion in the multivariate analysis.

The multivariate analysis was based primarily on ordinary least-squares regression. The approach taken was determined by the need to minimize the problems associated with very small sample size and the substantial amount of missing data. First, step-wise procedures were used to identify the three independent variables having the greatest impact on each dependent variable, and then the remaining independent variables were added one at a time to assess how much variation each of them could explain over and above that accounted for by the initial three. A brief discussion of the results of the multivariate analysis can be found in the text (see pages 53–54).

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PREPARED STATEMENT OF REVEREND MICHAEL J. FAULKNER

INTRODUCTION

Honorable members of the Congress of the United States, distinguished panelists, and friends, I would like to begin by thanking the members of the Joint Economic Subcommittee on Education and Health for inviting me to address you today on what is one of the most important issues facing our nation today.

I was raised in a middle-class family in Washington D.C. not far from here. Growing up, I was never told by an adult authority figure that sexual activity was inappropriate or unwise. I was not urged to exercise caution, except to use prophylactic protection. My values in the area of sexuality were shaped early on by my peers and by my exposure to pornography. I became sexually active by the age of thirteen and extremely active, with multiple partners, by the age of fifteen. While I am not proud of making this statement, I do feel the need to share this information as background so that you will know that my own personal journey leave me even more convinced and convicted of the ideals that I espouse today.

I would like to begin my discussion today by defining the debate as I see it. After sufficiently defining the debate, I will discuss several philosophical areas in which this debate and related questions can be addressed in the most responsible manner. Finally, I will conclude with examples of successful programs in the areas mentioned.

DISCUSSION OF ISSUES

I do not see the debate over unwanted teenage pregnancies as one over the use, misuse, or distribution of contraceptives or barrier devices. I see this debate focusing on the essential elements of our moral concern for the dignity and value of each human being. Contraceptives and contraceptive devices are not evil in and of themselves. I am not here to debate the question of whether or not young people are engaging in premarital sexual activity. As an educator and a minister who works primarily with young people, I can assure you that our young people are indeed having sex more frequently than ever before seen in our nation's history. The debate is not over whether or not to tell young people about contraceptives or their appropriateness in the educational setting. Rather, the focus should center on how this information is communicated, when, and by whom.

The Problem:

The impact of teen sexual activity is having a profound and detrimental effect on our nation's health care systems, our economy, and on the community structure in general. The most devastating effect of the teenage sexuality crisis is not the fact that young people are contracting sexually transmitted diseases in epidemic proportions. The worst thing is not the fact that over one million teenage girls will get pregnant this year (and those numbers are continuing to rise). The most detrimental effect is not that young people are in an extremely high risk category for the transmission of the HIV virus. The most detrimental fact about the teen sexuality crisis is that we as adults have failed to define these issues in the proper context for them. By that I mean that sex and all its wonder and beauty is only wonderful and beautiful when it is shared in the context of the mutually committed monogamous long-term relationship we know as marriage. Premarital sex becomes cheap and the immediate thrills pale by comparison to the sustained feelings of joy and euphoria that result from a healthy sexual relationship enjoyed within a marriage. Young people, however, are not hearing this message. They are not being told the truth concerning sexuality or how their sexuality can best be utilized for the maximum pleasure and enjoyment. Instead, this debate, and most of the information that we feed to young people has focused on technology.

The Technological Approach:

The debate has been centered on the technology that it will take to eliminate what some would call all the detrimental effects of early premarital sexual activity. When

young people say that they are afraid of contracting the HIV virus, we say "Use a condom." When young women tell us that they are afraid of becoming pregnant, we say, "Use a contraceptive." But when young people say that they are afraid of engaging in sexual activity with people they love today and who are gone tomorrow, there is no technological device we can give them. I know from personal experience and from counseling teenagers that some of the most detrimental effects or fallout of early teen sexual involvement are the emotional scars that result when they are torn apart and their partners move on to greener grass. Yet we have not addressed this issue, nor can we as long as the debate is framed around reducing what we would consider the most detrimental effects of this crisis.

FAULTY RATIONALE:

There are three reasons that we have engaged in a high-tech instead of a high-touch philosophy:

1) We opted for control economics as opposed to responsible education and behavior and moral expectations. That is, our overall concern for the quality of life has diminished, particularly when dealing with young people of color. We recognize the crisis in these communities is an extension of the failure that began with the generation before them. We find ourselves coming back to stopgap measures as opposed to long-term solutions.

2) The second reason that we find ourselves defining the problem from a technological approach is that we do not believe in young people anymore. We do not believe that they can control their sexual desires and urges for the most appropriate opportunity to express that most wonderful of all human emotions. Our lack of faith in these young people is demonstrated by the fact that relatively few programs which use the "A" word as the cornerstone for its educational program have been supported on the federal, state, and local level. The "A" word, of course, is abstinence, which has become in the minds of many, profane and outdated. One New York City official called me Neanderthal for talking to young people about abstinence. Our lack of faith over the past several years has resulted in a growing epidemic much like a runaway train.

3) This epidemic is fueled not just by the fire of technological approaches, or by the fire of our lack of faith in young people's ability to control themselves. This problem is fueled also when we adults refuse to give up our sexual vices. Consequently, we lack the resolve and moral commitment to tell young people what is best in controlling this problem. A society without moral guidelines for sexual relationships is not a society at all, but a group of people poised for anarchy and destruction. For without moral guidelines, there are no families. Without families, there is no community. Without community, there is no structure upon which to hinge any training or building for the future.

SOLUTIONS:

In order to solve these problems or properly address them, we must have a vision for the future. We need to be willing to set standards for young people and for the expected behavior that we have of them. These standards do not have to be set by any particular religious code or dogma, but by what we know as educators and health professionals as the most appropriate behavior for them. I am sure that my distinguished panel would all agree with me in saying that abstaining from sexual activity is the wisest choice that a young person can make. If that is the wisest choice, then why aren't we using abstinence as the cornerstone for all of our educational programs and emphases today? Instead, we have raised the condom to a new level of expectations.

Condoms?:

What we found about the condom thirty years ago is still true today. The condom, even with noxynol-9, is not a very effective mode of birth control because, for a number of reasons, it cannot totally prevent the transmission of semen during sexual intercourse. Nevertheless, I have heard said by high-ranking New York City officials

and others that abstinence is not realistic when dealing with young people and, therefore, is not worth discussing. Their antidote is to make condoms and condom usage more effective. With these prescribed remedies, however, we can never hope to win or solve the problem.

Contraceptives?:

I am not opposed to the discussion of contraceptives with young people. However, it is imperative that messages of such a sensitive nature not be done in a mixed group. Call me old-fashioned, but I believe that young men and young ladies ought to be separated when talking about intimate sexual matters. I am not opposed to this information being targeted at senior high school students because they are at a stage in their lives when they can handle it, and when they need to hear this information. We would go a long way to helping them in building their self-esteem if we separated them and did not have the uncomfortable situation of young men and young ladies sitting together while contraceptive devices and information are being passed around the room. The giggling and the comments make education in that setting a virtual impossibility.

(I will share an antidote here from my own personal experience.)

Illustrations:

Finally, let me cite a great example of a program that is on the right track, and which we need to support. You may be aware of the Emory University study of one thousand sixteen-year-old girls from low-income families in the Atlanta area. These young people, all of whom had been sexually active and using the health clinic, were given a list of twenty options of sex education materials they would most like to receive. Eighty-four percent said they wanted to learn how to say no to sex without offending their friends or partners. This is a message from the group that is most at risk, the most abused, and the most talked-about group in our discussion. When we talk about the teen sexuality crisis, although we know in our minds that this crisis extends beyond racial and socioeconomic barriers, our primary concern really is for those who will not be able to support the children or pay for pregnancy terminations: abortions.

We are talking about the poor who were born poor and who will bring into this earth more poor babies. We need to support these young people before they become parents by giving them a feeling of hope, self-esteem, and accomplishment. We can do this by setting the standards and giving them the resources and support to meet those standards, not simply the technology that we think is necessary to help them avoid the pitfalls of early sexual involvement. If a young lady gives birth out of wedlock before graduating high school, what are her chances for completing a college degree? We all know that statistics tell us she has virtually no chance. And yet, we continue to pump more dollars into technology rather than into the programs that have a proven track record for the outcomes desired.

The success of this type of self-help program can be paralleled with programs right here in Washington D.C. such as the Kenilworth community management model. Many people said that poor people in inner cities do not want self-help or self-ownership, that they do not want to be empowered, and that they want the government to take care of them. That message, of course, was ludicrous and racist, to say the least, for we see that the residents of the Kenilworth housing community have not only taken ownership of their community, but are a shining example of what people, any people, will do if given the opportunity. Our young people, particularly the poor and of color, are dying for an opportunity to prove to themselves and to others that they can exercise self-control.

CONCLUSIONS:

In order to stem the tide of the economic, health, and social devastation caused by teen pregnancies, members of this esteemed committee, I urge you to support programs such as the Title XX programs that promote abstinence-based sex education

materials. I urge you to support educators who have dedicated their lives to sharing the truth that young people can and will abstain. I urge you to invest in the future. Young people who use a condom thinking that it is an birth control device will inevitably, if they are fertile, become pregnant, impregnate someone, or contract a sexually transmitted disease. The statistics clearly tell us this. We need to invest in the most positive outcome for our future. We need to give young people a choice. Pushing a condom or other contraceptives in their faces and demonstrating how to use does not give them much of a choice at all.

Many people would argue with me and say, "Just because we show them how to use a condom does not mean they are going to have sex." No, it does not mean that they are going to have sex, but it does mean that when that question comes up, they are going to think that having sex with a condom is as good as not having sex at all. It is not. Sex is wonderful, sex is beautiful, and sex is meant to be enjoyed for marriage.

Thank you very much for allowing me to share these comments.